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Senate Ad Hoc Committee on Caregiver Wages and Workforce Development

Final Report

December 2002

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LEGISLATIVE STUDY COMMITTEE REPORTS

FINAL REPORT

SENATE AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

December 2002

Membership

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandenbosch

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SENATE AD HOC COMMITTEE ON

CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

SECTION 1. INTRODUCTION

Executive Summary

The Senate Ad Hoc Caregiver Wages and Workforce Development Committee (Committee) was established in July 2001 by the President of the Senate. The purpose of the Committee is to define critical policy concerns and emerging issues regarding long-term care and caregiving, and develop cost-effective strategies to promote and encourage caregiver workforce development that support and strengthen family and informal caregiving as a key component of long-term care.

Changing "Aging" Population

The Committee recognized that Arizona has a caregiver crisis. The number of Arizonans over 65 years old is increasing more rapidly than any other age group, from 13% in 2000 to an anticipated 17% in 2010. By the year 2030, over 21% of our population will be over 65. Those 85 and older may increase anywhere from 94% to 200% by the year 2010. At least 55% of those 85 and older will likely live in the Greater Phoenix area.

Caregiver Shortage

While demographics and costs will increase, the pool of paid and unpaid caregivers will likely shrink, due in part to families living further apart and more two-wage earner families. Arizona's paid caregiver workforce is unlikely to keep up with the expanding need because capped, inelastic and under-funded government payment systems limit providers' competitiveness in a tight labor market. The Arizona Health Care Cost Containment System (AHCCCS)/Medicaid system pays - on average - about $100 per patient-day for 70% of the 14,000 residents in Arizona's nursing homes. These funds are expected to cover room, board, three meals a day, some therapies, overhead, social activities, linens, mortgage and caregiver salaries, among other things.

To conduct further research and propose recommendations, the Committee divided into two workgroups: (1) Funding, Reimbursement and Collaboration; and (2) Recruitment, Education and Regulation.

I. Workgroup on Funding, Reimbursement and Collaboration (Workgroup FRC) found that staffing shortages within Arizona's long-term care (LTC) providers affect the cost, quality, and availability of care. Their report focuses on four primary issues: registries (temporary staffing pools), health insurance, reimbursement rate setting and new funding sources.

Effects of Registries

The Workgroup FRC discovered that the effects of registries include rising costs and a smaller pool of full-time caregivers available for permanent employment. Arizona's nursing homes have turned to registries for certified nurses assistants (CNAs) due to the shortage of caregivers. These agencies often have a ready supply of nursing assistants, partly because their employee compensation is not limited by AHCCCS rate setting

parameters. The higher costs for utilizing temporary care workers from registries are currently not reflected in AHCCCS' reimbursement rates for Arizona Long Term Care System (ALTCS) nursing facilities. Seventy-five percent of the 143 nursing facilities currently licensed in Arizona report paying nearly $23 million in FY 2001 for registry care workers.

Additionally, nursing assistants working in all types of health care settings are the least likely group of health care workers to have insurance. Health insurance provides significant benefits for caregivers and their families.

Reimbursement Rates

Another concern is that Arizona ranks 33rd in the nation for average Medicaid reimbursement rates. Appropriate reimbursement rates for nursing facilities and home and community based services are related to the Arizona Department of Health Services (ADHS) and AHCCCS collection of relevant nursing facility data to include direct care costs (nursing salaries/wages/benefits), capital costs and indirect care.

Workgroup FRC realizes the current state budget shortfalls results in existing funding sources stretching to cover workforce costs; however new funding sources would help to provide additional support for increased caregiver wages and workforce development.

II. The Workgroup on Recruitment, Education and Regulation's (Workgroup RER) research indicates that each agency, ADHS, AHCCCS, Area Agency on Aging, and DES, has similar but different standards for caregiver training, education, and oversight. Development and implementation of universal standards and practices may contribute toward a stable, qualified workforce, a higher quality of care and an overall reduction of costs. The Workgroup RER's recommendation is that through existing inter-agency workgroups and/or task forces, these issues be addressed and solutions be implemented consistently statewide within the next 12 months, thus avoiding the need for new legislation. Workgroup RER focused on three areas: education/training, recruitment/retention and accreditation/regulation.

Training Curriculum Needed

Workgroup RER found that the caregiving curriculum is fragmented, and minimal training hours do not prepare the worker for safe practice. There is no comprehensive, integrated core curriculum that can be delivered in multiple settings, serving as the base for a career pathway. Not all employers comply with existing mandated training and there is inconsistent oversight of training delivery compliance.

Additionally, the average age of a caregiver today is 44. According to the *Results of the 2002 National Survey of State Initiatives on Long-Term Care Direct Care Workforce*, approximately 90% of the caregiver workforce are women. More than 20% of long-term care workers do not have a high school education. Direct care positions also disproportionately employ women of color: one-third are African-American and

approximately 15% are either Hispanic or other workers of color. Competition between other service industries that recruit for entry-level positions further reduces the caregiver workforce.

Standardization of Definition of Caregivers Needed

Finally Workgroup RER found that multiple agencies (ADHS, DES, and AHCCCS and private service providers) "certify" caregivers using different criteria. Likewise, job titles with equal certification criteria are different. There are no common criteria across continuum of background, drug, or security information requirements. Additionally, requirements to report inappropriate or unprofessional conduct of a caregiver are different.

The work of the Committee evolved around the elderly and disabled population; however, the Committee finds that the recommendations are equally equitable to other areas of caregivers such as mental health, child care, and child welfare agencies. State agencies are encouraged to evaluate the recommendations and implement or adopt the recommendations as appropriate.

Guiding Principles

1. There is potential for growth and development at all stages of life.
2. Consumers should remain as independent and live at home as long as possible.
3. Those who give and receive care deserve respect, dignity and opportunities to exercise choice and control in daily life.
4. Appropriate, timely, effective service based on the needs of the consumer require an integrated, coordinated and comprehensive service delivery system.
5. The contributions of informal caregivers are irreplaceable and cannot be taken for granted.
6. Consistency and continuity is important for the consumer.

Objectives

1. Formulate policies that support and sustain informal caregiving.
2. Build and enhance partnerships and alliances.
3. Promote consumer participation in continuous constructive system improvement.
4. Promote public education so that each individual can be responsible for making informed long-term life-planning decisions.
5. Promote environments where loneliness, helplessness and boredom are replaced by meaningful companionship, empowerment and variety.
6. Promote shared accountability and communications across systems and levels of government for improved outcomes.
7. Standardize primary and continuing education, job titles and certification.
8. Require safe and adequate working conditions.
9. Professionalize and promote a career path for long term health care workers.
10. Coordinate funding mechanisms to maximize resources.
11. Standardize data collection and equitable rate formulae and methodologies.

FINAL RECOMMENDATIONS

I. Introduce legislation creating a Taskforce to implement the recommendations of the Senate Ad Hoc Caregiver Wages and Workforce Development Committee.

Section 1. Caregiver Wages and Workforce Development Taskforce

A. The caregiver wages and workforce development taskforce is established consisting of the following members:

1. Two members of the house of representatives who are members of different political parties and who are appointed by the speaker of the house of representatives. The speaker of the house of representatives shall designate one of the members as cochairperson of the taskforce.
2. Two members of the senate who are members of different political parties and who are appointed by the president of the senate. The president of the senate shall designate one of the members as cochairperson of the task force.
3. One member who represents a retired persons' community organization and who is appointed by the governor.
4. One member who represents a community college district and who is appointed by the governor.
5. One member who represents a senior living organization and who is appointed by the governor.
6. One member who represents a statewide association of residential providers for the elderly and who is appointed by the governor.
7. One member who represents an independent living organization and who is appointed by the governor.
8. One member who represents a faith-based organization and who is appointed by the governor.
9. One member of the public and who is appointed by the governor.
10. The director of the department of economic security or the director's designee.
11. The director of Arizona health care cost containment system or the director's designee.

B. The task force shall:

1. Be guided by the following principles and objectives:
   - (a) There is a potential for growth and development at all stages of life.
   - (b) Consumers should remain independent and live at home as long as possible.
   - (c) Those who give and receive care deserve respect, dignity and opportunities to exercise choice and control in daily life.
   - (d) Appropriate, timely, effective service based on the needs of the consumer require an integrated, coordinated and comprehensive service delivery system.
   - (e) The contributions of informal caregivers are irreplaceable and cannot be taken for granted.
   - (f) Consistency and continuity is important for the consumer.
   - (g) Formulate policies that support and sustain informal caregiving.
   - (h) Build and enhance partnerships and alliances.

(i) Promote consumer participation in continuous constructive system improvement.
(j) Promote public education so that each individual can be responsible for making informed long-term life-planning decisions.
(k) Promote environments where loneliness, helplessness and boredom are replaced by meaningful companionship, empowerment and variety.
(l) Promote shared accountability and communications across systems and levels of government for improved outcomes.
(m) Standardize primary and continuing education, job titles and certification.
(n) Require safe and adequate working conditions.
(o) Professionalize and promote a career path for long term health care workers.
(p) Coordinate funding mechanisms to maximize resources.
(q) Standardize data collection and equitable rate formulae and methodologies.

2. Continue the efforts of the senate ad hoc caregiver wages and workforce development committee and implement the recommendations set forth in its December, 2002 report, as follows:
   (a) Make recommendations to create standardization and mutual recognition across caregiver continuum for credentials, titles, scope of practice and limitations.
   (b) Make recommendations to require a collaborative process of comprehensive data collection for Arizona health care cost containment system to set reimbursement rates for Arizona long-term care system residents. Require Arizona health care cost containment system use current and accurate data and use equitable formulas and methodologies agreed to by all of the major stakeholders.
   (c) Make recommendations to develop a model pay and benefit structure for public and private agencies who hire caregivers based on levels of care, market wages, and training and education requirements.
   (d) Make recommendations to create and fund a standardized statewide database for providers who receive state funding to check training/credentialing, background, drug screening and fingerprinting information of paid caregiver applicants.
   (e) Make recommendations to create a seven-member task force to further identify funding problems and recommend solutions.

C. Task force members are not eligible for compensation or for reimbursement of expenses.

D. On or before November 15 of each year, the task force shall submit a written proposal for implementing the senate ad hoc caregiver wages and workforce development recommendations and any additional findings and recommendations to the governor, the speaker of the house of representatives and the president of the senate and shall provide a copy of this proposal to the secretary of the state and the director of the Arizona state library, archives and public records.

Sec. 2. Delayed repeal
This act is repealed from and after December 31, 2005.

II. Create standardization and mutual recognition across caregiver continuum:

- **Credential requirements.**
- **Title protection.**
- **Scope of practice including limitations.**

a) Standardize job titles and duties so that minimal competencies and educational requirements are consistent and provide for a career ladder. Require agencies to use these titles and duties.

b) Determine the content of a core curriculum for each job title, including interpersonal and life skills. Establish hours needed and institute standardized testing to be completed at end of training. Place new trainees into GED/ESL programs, if desired or needed.

c) Incorporate caregiver training/curriculum at the high school level, including basic life skills related to attitude, appearance, personal health and work ethic.

d) Require an annual assessment of skills, continued competency and professional development needs for all workers. All ongoing training shall be monitored, and consequences shall be applied for noncompliance.

e) Provide training in coaching and mentoring for those who directly supervise caregivers and encourage training for consumers of caregivers.

III. Require a collaborative process of comprehensive data collection for AHCCCS to set reimbursement rates for ALTCS residents. Require AHCCCS to use current and accurate data and use equitable formulas and methodologies agreed to by all of the major stakeholders.

a) Require AHCCCS to meet with a collaborative workgroup(s) comprised of NF and HCBS stakeholder representatives to coordinate the timing for data gathering, develop data collection tools, calculation methodologies and participation incentives (e.g. coordinated surveys, coordinated or joint announcements).

b) Require AHCCCS to set ALTCS reimbursement rates at levels sufficient for the care provider to comply with the FLSA.

c) Require AHCCCS and ADHS to use a single uniform cost report.

d) Require AHCCCS, ADHS, nursing facilities, HCBS providers, and program contractors to achieve shared agreements on reporting requirements for future AHCCCS rate setting efforts.

e) Require AHCCCS to recover the nursing facilities uncollectible share of cost amounts owed by ALTCS enrollees as an allowable reconciling item in the annual share of cost reconciliation process. AHCCCS will require Program Contractors to reconcile uncollectible share of cost amounts with each nursing facility in the annual share of cost reconciliation process.

f) *Require* AHCCCS to recover unused residen~~tial~~ personal needs funds when ALTCS residents are deceased, and to use such funds to establish financial incentives to promote higher quality care.

g) Require AHCCCS to use current available program contractor administration funds more efficiently.

IV. Develop a model pay and benefit structure for public and private agencies who hire caregivers based on levels of care, market wages, and training and education requirements.

a) Require state agencies to provide in their contracts with private entities direct care services, including home health services and supportive care services, and comply with the federal Fair Labor Standards Act (FLSA).

b) Require on-going training on OSHA requirements, personal safety, and the use and maintenance of equipment.

c) Encourage state agency collaboration to seek grant funding and incentive monies to develop programs to provide financial, health, transportation, and childcare support for the caregiver worker population.

d) Establish a cap on temporary workers' wages at 150 percent of the prevailing wage.

e) Require the Attorney General's Office to research the legality of banning the non-compete clause for temporary health care workers.

f) Develop methods for caregiver recognition for exceptional services.

g) Explore, educate and collaborate to find new funding to improve compensation for the regular staff and expand the number of people coming into the profession.

h) Instruct the Statewide Healthcare Insurance Task Force, to explore whether a "group pool" for health insurance would allow AHCCCS participating facilities to offer health insurance to employees at more affordable rates.

i) Develop a government supported health plan for caregivers without other means for health benefits.

j) Solicit federal Temporary Assistance for Needy Families (TANF) funding to improve CNA retention and to increase the number of LPNs and RNs available to work in long-term care.

V. Create and fund a standardized State database for providers who receive state funding to check training/credential, background, drug screening and fingerprinting information on paid caregiver applicants.

a) Provide state agencies with oversight authority over training program certification.

b) Identify the appropriate agency to develop and maintain the database with collaboration by State agencies.

c) Provide training and informational materials from Adult Protective Services on an ongoing basis.

d) Coordinate federal legislation with state statutes or administrative rules to minimize or eliminate duplicative, overlapping or conflicting requirements in the covered areas such as background check, drug screening and fingerprinting information.

VI. Create a seven-member task force to further identify funding problems and recommend solutions.

a) Require a collaborative study to include stakeholders and a disinterested third party (e.g. an Arizona university or another research institution or private foundation) on NF and HCBS capacity, closures and the economic, social and health implications of NF and HCBS closures.

b) Develop strategies to educate the general public as to the value of direct caregivers and implement a workforce recruitment and retention plan. For example, designate a week annually recognizing the direct caregiver.

c) Continue to develop programs assisting persons to care for their own family member, including a livable wage, health benefits, respite, retirement plan, training and support.

d) Invite Arizona's universities and other members of the research community in collaboration with LTC providers, program contractors, registries, and nursing professionals in LTC to conduct research on registries.

e) Explore innovative recruiting opportunities for older workers, international workers, and other potential workers.

f) Establish staffing guidelines based upon measurable quality outcomes.

g) Fund programs that empower consumers to be less reliant on caregivers by offering Independent Living Skills Training, Peer Mentoring and Home Modifications.

MEMBERS:

Four members of the Senate, not more than two from the same political party and one designated as Chair, and eight members of the public, appointed by the President of the Senate.

Senator Virginia Yrun, Chair
District 13 – D

Senator Edward Cirillo
District 15 - R

Senator Susan Gerard
District 18 – R

Senator Ruth Solomon
District 14 - D

Bonnie Danowski
Arizona Interfaith Network

Gwen Dean
Arizona Bridge for Independent Living

George Good
Rural Metro Fire District

Mary Lou Hanley
DES Division of Aging & Community Services.

Patricia Harris
Maricopa County Community Colleges

Guy Mikkelsen
Foundation for Senior Living

Ritch Steven
AARP

Gene van den Bosch
AZ Association of Homes and Housing for the Aging

Special thanks to Essential Readers:

Dick White
Arizona Interfaith Network

Mary Temm
Temm & Associates, Inc.

Denise Pederson
Cochise Health Systems

Art Evans, Ph.D
Arizona Interfaith Network

William Arnold, Ph.D
Director of Gerontology Program
Arizona State University

Timothy Schmaltz
Center for Spirituality and Ministry in the Marketplace

Marguerite Harmon, CEO
Catholic Community Services of Southern Arizona

AUTHORITY AND PURPOSE:

The Committee was created by the President of the Senate in July 2001, to define critical policy concerns and emerging issues regarding long-term care and caregiving, and develop cost effective strategies to promote and encourage caregiver workforce development that supports and strengthens family and informal caregiving as a key component of long-term care.

REPORTING REQUIREMENT:

The Committee shall submit a written report of its recommendations to the President of the Senate, and provide a copy of its report to the Secretary of State and the Director of the Arizona State Library, Archives and Public Records by December 15, 2002.

SENATE AD HOC COMMITTEE ON

CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

SECTION 2. COMMITTEE ACTIVITIES

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

SENATE AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: Wednesday, August 29, 2001

Time: 10 a.m.

Place: Senate Hearing Room 3

AGENDA

1. Welcome and Introductions
2. Review Committee Purpose Statement
3. Arizona Demographics and Trends

   - Department of Economic Security Presentation
4. Discussion of Information Needed
5. Schedule Next Meeting
6. Adjourn

Members:

Senator Virginia Yrun, Chair
Senator Susan Gerard
→ Bonnie Danowski
George Good
Patricia Harris
Rich Stevens
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandebosch

Persons with a disability may request a reasonable accommodation such as a sign language interpreter, by contacting the Senate Secretary's Office: (602)542-4231 (voice). Requests should be made as early as possible to allow time to arrange the accommodation.

BG/cd
08/20/01

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: Tuesday, September 18, 2001

Time: 2 p.m.

Place: Senate Hearing Room 1

AGENDA

1. Call to Order
2. Support for Family Caregivers Initiative
3. Federal Funding Sources
4. Call to the Public
5. Adjourn

Members:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandebosch

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BG/cd 09/17/01

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: **Tuesday, October 23, 2001**

Time: **10 a.m.**

Place: **Senate Hearing Room 1**

AGENDA

1. Call to Order
2. Tim Schmaltz - Presentation on Washington Conference
3. Other States' Responses and Pilot Projects in Arizona
4. Discuss Strategies
5. Call to the Public
6. Adjourn

Members:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandebosch

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BG/cd 10/16/01

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: Wednesday, November 7, 2001

Time: 10 a.m.

Place: Senate Appropriations Room 109

AGENDA

1. Call to Order

2. Presentations and Discussion Regarding Regulations & Opportunities for Change:
   - Department of Health Services
   - Department of Economic Security
   - Board of Nursing

3. Funding Mechanism Presentation by AHCCCS

4. Presentations on the Gap between Actual Costs and Reimbursement Rates:
   - Developmental Disabilities providers
   - Senior Living providers
   - Child Care providers

5. Next Steps

6. Call to the Public

7. Adjourn

Members:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandebosch

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BG/cd 11/01/01

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: Monday, November 19, 2001

Time: 10 a.m.

Place: Senate Second Floor Caucus Room

AGENDA

2. Call to Order
3. Providers' Presentations on the Gap between Actual Costs and Reimbursement Rates
4. AHCCCS Follow-up
5. Next Steps
6. Call to the Public
7. Adjourn

Members:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandenbosch

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BG/nd 11/15/01

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: Thursday, December 6, 2001

Time: 10 a.m.

Place: Senate Hearing Room 1

AGENDA

1. Call to Order
2. Arizona Health Care Cost Containment System (AHCCCS) Follow-up
3. Presentations on Innovative Programs
4. Next Steps
5. Call to the Public
6. Adjourn

Members:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandenbosch

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BG/cd 11/27/01

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC STUDY COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

DATE: **Thursday, February 7, 2002**

TIME: **9:00 a.m.**

PLACE: Senate Appropriations Room 109

AGENDA

1. Call to Order

2. Reports from Workgroups
   a. Reimbursement, collaboration and funding
   b. Recruitment, training, retention and regulation

3. 2002 legislative proposals

4. Public testimony

5. Adjourn

MEMBERS

Senator Virginia Yrun, Cochair
Senator Edward J. Cirillo
Senator Sue Gerard
Senator Ruth Solomon
Bonnie Danowski
Gwen Dean
George Good
Mary Lou Hanley
Patricia Harris
Guy Mikkelsen
Ritch Steven
Gene Vandebosch

BG/mh
1/18/02

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ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: Friday, March 22, 2002

Time: 1:00 P.M.

Place: Senate First Floor Caucus Room

AGENDA

1. Call to Order

2. Presentation on the CARE Program - Catherine Garner, Dean, University of Phoenix

3. Reports from Workgroups:

   a) Recruitment, Education & Regulation - Patricia Harris

   b) Funding, Reimbursement & Collaboration - Gene Vandenbosch

4. Call to the Public

5. Adjourn

Members:

Senator Virginia Yrun, Cochair
Senator Edward J. Cirillo
Senator Sue Gerard
Senator Ruth Solomon
Bonnie Danowski
Gwen Dean
George Good
Mary Lou Hanley
Patricia Harris
Guy Mikkelsen
Ritch Steven
Gene Vandebosch

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BG/tam 03/05/02

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: Friday, May 24, 2002

Time: 1:00 p.m.

Place: Senate Hearing Room 1

AGENDA

1. Call to Order
2. Reports from Workgroups:
   a. Recruitment, Education and Regulation – Patricia Harris
   b. Funding, Reimbursement and Collaboration – Gene Vandenbosch
3. Discussion on Guiding Principles
4. Discussion on Matrix
5. Call to the Public
6. Adjourn

Members:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandenbosch

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BG/cd 05/09/02

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: Tuesday, August 20, 2002

Time: 10 a.m. to 12 noon

Place: Senate Hearing Room 1

AGENDA

1. Call to Order
2. Distribution of the Draft Committee Report
3. Collection of Essential Readers
4. Formation of Implementation Workgroup
5. Next Steps
6. Call to the Public
7. Adjourn

Members:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandenbosch

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TL/cd 08/13/02

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Date: Tuesday, November 12, 2002

Time: 11:00 a.m.

Place: Senate Hearing Room 1

AGENDA

7. Call to Order
8. Approval of Minutes
9. Discussion of Executive Summary
10. Vote on Final Recommendations
11. Call to the Public
12. Adjourn to 1st Floor Caucus Room for Reception

Members:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandenbosch

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TL/nd 11/05/02

ARIZONA STATE LEGISLATURE

SENATE AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Wednesday, August 29, 2001
10:00 a.m. Senate Hearing Room 1

Members Present:
Senator Virginia Yrun, Chair
Senator Edward Cirillo
Senator Ruth Solomon
Bonnie Danowski
George Good
Mary Lou Hanley
Patricia Harris
Guy Mikkelsen
Rich Stevens
Gene Vandebosch

Members Excused:
Senator Susan Gerard

Members Absent:
Gwen Dean

Staff:
Barbara Guenther, Senate Research Analyst

Tape 1, Side A

Chair Yrun called the meeting to order at 10:03 a.m. and attendance was noted. For additional attendees, see Sign-In Sheet (*Attachment A.)

WELCOME AND INTRODUCTIONS

Senator Yrun asked the members of the Committee to make their own introductions and make brief statements regarding their backgrounds and key concerns.

REVIEW COMMITTEE PURPOSE STATEMENT

Senator Yrun distributed a handout entitled "Senate Ad hoc Committee On Caregiver Wages and Workforce Development, Purpose Statement" (*Attachment B). She read from the handout.

ARIZONA DEMOGRAPHICS AND TRENDS – Department of Economic Security

Presentation Dan Anderson, Research Administrator, Department of Economic Security (DES), distributed a handout entitled "Arizona Population by Age" (*Attachment C). His testimony came directly from the handout.

Senator Cirillo commented another reason for the growing senior population is due to better health care delivery systems and opined that number may increase to an even larger percentage.

Mr. Steven stated that the increase in the elderly population would increase the demand for chronic care. He stated this need will be met in a more independent delivery system, rather than an institutional delivery system, which will place a greater demand on the need for high quality caregivers in a variety of settings.

Senator Yrun requested Mr. Anderson to research the distinction of gender in the 60-85 and older age brackets. Mr. Anderson noted that he would provide the Members that data.

Mr. Good asked if it would be possible to estimate the number of caregivers that will be required to care for our aging population, with the increased estimated data available. Mr. Anderson replied that data is not currently being collected.

Senator Yrun asked Barbara Guenther, Senate Research Analyst, if statistical information is available regarding the optimal staffing pattern. Ms. Guenther noted that there are several different articles that estimate the number of caregivers that will be needed. She commented that she would provide this information to the Members.

Senator Cirillo commented that it is dangerous to extrapolate demographic data over a long period of time when there are so many variables. He listed, for example, the development of new medications that would change the staffing needs.

Patricia Harris asked if the data that Ms. Guenther had included caregivers who perform services that include preparing meals to administering medication. Ms. Guenther commented that she would put together a packet that will delineate the source and data with their conclusions within a ten-year period.

Senator Cirillo asked if non-paid voluntary caregivers, such as wives, mothers, and daughters are included in Ms. Guenther's data. Ms. Guenther remarked that data is available and would be included in the packets she would provide.

Ms. Danowski remarked that there are 426,000 family caregivers in the state. She stated the toll that this takes on these people is incredible, as they provide care 24 hours per day, seven days a week.

DISCUSSION OF INFORMATION NEEDED

Senator Yrun asked the members to supply suggestions regarding the kind of information that will need to be studied over the next several meetings, specifically related to policy

concerns, emerging issues relating to long-term care, cost effective strategies for meeting those needs, and workforce development issues, which include the informal caregiver network.

The following are suggestions of data the members would like to have presented:

- demographic data from the Healthcare Committee
- caregiver salary demographics with comparison to other professions
- nursing shortage and its impact
- community college classes and the number of graduates
- quality of life and care issues
- changing trends in nursing homes, assisted living, and home community based care
- turf issues regarding policy and direction
- turnover rates
- training needed for caregivers
- the number of caregivers, their salaries and what benefit packages are available
- the number of certified nursing assistants, homemakers, and food service workers, with their salaries.
- the effect regulation has with regard to professional issues and institutional issues.

Senator Yrun commented that additional suggestions could be sent to Ms. Guenther.

Monsignor Edward J. Ryle, Director, Arizona Catholic Conference, testified that he would provide further research to Ms. Guenther. He noted that another issue that is developing in the field of aging services is accreditation as a tool to be used by providers to improve the quality of the services that are rendered.

Timothy Schmaltz, Director of Policy and Program Development, Foundation for Senior Living, stated that caregiver workforce special conditions exist in rural areas. Additionally, he requested that the Committee consider the impact of other state agencies contracting methods on setting wages in an artificial way. He noted that he would shortly be attending a direct care conference in Washington, D.C. and stated that he would provide data he collects from this event to the Committee.

Bev Hermon, Arizona Association Providers for People with Developmental Disabilities, commented that she would have liked to see someone from the developmental disabilities field on the Committee and commented that she would be providing the Committee with data for consideration.

Anne McNamara, Project Manager, Colleagues in Caring, testified other data that the Committee might find useful is that of parish and faith-based nursing statistics and noted that additional data should be forthcoming in the form of a nursing workforce information survey of all RNs and LPNs in the state.

Peggy Mullan, President/Chief Executive Officer (CEO), Beatitudes Camps of Care, testified that it is her hope that the Committee take a systemic look at this situation and

noted that the effect of temporary workers in the caregiver workforce should be evaluated as well.

Mary Lynn Kasunic, Executive Director, Area Agency on Aging, testified of her concern of the shortage of home-care agencies that are willing to provide services in the patients' homes. She urged the Committee to investigate the "real" cost to provide these services to individuals in their homes.

Bob Rosenberg, Managing Trustee, Advance Allied Foundation, testified that aging and long term care are separate issues and noted his concern that this be evaluated fully. He remarked that the hours that families volunteer to take care of family members saves the taxpayers of the state approximately $3.25 billion per year. He commented that the study that this statistic was quoted from would be provided to the Committee. Mr. Rosenberg also noted that 65% of family caregivers predecease their care recipient, per the National Family Caregivers Association.

Tape 1, Side B

Judy Clirin, R.N., Owner and CEO, Catalina In-home Services, testified that her organization has been providing nursing coordinated personal care and support services in the Tucson community for twenty years. She opined that developing a statewide curriculum for training a universal worker who would then be able to choose what area of work they wanted to go into, would address some of the problems that currently exist in this industry. Additionally, for each area of work, there could be an established opportunity for career ladders.

SCHEDULE NEXT MEETING

Senator Yrun proposed that the Committee mark off a series of dates for future meetings in order to have the necessary time to obtain and evaluate data and develop the final report. She recommended the meetings begin at 10:00 a.m. for two hours and suggested the following dates as a guideline for possible meeting dates: September 18, October 9 and 23, November 7 and 19, with the final meeting being held on December 6. She stated that ideally, the Committee would be reviewing the report at the December 6th meeting. She noted that these dates would be changed in the event of other existing interim committee meetings or for special session.

Mr. Mikkelsen commented that our society is one that measures everything. With advances in technology, measuring success has been refined to outcome figures. He stated that this is an opportunity for the Committee to measure acute care episodes with the chronic nature of the aging process, which can be predicted with fairly great accuracy. He commented that it may be time to re-think what a successful outcome is measured by, which is the quality of life and the process of caring.

Without objection, the meeting was adjourned at 11:15 a.m.

Respectfully submitted,

Tracey Moulton
Committee Secretary

*(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ARIZONA STATE LEGISLATURE

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Tuesday, September 18, 2001
2 p.m., Senate Hearing Room 1

Members Present:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandebosch
Senator Edward Cirillo
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven

Members Absent:

Senator Solomon

Staff:

Barbara Guenther, Senate Family Services Committee Analyst

Chairman Yrun called the meeting to order at 2:04 p.m. and a moment of silence was observed for the families affected by the September 11, 2001 terrorist attacks on New York and Washington, D.C.

Senator Yrun referred to a packet (*Attachment 1) distributed by Ms. Guenther that shows meeting dates and times, as well as the tentative agendas.

Lynn Larson, Policy Planning and Program Development Unit Manager, Aging and Adult Administration, Department of Economic Security (DES), provided a handout (*Attachment 2) covering the Arizona Family Caregiver Support Program which is part of the National Family Caregivers Support Program. It is the new Title III(E) program established by the Older Americans Act Amendments of 2000. The services of this program are primarily provided to family caregivers, as well as grandparents or older individuals who are relative caregivers.

Ms. Larson identified the five primary services provided under the program: 1) information; 2) assistance; 3) counseling and training; 4) respite care; and 5) supplemental. She noted that Arizona received $1.9 million to implement these services.

Senator Cirillo asked if the $1.9 million was a one-time fund. Ms. Larson replied that they will be receiving $1.9 million annually, but the allotment may change as the population changes, since the funds are distributed based on population numbers.

Ms. Danowski wondered what age group was affected by this program. Ms. Larson responded that the services are provided to the caregivers of individuals 60 years or older. She pointed out that 10% of the funding may be used for services to grandparents caring for children.

Allan Shaffer, Arizona Long Term Care System (ALTCS) Administration, Arizona Health Care Cost Containment System (AHCCCS), distributed a handout (*Attachment 3) regarding the ALTCS model and funding. He indicated that the program provides a comprehensive package of services for the Acute Care Programs. Approximately 3% of the 640,000 AHCCCS members represent elderly and physically disabled individuals and use approximately 27% of the budget.

Mr. Shaffer explained that the overall AHCCCS budget is $2.3 billion, with $633 million covering the elderly and physically disabled programs in fiscal year (FY) 2002 and $695 in FY 2003. The budget for developmentally disabled programs is $404 million for FY 2002 and $467 million for FY 2003. He stated that the federal government provides 65% of the funding and the State and county provides 35%. For FY 2002, the State and county share is divided as follows: 77% paid by county and 23% paid by State. For FY 2003, 75% paid by county and 25% paid by State.

Senator Cirillo questioned why the department splits the funding for the developmentally disabled and the elderly and physically disabled programs and wondered if combining the two programs would save on administrative costs. Mr. Shaffer answered that even though the dollars are appropriated differently, the entire program is administered under the AHCCCS administration.

Senator Gerard referred to the many nursing homes that have closed and others that are still open but operating in the red. She mentioned a recent 5.5% increase given to the program contractors that was appropriated at the State level. She questioned if the federal government had to approve that increase, and if so, is that an easy task. Mr. Shaffer replied that they send the rate setting methodology to the federal government 30 days prior to implementation and have never had a problem in getting their approval.

Senator Gerard suggested that if the State appropriates money for increases for direct caregivers, then it will happen. Mr. Shaffer responded yes, as long as they provide background and substantiation to the federal government. Senator Gerard asked about the mechanisms AHCCCS has in place to ensure the increases are received at the caregiver level. Mr. Shaffer replied that they have advised the program contractors to revise their

contracts with the nursing facilities to ensure the pass through of those funds as wages. He stressed that ALTCS will monitor the contracts.

Senator Gerard pointed out that they currently have a tiered pay system based on acuity levels; specifically, someone who has a greater need for care gets paid more. Mr. Shaffer noted that some contracts allow for a case mix where the rates are averaged; however, in Maricopa County, they did away with that method.

Senator Gerard said that ALTCS is looking at the acuity levels to see if they have changed. Mr. Shaffer noted that effective November 1, they are implementing an assessment tool to look at acuity of nursing facility residents that will impact the daily rate reimbursement.

Mr. Steven asked how the different payment levels are determined in order to reflect adequate treatment. He wondered if any particular level is losing more money than another. Mr. Shaffer replied that he is unable to answer that question at this point, but would be willing to address that in a future meeting.

Mr. Mikkelsen questioned if ALTCS reviews any Fair Labor Standards Act (FLSA) compliance issues. He pointed out that there have been several national studies indicating the industry is notorious for violating the FLSA. Mr. Shaffer responded that the agency has not looked at any FLSA issues. However, if they discovered any, they would take appropriate action. Mr. Mikkelsen noted that at one point it was suggested that a fairly detailed worksheet and description of the requirements be made available to those signing contracts with the State.

Senator Yrun referred to the notes (*Attachment 4) from the August 29, 2001 meeting. She asked the Committee to review the document and the upcoming agendas to ensure all areas are addressed. She also directed their attention to a handout (*Attachment 5) provided by the American Public Human Services Association that covers the issues and indicates what other states are doing to address these issues. She pointed out the specific action steps suggested on page 3.

Cheri Tomlinson, Policy Office, AHCCCS, distributed a report (*Attachment 6) published by AHCCCS and DES reviewing Arizona's long-term care programs. The report forecasts and plans for the needs of the elderly and physically disabled. She pointed out that the data shows that there is a huge growth in Arizona's elderly population, specifically in the rural counties. In addition, ALTCS participation is growing significantly. Previously there has been a 6% to 8% increase in this population; however, recently there has been a 9% growth, which is higher than anticipated.

Ms. Tomlinson explained that some of their concerns include the baby boomers who will begin retiring in 2011, and considering the current labor shortage, what that impact will be. She mentioned that typically society has looked at long-term care as a service for the extremely old. However, that is changing. In reviewing the data, note that there is a

significant percentage of individuals who are 80 years old or older; yet there also is a significant percentage under 65 years of age. This is changing who they serve.

Senator Yrun asked if they track what amount of the 27% is day-to-day living versus institutional care. Ms. Tomlinson said that they are reviewing that data and may be able to provide that information at a later date.

Mr. Steven asked if they have conducted any analyses regarding the caregivers perception of quality of life or the detrimental impact of high turnover on the residents. Ms. Tomlinson replied that AHCCCS has not done a study in that area although they have looked at some of the research. Mr. Steven questioned if they have done any surveying of caregivers to determine an income level that would keep them in that position. Ms. Tomlinson indicated that they have just received a satisfaction survey and their next phase is to collect demographic data. She said that they also have been working with a national advisory panel, as well as agencies in other states.

Mr. Steven asked when data would be available for the Committee to use as part of their consideration. Ms. Tomlinson replied that the demographic information will be available next year and the national information would not be available in time for this Committee.

Mary Lynn Kasunic, Executive Director, Area Agency on Aging, stated that when they examine the issue of long-term care and the assistance that the elderly need, they are usually talking about 15 to 18 years of service. The system of helping the elderly often begins with little things such as transportation, home repairs, benefit assistance, etc. She said that she would recommend the Committee request from the different agencies a comprehensive report regarding the numbers and types of services provided. She pointed out that in Maricopa County, their agency works with approximately 70,000 people a year, statewide it is over 100,000.

In response to Senator Yrun's question, Ms. Kasunic replied that in the nonmedical home and community-based system funded through DES to the eight area agencies on aging, they serve three client populations: 1) the older adult, generally 60 years of age and over, and in some programs such as volunteerism, they might serve 55 and over; 2) the disabled between the ages of 18 and 59 with long-term care needs; and 3) in Maricopa County, they also serve the Human Immunodeficiency Virus (HIV) population of all ages.

Timothy Schmaltz, Director of Policy and Program Development, Foundation for Senior Living, noted that he attended a national conference last week and provided the Senate Research Analyst with a packet of the information distributed at that conference. He said that he would be glad to summarize the information and focus on solutions. Senator Yrun commented that he is scheduled to cover the topic at the Committee's October 9, 2001 meeting. She asked that the materials be provided to the Committee prior to the meeting.

Senator Gerard announced that St. Luke's Health Initiatives group is having a meeting at the Heard Museum from 8:30 a.m. to noon on September 19, 2001.

There being no further business, the meeting was adjourned at 2:50 p.m.

Respectfully submitted,

Carol Dager
Committee Secretary

*(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ARIZONA STATE LEGISLATURE
SENATE AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Tuesday, October 23, 2001 — 10:00 a.m.
Senate Hearing Room I

Members Present:

Senator Virginia Yrun, Chair
Senator Susan Gerard
Bonnie Danowski
George Good
Ritch Steven
Senator Edward Cirillo
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandebosch

Members Absent:

Patricia Harris
Senator Ruth Solomon

Staff:

Barbara Guenther, Senate Research Analyst

Tape 1, Side A

Chair Yrun called the meeting to order at 10:10 a.m. and attendance was noted.

PRESENTATION ON WASHINGTON CONFERENCE

Richard White, Director, Office of Social Justice and Outreach Ministries, St. Patrick's Catholic Community, gave a presentation on the Washington Conference which involved states around the country working on direct work force issues on caregiver wages and workforce development. He stated that the focus was that there is a national crisis on salaries and compensation. Workers do not receive overtime or have opportunities for advancement. Workers do not even have basic benefits. The working environment needs to be improved and workers treated with dignity. He stated that Michigan provides four to five weeks of orientation, even though they are only required to give 75 hours. One of the recommendations is to create a long-term care workforce commission on a national and local level. Michigan has also established a cooperative

healthcare network, which is a federation of worker-owned homes. They offer the highest wages possible.

California has implemented county public authority bodies and is contracting with non-profit consortiums for the delivery of supportive services. The main purpose is to link consumers with caregivers.

The American Medical Director's Association was one of the groups represented at the Conference and they mentioned that workforce issues, including wages and benefits, career development, and workplace safety must be addressed.

There are numerous solutions shown to us by other states, as well as the workforce development process in Tucson. The solutions must be systemic, including all caregiver programs. It will cost money, however. Mr. White explained how some states are accomplishing this.

Senator Cirillo commented that the costs will be much higher if all of these issues are addressed and no one will be able to afford to go into the homes. Mr. White stated that the nursing homes are not empty in the states that are implementing this.

In response to Mr. Mikkelsen, Mr. White stated that there are a number of states that work with regulatory agencies.

Bonnie Danowski stated that they have been working on getting a $3,000 tax credit for family caregivers, which would be used for services and equipment.

Mr. Steven commented that monies are going to increased liability insurance costs.

Ms. Danowski commented that there is a program in Tucson called Job Path that has developed what Mr. White laid out regarding training people, career path, and benefits and has been highly successful.

In response to Mr. Good, Mr. White explained that respect for workers was addressed. There were CNA's participating in the conference and they articulated that 80 to 90 percent of the service comes from them and they are not recognized.

Senator Cirillo commented that the respect for the profession needs to increase.

Barbara Guenther, Senate Research Analyst, testified that the National Conference of State Legislatures reported on three primary areas of state initiatives: 1) expanding respite care for family caregivers; 2) managed care projects; and 3) empowering consumers through cash payment of benefits or paid case management by self or relatives. Also, recruitment and retention strategies were recently initiated (*Attachment A).

Ms. Guenther further discussed the Tucson Direct Caregiver Association. It is an example of some of the local efforts that are underway (*Attachment B).

In response to Mr. Steven, Ms. Guenther commented that several funding sources are being explored, including Temporary Assistance for Needy Families (TANF) and workforce initiative funds. A lot of them are State general fund appropriations as well as federal funds.

Mr. Mikkelsen commented that Medicare expansion across the country is very successful.

Mr. Steven asked if any states were putting into place measurement indicators that would indicate quality improvement. Ms. Guenther commented that most of the states do have performance measures built into their initiatives.

In response to Senator Yrun, Ms. Guenther stated that she did not see high school co-enrollment with a community college for training for CNA's mentioned.

Senator Gerard commented that it is already going on in the Sunnyslope area of the State.

Senator Cirillo asked about states putting monies into higher wages. Ms. Guenther stated that several states pass the increases directly to the workers.

In response to Mr. Steven, Ms. Guenther stated that some specify nursing facilities and some target community and home based care.

Senator Yrun asked if any of the states focus on promoting long-term care products. Ms. Guenther stated that she did not recall seeing that issue.

Senator Cirillo suggested beginning a long-term care policy for state workers.

Senator Yrun suggested that they look at the handout from the previous meeting and prioritize strategies (*Attachment C). The Committee discussed the issues identified.

Mr. Steven commented that rural issues should be included as well as the urban issues.

Senator Yrun commented that it would be helpful to hear about the regulatory schemes that effect all of the different levels of the system.

Senator Cirillo commented that DHS would be good for this.

Senator Yrun suggested that they have someone from the Board of Nursing come to speak.

Mr. Steven stated that the service providers are regulated by law. Others are not. Private source funds supplement government contracts. Most service providers would go out of business without private funding.

Tape I, Side B

Senator Yrun asked which issues they would like to spend their time on. She suggested the regulatory scheme and the funding. She also suggested a detailed presentation from AHCCCS.

Lois Von Halle, representing herself, stated that she is a full-time family caregiver for her husband who is ill and a quadriplegic. She is requesting outside help for times when she is not available. She sees the need for help for caregivers.

Bev Hermon, representing the Developmentally Disabled, stated that their concern is services being cut due to the budget. She requested that the Committee help wherever they can. There is a problem with paying $44 per person for fingerprinting. She stated that they greatly appreciate all the help.

In response to Mr. Vandebosch, Ms. Hermon stated that they are having some luck in filling vacancies. The layoffs, however, are not helping. She stated that the Developmentally Disabled providers would go under without the United Way Campaign.

Kathleen Pagels, representing Alzheimer's Association, stated that the quality, affordability and availability of care is a primary family care concern. The caregivers are concerned about workload. Families are also concerned about checks and balances in the system. She supports a public awareness campaign. She thanked the Committee for their concerns.

There being no further business, the meeting adjourned at 11:30 am.

Respectfully submitted,

Debbee Kennedy
Committee Secretary

*(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ARIZONA STATE LEGISLATURE

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Wednesday, November 7, 2001 – 10:00 A.M.
Senate Appropriations Room 109

Members Present:

Senator Virginia Yrun, Chair
Bonnie Danowski
George Good
Ritch Steven
Senator Edward Cirillo
Mary Lou Hanley
Gene Vandenbosch

Members Absent:

Senator Susan Gerard
Patricia Harris
Gwen Dean
Senator Ruth Solomon
Guy Mikkelsen

Staff:

Barbara Guenther, Senate Family Services Analyst

Senator Yrun called the meeting to order at 10:12 a.m., and attendance was noted.

Presentations and Discussion Regarding Regulations and Opportunities for Change:

Arizona Department of Health Services (DHS)

Mary Wiley, Assistant Director, Division of Assurance and Licensure Services, DHS, distributed a handout entitled Division of Assurance and Licensure Services (*Attachment A). She presented an overview of the Division's primary responsibilities including:

- Licensure Surveys
- Complaint Investigations
- Enforcement Remedies
- Technical Assistance
- Public Records

Ms. Wiley referred to the handout, page 3, and clarified that the second column entitled "Number of Residents" should be "Number of Facilities."

Mr. Steven referred to the citations issue and asked whether it was the result of staff shortages. Ms. Wiley responded there are problems with staffing shortages throughout the facilities. However, she said no ratios are available to quantify. In addition, DHS does not collect the number of rules and violations regarding staffing. She noted that problems may surface in different areas of the rules that are related to staffing, either directly or indirectly. Mr. Steven asked whether quality of care would be enhanced if staffing increased. Ms. Wiley replied it would appear that quality of care would be enhanced, however, at the same time a recent enforcement action was taken on a facility. In that instance the problem did not relate to staffing, but rather due to a lack of training and being ill-equipped to handle the patients.

Mr. Vandenbosch asked whether any joint training opportunities are offered for training surveyors. Ms. Wiley responded a contract exists with the Veterans Home for joint training with the surveyors. She said training is also offered to providers, such as in long-term care facilities on nutrition or abuse and neglect. She commented that her department would be open to additional joint training.

Ms. Danowski asked about the number and frequency of visits by surveyors to nursing homes.
Ms. Wiley responded there are many different kinds of long-term care areas. She said within the nursing home area there are 33 surveyors. She noted the frequency of visits depends on the activities and complaints within a facility.

Ms. Hanley asked whether the surveyors are able to meet the timelines established by the priority guidelines. Ms. Wiley replied that, unfortunately, some of the "priority 3" investigations are backlogged due to staffing.

In response to Senator Yrun, Ms. Wiley stated that a "priority 1" complaint resolution depends on the nature of the complaint and cited examples. She indicated she could provide further information regarding the details of complaints. Senator Yrun requested that Ms. Wiley provide that information to staff.

Mr. Steven asked whether staffing problems occur more in rural areas than in urban areas. Ms. Wiley responded that type of information is not quantified, however, staffing problems occur in the rural areas to find qualified staff for nursing homes and assisted living.

In response to Mr. Good, Ms. Wiley responded that there are three offices established and five different programs within those offices. Complaints are handled by surveyors within each program.

Ms. Wiley indicated she would prepare a grid detailing requirements and training of staff as requested by Senator Yrun.

Mr. Steven asked what it would take to have improvements in the facilities surveyed. Ms. Wiley responded staffing is a major issue and it would be helpful to be able to select from a larger workforce.

Senator Yrun asked whether other states use ratios regarding the number of staff serving clients. Ms. Wiley replied other states use ratios, but it has been somewhat controversial. She explained the procedure within Arizona. Senator Yrun asked for an explanation on the use of the fines and sanctions. Ms. Wiley explained there are two types of fines. One type is long-term care fines collected through Medicare into a special fund that is designated for certain uses in Arizona. DHS makes recommendations on the use of the State fines, which go to the general fund. Senator Yrun asked Ms. Wiley to provide a fact sheet on the fine schedule, disbursement and balance remaining to staff. Senator Yrun asked whether consumers are allowed to use the DHS web site to file complaints. Ms. Wiley replied complaints are currently being filed on the web site, and final enforcement actions are being placed on the site. She said it would be helpful to include the results of the surveys and complaint investigations also on the site, but at present it is too costly. She indicated a request for funding to provide that information on the site will likely be presented next year to the Legislature.

Department of Economic Security (DES)

Tony Zabicki, Federal Plan Coordinator, DES Child Care Administration, stated that he would present an overview of his division. He commented that his division is not intensively involved in the regulation of child care, however, links have been established with child care providers who are regulated by DHS. He distributed a fact sheet outlining the activities handled by his division (*Attachment B). He pointed out that many of those activities are not regulatory, but rather the nature of providing child care assistance and benefits to eligible families.

Mr. Zabicki stated that Child Care Administration generally makes payments to eligible child care providers on behalf of families who are eligible for services through DES. He said payments are also made to small family group homes certified by DES, and in some instances to certain relatives. He commented on the numbers of financial agreements currently in place.

Rick Zaharia, Assistant Director, Division of Developmental Disabilities, DES, stated that his division services approximately 20,000 individuals with various disabilities. He noted that approximately 10,000 of those individuals receive Medicaid funding through the Arizona Health Care Cost Containment System (AHCCCS) through a variety of settings. He commented that his division works with 120 agencies statewide to provide the services, which includes 2,000 independent providers for in-home services. He distributed a handout outlining the answers to questions previously raised by the Committee (*Attachment C).

Senator Cirillo asked whether the situation with providers is analogous of the situation with school districts regarding teachers' salaries. Mr. Zaharia responded that the analogy

may be a good one, but he believes it does not apply fully in this case. He explained service delivery is monitored through a support coordinator case management network, as well as by program monitors from both central office and district levels who are continually monitoring results.

Mr. Steven asked for an explanation on the standards of performance used to measure the quality of service that constituents receive. Mr. Zaharia replied that the primary vehicle for monitoring is referred to as an individual service plan, which was designed by a team including the consumer, family members and other professionals. He said that the service plan stipulates and monitors the needs of the consumer through the authorized services of his division. Mr. Steven asked whether the turnover of direct caregivers is monitored. Mr. Zaharia replied that the turnover is self-evident. He said turnover is reviewed, and corrective action plans are discussed with providers. He emphasized that turnover and instability in the workforce are the primary problems within the provider system.

Mr. Vandenbosch asked whether the low-wage problem is the primary issue in the turnover of the caregiver situation. Mr. Zaharia replied that although a wage increase is the primary issue, the turnover in the workforce is multi-variant. Other factors include training, supervision, and co-workers, which all impact the caregiver workforce. He outlined the federal and state funding sources.

Henry Blanco, Program Administrator, Aging and Adult Administration, DES, stated his office is not directly involved with licensing and regulation of the services for long-term caregivers or long-term care facilities. He said his office receives State appropriation and federal applied grants for non-medical home and community based services. He commented that his department works with a primary population of approximately 15,000 consisting of individuals 60 years of age or older in Arizona. He explained the waiting list procedure. In response to Mr. Steven, Mr. Blanco explained the staffing procedure for clients.

Ms. Danowski asked Mr. Blanco to explain the mechanism in place to respond to client dissatisfaction. Mr. Blanco responded that each individual is case managed to address any particular issues.

In response to Senator Yrun, Mr. Blanco responded that his office does not collect information relating to the number of full time employees (FTE) at the sub-contract level. He said he would inquire as to whether other states collect that type of staffing information directly.

Mr. Steven asked how future demand for services is forecast. Mr. Blanco responded population growth numbers are utilized in the State. He said a budget request would be submitted on a biennial basis to address the projections including the waiting list problem. Mr. Steven asked whether the funds are distributed uniformly across the State or whether it varies in rural versus urban areas. Mr. Blanco responded that the home and community based funds are distributed on populations of 60 years of age or older across the State uniformly.

Board of Nursing

Joey Ridenour, Executive Director, Arizona State Board of Nursing, stated that the Board regulates approximately 47,000 registered nurses (RN), 10,000 licensed practical nurses (LPN), and 20,000 certified nursing assistants (CNA). She said the views expressed today are drawn from her 15 years of regulatory experience and as the current President of the National Council of State Boards of Nursing. She commented on the current shortage of nurses as well as future projections. She remarked that regulatory and policy issues may be exacerbating the shortage, and itemized those issues. Ms. Ridenour commented on the primary reasons for job dissatisfaction and nursing shortages from a survey conducted as reported in the May-June 2001 issue of "Health Affairs." She commented on the following issues:

There are not enough nurses to "get the job done."
Potential solution: The Governor's soon-to-be-appointed Blue Ribbon Task Force on the nursing shortage should be led by an experienced facilitator.

Increasing complexity of documentation resulting from regulatory requirements.
Potential Solution: Each organization needs to be aggressive to help streamline the documentation process and to work hand-in-hand with regulatory bodies to find agreement.

Need for aggressive support for federal and state funding for nursing programs to increase enrollment of students.
Potential Solution: The nursing programs need to be an integral part of the Governor's Blue Ribbon Task Force on the nursing shortage.

Recruitment Strategy for employment of foreign nurses.
Potential Solution: Support the federal government in expanding visas, and to maintain consistent licensure requirements for foreign and domestic nursing licenses.

State Boards of Nursing have an important contribution to make during this uncertain time regarding recruitment and retention of nurses. It would be a mistake to lower licensing standards to increase the number of graduate nurses.
Potential Solution: The Board should participate on the Blue Ribbon Committee to invite debate on statutes and rules that are out of date and contributing to the shortage.

Ms. Ridenour emphasized the need to focus on creative ways to collaborate with others to expand the nursing scope of influence while enhancing the quality of care.

Mr. Steven asked whether any data is available regarding CNAs or other forms of direct caregivers with respect to turnover and availability. Ms. Ridenour responded that

according to national data, the projected need for unfilled positions for CNAs in the next eight years is 750,000.

In response to Mr. Vandenbosch, Ms. Ridenour stated that the primary barrier for nurses or CNAs to remain in the profession appears to be that there are not enough people "to get the job done."

TAPE 1, SIDE B

Ms. Ridenour commented that a survey is being conducted to explore the reasons. She pointed out that even though there are many licensed nurses in the State, it does not necessarily mean that they are employed as nurses.

Senator Cirillo remarked that one of the reasons that nurses are being driven out of the profession is due to the overtime issue. Ms. Ridenour replied that is an issue that has been debated over recent months. She commented that she is not aware of any complaints to the Board. However, in discussing it with the Nurses Association, there is concern that mandatory overtime will be an evolving issue as the shortage escalates.

Mr. Good stated that training is a major issue, and he asked whether continuing education is required for renewal of licenses. Ms. Ridenour responded that no mandatory requirement exists currently. She noted that a national study is being conducted to collect information on whether continuing education for licensing renewal should be made mandatory versus voluntary.

Ms. Danowski asked whether the career path of nurses is followed. Ms. Ridenour replied that an individual is present who handles the survey of nursing and CNA programs and could respond to that issue.

Pam Randolph, Nursing Consultant, Board of Nursing, stated that a CNA position is used many times as a ladder for careers, and she explained the program.

Funding Mechanism Presentation by AHCCCS

Branch McNeil, Deputy Director, AHCCCS, stated he would like to respond to an earlier question as to why some developmentally disabled members are not federally eligible for AHCCCS. He indicated that they may not meet the income eligibility criteria or they may not pass the pre-assessment medical screening or be determined disabled by the Social Security Administration.

Mr. McNeil distributed a handout to accompany his slide presentation (*Attachment D), entitled AHCCCS/Funding Mechanism for Arizona Long Term Care System (ALTCS). He described the various AHCCCS and ALTCS programs included in the handout. He also explained the capitation rate development process and components.

In response to Mr. Vandenbosch, Mr. McNeil indicated he would research and attempt to provide information regarding the average and total cost of registry for a facility.

Mr. McNeil stated a rate study has been completed, and a meeting will be held the following Thursday with the nursing home industry to discuss the results. He pointed out that AHCCCS is in the process of working with the Governor's office and the Joint Legislative Budget Committee (JLBC) to discuss any possible change in rates.

Senator Yrun thanked everyone for the informative presentations. She apologized for not being able to complete the agenda today due to time constraints. However, she invited everyone to be present at the next meeting on November 19. She noted the meeting would include any follow-up questions on the AHCCCS presentation. The meeting also will include Item 4 on today's agenda "Presentations on the Gap Between Actual Costs and Reimbursement Rates."

There being no further business, the meeting adjourned at 12:05 p.m.

Respectfully submitted,

Nancy L. DeMichele, Committee Secretary

*(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115)

ARIZONA STATE LEGISLATURE

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Monday, November 19, 2001
10:00 a.m. Senate First Floor Caucus Room

Members Present:
Senator Virginia Yrun, Chair
Senator Edward Cirillo
Senator Ruth Solomon
Bonnie Danowski
Gwen Dean
George Good
Mary Lou Hanley
Patricia Harris
Guy Mikkelsen
Ritch Steven
Gene Vandebosch

Members Excused:
Senator Susan Gerard

Staff:
Barbara Guenther, Senate Research Analyst

Tape 1, Side A

Chair Yrun called the meeting to order at 10:03 a.m. and attendance was noted.

PROVIDERS PRESENTATIONS ON THE GAP BETWEEN ACTUAL COSTS AND REIMBURSEMENT

Bev Hermon, Behavioral Health Consulting, remarked that the identifiers the Committee had asked for in the developmentally disabled field are the same for the behavioral health field. She distributed a handout entitled "Presentation to the Senate Ad Hoc Committee on Caregiver Wages and Workforce Development" (*Attachment A). Her testimony came directly from the handout.

Senator Solomon, commenting on a related issue, asked if the Governor's recommendation to close the Coolidge facility would cause any difficulty in placing the residents. Ms. Hermon remarked that the key issues in determining whether the Coolidge facility is closed will depend on whether the appropriate evaluations have been done for each of the current clients, or their families have the opportunity to determine what the best placement is for them, and the State being able to locate other facilities, if necessary. She remarked that many of the clients' families are aging and do not live in Coolidge so they are traveling long distances to visit family members. She stated that she did not see the closing of the facility as being a problem and estimated that it would take approximately a year and a half.

Guy Mikkelsen stated that given the current service delivery system, the home and community based services providers are falling $1.00 to $1.50 short in reimbursement. He commented that in the fiscal note to S.B. 1322, last year, the Joint Legislative Budget Committee indicated that in order to have a broad array of services paid for at market rate, and additional $30 to $50 million funding would be needed.

Mr. Mikkelsen explained the history of contracting for social services to private entities and noted that at the creation of Title XX, the Social Services Block Grant was funded at $2.5 billion, while the State was only spending $1.7 billion. Those funds today should be at approximately $6.5 billion for the states to continue to enjoy the same level of support. Instead, Arizona has lost tens of millions of dollars in recent years from the decrease of funding to Title XX.

Mr. Mikkelsen remarked that because of the trend to buy as much social services as possible at the cheapest possible price in the market place, the State is now at a point where the shared volume and the demographic shift is challenging all the assumptions made that this was the best way to handle contracting social services.

Mr. Mikkelsen stated that what our society is looking at is not a matter of money, but rather it is a matter of public policy priority. The federal government is not interested in domestic policy; and Arizona, as well as other states, has succumbed to programs like Temporary Assistance for Needy Families (TANF) and have refinanced everything with TANF money, thinking that the State's welfare numbers would stay down. As this was and is not the case, the burden of this problem is being placed on the workforce of health care services, with a lack of benefits and salary.

Mr. Mikkelsen commented that it is important to determine how to attract people to these care-giving professions, and more respect needs to be given to the people who are doing these jobs.

Senator Cirillo commented that this is an endemic problem where it is acceptable for athletes to make millions of dollars and certain professions responsible for dealing with our society's most helpless citizens are paid so poorly. He commented that the suggestion of increasing sales taxes would also be felt by the people who are making such low salaries. He stated that in trying to find a solution to this problem it is important not to hurt the very people that the Committee is trying to help.

Peg Mullan, President and CEO, Beatitudes Care Center, testified that the facility has approximately 300 retiree, 60 assisted living and 188 skilled nursing clients, with 320 full time employees. The facility has approximately 188 regular beds, 21 Medicare or short term rehabilitation beds, 44 special Alzheimer bed units and 120 long term care beds. She explained that the staff consists of 70 certified nurse assistants, 15 registered nurses, 28 licensed practical nurses, 2.5 full time therapists, 4 social service employees, 4 activity employees and a host of other ancillary maintenance, ground keeping, housekeeping and dietary staff. The total of employees and clients creates approximately a thousand person

community. She remarked that coordinated care for the clients and campus is done 24 hours a day, seven days a week and 68% of the facilities annual budget is spent on labor costs. The Beatitudes receives $4 million from the Arizona Long-Term Care System (ALTCS) with $3 million gap. Due to the extensive landscape of 22 acres, the gap without this item would be $2 million.

In addition, Ms. Mullan remarked that the cost of liability insurance is another factor that has made the administration of this facility, as well as others more difficult. She noted that even with zero claims, in 1998, the facility paid $98,000 in liability insurance, and $187,000 in 2001. The high cost of registry nursing is another factor that is being faced by facilities. She remarked that her facility's turnover rate is lower than most facilities, but it is a costly factor, nonetheless.

Ms. Mullan explained that because of these factors, her facility has had to dangerously deplete its financial reserves and if the situation with funding is not addressed quickly, the facility will not be able to continue beyond this next year.

Mr. Steven asked what the Committee could do to help prevent this from happening. Ms. Mullan stated that fiscal assistance is the only viable solution available. She reiterated that most long term facilities have already done as much cost reduction as possible and used most if not all their financial reserves.

Mr. Steven asked if providers, other than Medicaid, were paying their fair share as well. Ms. Mullan remarked that managed care providers payments have paid what has been predetermined for costs.

In response to Senator Solomon, Ms. Mullan stated that although there is a State match of funds, this is a societal problem as well. She noted that the number of long-term care patients is on the increase, as people live longer lives and opined that the State needs to re-evaluate the Arizona Health Care Cost Containment System (AHCCCS) methodology and formula. She opined the current payment methodology is not correct. She noted that she is appreciative of the efforts made by the AHCCCS Administration in reviewing the current system, but remarked that working with any government agency is a long process. She stated that her facility may not be able to wait the length of time it may take to rectify the current situation. She reiterated the need to obtain funding now.

Senator Solomon asked what other factors contributed to the current situation outside of skilled nursing staff shortages. Ms. Mullan remarked that it is a combination of many factors that has created the "perfect storm" effect on long and short term health care provision. She stated that in addition to increased insurance premiums, and the current reimbursement methodology, low salaries contribute to increased turnover, which causes further costs in recruiting and training of staff. It becomes a circle of contributing factors to create the current situation.

Patricia Harris commented that as a registered nurse, she has an interest in health caregiver wages. She also noted her concern with the unstable balance that all health care

providers and institutions are facing, as well as acute care regarding wages and bringing qualified people to the profession. She asked if Ms. Mullan had developed any ideas regarding how to handle this situation. Ms. Mullan remarked that it is a complex and difficult question to answer. She stated that the creative financial fixes of "robbing Peter to pay Paul" can only be done for so long and then there are no further options available. She stated that many facilities are at that point right now.

Tape 1, Side B

Senator Yrun asked if Ms. Mullan has found in discussions with colleagues around the country that the relative gap in reimbursement that she is experiencing in Arizona is shared, or is reimbursement in other states managed with different assessment tools. Ms. Mullan commented that the system in Arizona is quite unique, as AHCCCS is a model that requires adequate support for it to function correctly. She stated that this situation is found across the country in different degrees. She stated that she would report back to the Committee with data that she would recommend.

Larry Littmon, Financial Analyst, remarked that he provides financial analysis for 25 Arizona facilities. He distributed handouts entitled "Facility Premium Increases 1999, 2000, 2001" (*Attachment B) and "Healthcare System Services, Arizona Facilities, Average of Nursing, Overhead and Capital Cost" (*Attachment C). His testimony came directly from the handouts.

Mr. Littmon concluded by saying that cost associated with providing care to residents in long and short term facilities has increased dramatically in the three year period of 1999-2001. He expressed his appreciation to AHCCCS for being willing to review the methodology of the current formula. He explained that AHCCCS asked for the data on 63 buildings, for the years of 1999-2001. He noted that due to bankruptcies, changing of management, etc., he obtained data for the requested time frame from 23 buildings and lesser data from the remaining 63 facilities. He stated that in the meeting with AHCCCS, because the data provided was incomplete, any changes in the formula would not be feasible.

Mr. Littmon expressed his disappointment that the data that was provided to AHCCCS was discounted.

AHCCCS FOLLOW-UP

Senator Yrun announced that because of time constraints questions would be posed for the AHCCCS Department to address in writing.

Branch McNeil, Deputy Director, AHCCCS, remarked that because of the time constraint on the Committee, he expressed his disappointment that he would not be able to address in detail, any comments to Mr. Littmon's testimony.

Senator Cirillo remarked that there are considerable increases noted for some facilities in the handouts from Mr. Littmon. He stated that he would like an explanation of these increases.

Ms. Harris remarked that all the information that has come to her attention demonstrates a health care workforce shortage, salary and lack of respect. She asked if it is the opinion of AHCCCS that there is a workforce problem. Mr. McNeil remarked that some of the administration costs of nursing staff salaries are generated by competitiveness between facilities. He agreed that there is a struggle in the health care field, and also in many workforces outside of the health care field, including State agency employment.

Mr. Vandebosch requested an outline of the agency's short and long term solutions to this situation.

Mr. Steven asked what type of sample methodology AHCCCS would want from providers to incorporate adequate liability, registry and turnover costs into a reimbursement adjustment to the formula. Mr. McNeil commented that the reason the Department did not make any formula adjustments based on Mr. Littmon's data was because that data may not have been representative. He stated that when the agency reviews facilities, it is the average costs that are considered.

Senator Yrun asked the Committee members to submit any questions that they wished answered by AHCCCS in writing, in advance of the next meeting.

Without objection, the meeting was adjourned at 11:30 a.m.

Respectfully submitted,

Tracey Moulton
Committee Secretary

*(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ARIZONA STATE LEGISLATURE

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Thursday, December 6, 2001
Senate First Floor Caucus Room 10:00 a.m.

Members Present:

Senator Virginia Yrun, Chair
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven
Senator Edward Cirillo
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandenbosch

Members Absent:

Senator Susan Gerard
Senator Ruth Solomon

Staff:

Barbara Guenther, Senate Research Analyst
Tracey Landers, Senate Assistant Research Analyst

Chairman Yrun called the meeting to order at 10:04 a.m. and attendance was noted.

Branch McNeal, Arizona Health Care Cost Containment System (AHCCCS), stated that he would be providing some responses to questions that were asked in previous meetings. He referred to a question regarding the State being reluctant to request Title 19 money. He replied that although it may have appeared that AHCCCS has been reluctant, it is not true. AHCCCS does require complete and verifiable data when setting rates. He emphasized that it took two separate requests over four months to gain enough information from the nursing facilities to begin the rate-setting process. In the survey, AHCCCS requested three pieces of information from all of the nursing facilities in Arizona. He noted that they received responses to all three of the questions from only 55 of the 135 nursing facilities. After the rates were set, the nursing facility representatives expressed concern over a few of the rate components (liability and registry). AHCCCS was more than willing to accept additional documentation supporting their claims. The nursing facility industry could not provide enough verifiable data contradicting the rates that were set.

Mr. McNeal stressed that they need to make decisions based on good information. He said that he has heard discussions about the rates being short $10 or $15 a day. A $10 rate

increase represents $34 million annually and $51 million annually for a $15 rate increase. He pointed out that there are some nursing facilities that are profitable at the current rate.

Mr. McNeal addressed another question regarding the formula for determining provider rates being reflective of today's environment. He noted that in order to calculate rates as was done for October 1, 2001, they have to start approximately a year in advance. They requested the most recent available cost data, wage survey, and unemployment reports from all of the nursing homes. Because this request was distributed in October 2000, the most recent data available was for 1999. The deadline for the information was November 2000, which was extended to December. Once all the data was returned, it was four months from the time of request.

Mr. McNeal pointed out that the rates were based on the best and only data available; however, many nursing facilities did not respond to the AHCCCS request. Therefore, there are nursing facility costs that are not reflected in the rate calculations which could impact the final rate calculations. He explained that the 1999 cost data was inflated forward to the rate year.

Mr. McNeal indicated that they received less than an adequate sampling of registry and liability cost. He referred to a question regarding what the average real cost of using registry nursing staff pools for nursing facilities. He noted that registry costs were included in the rate calculations. AHCCCS did not recalculate the direct care component based on registry data provided by the nursing facility, because the data provided did not show the need for AHCCCS to reissue a rate survey to all nursing facilities and recalculate. The nursing facilities provided AHCCCS the data after the rates had been set and distributed. Also, the data provided was incomplete. Each nursing facility provided hourly wages for registry. No total wages paid or total hours worked were provided. Because no registry of employed wages paid by nursing facilities were provided, no utilization projections could be made. It could not be determined if registry utilization had increased or decreased in 1999.

Mr. McNeal explained that total nursing facility expenditures and hours were provided at the end of the document; however, there was no back-up materials to substantiate the totals provided. Assuming that the total was correct, registry costs were in line with what AHCCCS supplied with the direct care component.

Mr. McNeal stated that 51 nursing facilities responded to the nursing facility industry survey and 20 of those reported zero registry cost. Ninety-seven nursing facilities responded to the AHCCCS survey. Only 39 nursing facilities responded to both surveys. He stressed that registry data was inconsistent between the two surveys. Eleven of the nursing facilities that reported zero registries to the industry survey reported registry to AHCCCS. Three of the nursing facilities reported they had no registry for three to five months. Only three of the top ten nursing facilities reporting registry to AHCCCS responded to the nursing facility industry survey, with one reporting zero on the nursing facility industry survey. He suggested that they are trying to take into account the most

recent data; however, they have a difficult time doing so with incomplete and inconsistent data.

Mr. McNeal next discussed the cost of liability insurance for a nursing facility. A question was raised if that cost is included in reimbursement rates. He noted that liability insurance costs were included in the calculations of the rates as part of the indirect care component. Indirect care component was inflated 9% to 12% for each of the nursing facilities based on their fiscal year-end. He stated that in eight of the nursing facilities that provided liability premium information for fiscal year 1999, liability insurance represented from 0.4% to 1.2% of the total indirect costs for seven of the nursing facilities, and approximately 4.6% for one of the nursing facilities. The indirect portion was inflated forward.

Mr. McNeal referred to the previous question regarding the registry component and the data received by AHCCCS. He pointed out that it is not that they received and disregarded it. Instead when they received it, they reviewed it but felt it would not make enough of a difference to take action on. When they saw the small percentage that it made in terms of the rate, they had already completed the rate setting process and done a number of things that were in favor of the nursing facilities.

Mr. McNeal noted a question regarding the number of nursing homes closed and whether there has been an increase in home and community-based services. He pointed out that there has been tremendous growth in the home and community-based program, and much slower growth in the number of Arizona Long-Term Care System (ALTCS) members residing in nursing facilities. The significant majority of people who were living in the facilities that closed were moved to other nursing facilities.

Mr. McNeal stated that he was quoted in saying that AHCCCS does not consider Arizona's current workforce shortage to be a crisis and would prefer the term issue. The questions asked were: 1) at what vacancy and turnover rate, would AHCCCS consider the workforce situation to be a crisis; 2) what would be AHCCCS recommendations to the Legislature if the situation became a crisis; 3) if there is not a crisis in the workforce, why is staff turnover so high; 4) and what are the repercussions of high turnover on peers, recipients, family caregivers, and paid caregivers. He responded that his resistance to the word crisis was because he does not like people putting words into his mouth. AHCCCS does not disagree that there is a significant workforce issue in all areas, even of State workers. He stated that he was reminded that there has been a 100% turnover in the nursing homes, while with State workers, there is a 20% turnover.

Mr. McNeal suggested that for unskilled labor, the market should be turning in favor of getting people easier. He said that will not necessarily stop turnover. He noted that it is difficult hiring entry-level positions in any industry. Entry-level positions in healthcare have always been a challenge regardless of the economic times.

Mr. McNeal explained that the result of high turnover is that the care is not as good as it should be. He mentioned that one of the things he has heard is that wages alone are not

the answer to keeping people at those low levels and avoiding turnover. People in low level positions will always seek to improve their own status and look for other job opportunities.

Mr. McNeal discussed what type of short-term and long-term planning AHCCCS is doing to ensure an adequate workforce. Although shortage of long-term care workers is a recurring phenomena, the current shortage driven in part by fundamental shifts in the labor market, the aging of the population, and other social and demographic changes is unlikely to be resolved either quickly or easily. Other factors contributing to nursing facility shortages: 1) local and economic conditions have the strongest affect on turnover rates; 2) for-profits reported higher turnover rates than not-for-profits; and 3) homes in which nurses accept nursing assistance advice recorded one-third lower turnover. He commented that national recommendations are: 1) changing the organizational culture; 2) changing the organization and delivery of nursing care; 3) working on strategies to change work roles, including new types of workers; 4) more career advancement opportunities; 5) rewarding and satisfying workplace requires effective leadership and supervision; 6) having a physical environment that can support and empower workers; and 7) technology. Over time these changes will slowly transform the image of long-term care work; therefore, building public support that will allow long-term care providers to recruit and retain high quality workers.

Mr. McNeal pointed out that AHCCCS specifically continues to do the following as it relates to labor force issues: 1) to focus on working with providers to provide statistically sound data regarding rates; 2) to provide access during the annual operational financial review; 3) how the program contractors are dealing with labor shortages; 4) how the program contractors are involving their member and provider counsels in dealing with the labor shortage. He indicated that they encourage the program contractors to collaborate to develop a user-friendly guideline on how to become an ALTCS provider and to develop a simple matrix providing basic ALTCS services. AHCCCS believes that the approach nationally and in Arizona is multifaceted. Some promising approaches to consider are: 1) having businesses look at recruitment and retention practices; 2) having the community initiate a campaign to promote a higher profile and more positive image of care professionals; 3) improving business practices so that it is easier to do business with government; 4) having providers develop partnerships among paraprofessionals to establish best practices; 5) develop volunteer opportunities; and 6) use more innovative marketing strategies. This is a community issue that requires everyone's involvement; to expect AHCCCS to solve it is short-sighted, impractical, and impossible.

Mr. McNeal referred to the next question and noted studies commissioned by AHCCCS showed that direct care workers are underpaid. He indicated that in order to substantiate AHCCCS' request for additional funding for home and community-based and nursing facility direct care workers, AHCCCS did acknowledge that there was a need for an increase in the wages in these areas. In response, AHCCCS raised rates 16% this year and 8% last year for a total of 24%. He explained that the nursing facility rates were increased by 5.6% this year, effective October 1, 2001.

Mr. McNeal discussed the next question regarding who should ensure compliance of the Fair Labor Standards Act (FLSA). He stated that the FLSA is administered by the Wage and Hour Division of the United States Department of Labor. The federal government has a Phoenix office called the Employment Standard's Division that deals with wages. It is a federal responsibility rather than a state or AHCCCS responsibility to monitor labor standards.

Mr. McNeal reviewed the question regarding how Department of Economic Security (DES), Department of Human Services (DHS), and AHCCCS can become better partners in healthcare. He replied that the three agencies have formed a tri-agency team charter. The mission of the team is to lead in improving the lives of Arizona's aging population by: 1) coordinating communications and integrating processes among aging population programs at the DES, DHS, and AHCCCS; 2) improving public access to information that is of concern to older adults; and 3) providing mutual support for individual agency's aging initiatives. The team meets monthly and some of their current projects include: 1) developing a web page designed for consumers; 2) working on community-based services and settings report; and 3) improving communications among the agencies. AHCCCS participates on the interagency council which coordinates a long-term care service delivery system.

Senator Cirillo asked when was the last time AHCCCS met with providers. Mr. McNeal replied that they did meet with the nursing facilities in the middle of the rate-setting process to review the data.

Mr. Good suggested that the process seemed to handicap AHCCCS in how they budgeted, considering they had to use 1999 data. Mr. McNeal explained that they use 1999 data but role it forward to midpoint of 2001. The inflation rate was 3.5%.

Mr. Steven stated that he heard Mr. McNeal say that care is not as good as it could be, that AHCCCS has done as much as it can with rates, and are willing to meet with people to work things out. Mr. McNeal responded that the context in which he said those things was in response to the question regarding the causes of high turnover; that can cause lack of continuity of care.
Mr. Steven asked if the care being provided by the caregivers is adequate in all cases. Mr. McNeal replied that he cannot speak to all cases, but according to licensure standards, care is adequate because otherwise facilities would be shut down. He said that money is not the only answer in improving care.

Mr. Steven questioned that if the national studies showed that higher staffing ratios result in better care, more satisfied families, and less turnover, but the formula for determining payment is based on less staff than currently exists, how does AHCCCS get to the next level if there is not enough money. If the caregiver suggests they need additional staff which requires more money, is AHCCCS willing to work with them to improve quality of care. Mr. McNeal replied that he thinks the agency is willing to do so. What would have to happen is an appropriation of specific funds that is not data driven on today's cost experience but is driven on the realization that higher staffing ratios could improve care.

Mr. Steven indicated that the Committee should make that recommendation, noting that AHCCCS is willing to participate, although they cannot initiate the request. Mr. McNeal replied that they are willing to facilitate it if given the direction from this Committee and the Legislature.

In response to Senator Yrun, Mr. McNeal replied that AHCCCS oversight is directly with the program contractor and not the nursing facilities.

Mr. Mikkelson asked if the federal funds are open-ended. Mr. McNeal replied no. The federal government often agrees with rate increases as long as there is a reasonable basis for the increase. Mr. Mikkelson questioned how Arizona compares on a per-person expense basis with other states such as Minnesota or Washington. Mr. McNeal answered that he does not have that information with him but could provide it.

The meeting recessed at the sound of the gavel at 11:30 a.m.

The meeting reconvened at 11:37 a.m. in Senate Hearing Room 3.

Andrea Robson, Cochair of Oversight Committee, JobPath, distributed a handout (Attachment A) and provided an overview of JobPath, a program that started in 1996. She noted that their mission is to assist qualified adults in attaining living wages through long-term, quality skills training.

Senator Yrun asked what the maximum number of students is in the program. **Herminia L. Cubillos, Director, JobPath,** replied 200. Ms. Robson pointed out that there is a waiting list and that they are equipped to handle 300 to 400 if they had the funds.

Ms. Cubillos noted that they originally recruited through churches. They were looking for people who were interested in changing their lives, had to be in the country legally, and had to have a certain level of English proficiency, because the training for housekeeping was done in English.
Senator Yrun inquired about the base pay. Ms. Cubillos replied that it is $8 an hour. Senator Yrun also questioned if there was a union. Ms. Cubillos answered no.

Ms. Harris asked if they had considered bringing the program to Phoenix. Ms. Cubillos replied no, they are successful in Tucson; however, Lutheran Social Services has introduced their concept of the program to the East Valley. Ms. Robson explained that Arizona Interfaith is trying to implement a similar program in Maricopa County.

Mr. Steven inquired about the cost of operating the program. Ms. Cubillos replied that it is an expensive program, $5,000 per person. She stated that their current budget is $725,000, and for the last three years, it was $700,000 a year for 200 people. Mr. Steven indicated that the retention rate appears high. Ms. Cubillos noted that the first step of their program is recruitment and assessment, which is expensive and labor intensive.

Ms. Hanley asked about the recruitment and assessment process. Ms. Cubillos replied that they visit with school officials and church leaders who can help them reach the people who would benefit from the program. Ms. Hanley asked how many people are on the waiting list. Ms. Cubillos responded that there were 100 people on the waiting list.

Judy Clinco, Direct Caregiver Association, provided a handout (Attachment B) and discussed the critical shortage of caregivers and chronic turnover of employees. She explained the Caregiver Resource Center, which is a model community-based program to be replicated across the country. She covered the goals of the Center, benefits for members, sources of funding, and recommendations.

Senator Yrun announced that she was setting up four workgroups and identified the chairman for each: 1) Mr. Vandenbosch, Reimbursement and Collaboration; 2) Mr. Mikkelson, Funding; 3) Ms. Harris, Recruitment and Retention; and 4) Ms. Hanley Licensing and Accreditation. She asked each of the members to sign up for one of the workgroups and suggested that they meet approximately six times before May.

Greg LeCheminant, Executive Director, Heritage Health Care Center, distributed a handout (Attachment C) regarding some ideas to consider for improvements for skilled nursing facilities. He pointed out that he has not seen a 10.5% increase in his rates over two years. He noted that the program contractors' job is cost containment and indicated that it is a frustrating system to deal with.

There being no further business, the meeting adjourned at 12:45 p.m.

Respectfully submitted,

Carol Dager
Committee Secretary

*(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ARIZONA STATE LEGISLATURE

AD HOC STUDY COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Thursday, February 7, 2002
9:00 a.m., Room 109

Members Present:

Senator Yrun, Chairman
Senator Cirillo
Ms. Danowski
Ms. Dean
Ms. Harris
Mr. Mikkelsen
Mr. Steven
Mr. Vandebosch

Members Absent:

Senator Gerard
Senator Solomon
Mr. Good
Ms. Hanley

Staff:

Barbara Guenther

Tape 1, Side A

Senator Yrun called the meeting to order at 9:22 a.m., and attendance was noted.

Ms. Harris presented handouts entitled "Recruitment, Education, Regulation Workgroup" (*Attachment A). They consisted of information on participants of the group and minutes of the two meetings. Their participants are from outpatient and inpatient settings. She invited people to contact any of the participants to attend the meetings.

Mr. Vandebosch presented a handout entitled "Workgroup on Funding, Reimbursement, and Collaboration" (*Attachment B). His testimony came directly from the handout.

Senator Yrun asked if there is not a common or standard definition for some of the data points requested and therefore nursing facilities are interpreting the questions differently

and submitting non-comparable data on a particular question. Mr. Vandebosch stated that it would be addressed.

In response to Senator Yrun, Mr. Vandebosch stated that liability insurance will be taken up in a work group and by the various stakeholders.

Anne Winter, Financial Manager, Arizona Health Care Cost Containment System, (AHCCCS), stated that AHCCCS is committed to looking at more current data, including that of liability insurance and registry. She will make a presentation at the next meeting on this issue.
In response to Senator Yrun, Mr. Vandebosch stated that the average time of fingerprinting is over 90 days and sometimes it takes up to 120 days. This is a serious issue. There is a pattern where people work up to 90 days and then move on. He further stated that there is a bill proposed that will address the concerns of the nursing facilities. The facilities will be able to use a State criminal background check instead of full fingerprint clearance if the applicant is an Arizona resident for at least three years.

Senator Cirillo stated that there are two bills to help solve the nursing shortage.

Barbara Guenther, Research Analyst, stated that S.B. 1154 establishes a public/private partnership between the state government, community colleges and high schools to encourage people to join the health care field.

Ms. Harris asked if S.B. 1154 requires the doubling of the nursing graduates within the next five years. Ms. Guenther stated that the bill was assigned to the Health Committee and she would check into that further. Ms. Harris stated that it is a requirement to double the capacity of enrollment throughout the State.

Senator Cirillo asked if the Committee was extended. Ms. Guenther stated that the President did grant authorization to continue this Committee. The next scheduled meeting would be March 22 at 1 p.m.

Senator Yrun requested that information on S.B. 1152* and S.B. 1154 be sent to the members with the next set of minutes for this meeting.

There being no further business, the meeting was adjourned at 9:55 a.m.

Respectfully submitted,

Debbee Kennedy
Committee Secretary

*(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ARIZONA STATE LEGISLATURE

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Friday, March 22, 2002
1 p.m., Senate First Floor Caucus Room

Members Present:

Senator Virginia Yrun, Chair
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandebosch
Senator Edward Cirillo
George Good
Patricia Harris
Ritch Steven

Members Absent:

Senator Susan Gerard
Bonnie Danowski
Senator Ruth Solomon

Staff:

Tracey Landers, Senate Assistant Research Analyst

Chairman Yrun called the meeting to order at 1:00 p.m.

PRESENTATION

Catherine Garner, Dean, College of Health Sciences and Nursing, University of Phoenix (UOP), distributed a handout (*Attachment A) and provided an overview of the nursing programs at UOP. She pointed out that 1,400 students are going to school exclusively online.

Ms. Garner explained that they have a program that takes at-risk high school students (currently 18 girls in the class) and tutors them in the basics of reading and writing. Nurses visit the classroom and talk to these students about what their job entails.

Senator Cirillo questioned why one of the courses must be obtained at the Community College of Denver (CCD) rather than at UOP. Ms. Garner replied that it has to do with the rules for residency.

Senator Yrun asked for a clarification on the residency rules. Ms. Harris responded that all colleges have a residency requirement whereby a student must enroll in a certain number of credits before receiving a degree or certificate. Otherwise, students would be

transferring credits from other institutions and the college would be granting a degree without a student ever entering a classroom. Most colleges have a residency requirement meaning that the student really did attend the college, either through distance training learning, online, or within the classroom. CCD has a three-credit residency requirement; Maricopa Community College (MCC) has a 12-credit residency requirement. If UOP would enter into an arrangement, it would look differently than CCD but similar. They need to ensure the curriculum is comparable and transferable. The degree would be an Associate of Applied Science (AAS) in Nursing which leads to board eligibility to become a registered nurse (RN). Only the State can license. Curriculum is developed centrally.

Mr. Stevens noted that currently there are 4,000 licensed practical nurses (LPN) in Arizona. The goal is to increase that number by 5% in the next two years.

Senator Cirillo stressed that it is important during a nursing shortage crisis that there are top-notch supervisors to supervise the nurses. It was noted that entry-level practitioners cannot be taught without faculty. The lowest level of teaching faculty the Board will allow is Bachelor of Science in Nursing (BSN).

Senator Yrun asked who does the certified nurses assistant (CNA) training. Ms. Harris responded that the Maricopa Community Colleges do and briefly outlined the certification requirements. She indicated that there are a number of ways to become certified by the State. Some programs are as short as six weeks and some as long as a semester. The training is provided in high schools, at hospital sites, at long-term care facilities, and within seven college campuses. As soon as a section is opened, it is filled. Any care facility can provide training if they meet the State standards. There is no restriction to the number of programs that can be developed. The problem is that many of the students do not last two weeks or they change their mind sometime during the program. She pointed out that there is not a steady flow of applicants. She also talked about the many three-way partnerships in the Valley that consist of community colleges, high schools and local hospitals.

Senator Yrun questioned what the cost is to train an LPN. Ms. Garner answered that it costs approximately $200 per credit hour at UOP. To move from LPN to RN, the cost is $43 a credit hour with a minimum of 30 credits in the first year of a two-year program. An LPN who works toward the AAS degree must meet the college prerequisites; however, many do not have English, math, etc. If an LPN already has the basics, they can enter into the second year of the course.

Senator Yrun asked if there are any magnet status high schools covering healthcare. Ms. Harris replied that she does not believe there are any magnet high schools for healthcare; however, many offer healthcare training either through curriculum or dual enrollment with the community colleges. The East Valley Institute of Technology (EVIT) partnered with three high schools to provide students who are interested in healthcare career opportunities to attend EVIT half day for integrated curriculums. When one of these students graduates from high school, they are ready for a healthcare job and would only

need three semesters of college work to become an RN. One of the programs (East Valley Health Academy) was funded by Banner Healthcare who donated $250,000 to start the program.

There was some discussion on SB 1154 which addresses the nursing shortage and the fact that the universities were against the bill. It was noted that primarily their opposition to the bill was that they did not want a mandate as to what to do, because they feel they are working on the issue.

The Committee members also discussed the concern of the aging population and the need for geriatric care and the lack of nurses to support that population. Many of the long-term care facilities are experiencing budgeting problems because of decreases in Medicare coverage.

Ms. Harris reported on the progress of the nursing recruitment, education and regulation workgroup (*Attachment B). She indicated that the major issues are education training, recruitment and retention, and accreditation regulation. Under education training, they reviewed the inconsistent job titles and descriptions, which makes it difficult to train someone for a specific title. There are no standard requirements for continuing or updating training with minimal support for those undergoing the education. When looking at the recruitment and retention issue of this workforce, some of the turnover numbers are astounding. She indicated that they are trying to put together a grid that determines who does what task, who works for what agency and what the environment is. At this point, there is still quite a bit of work to determine what agency is doing what. She stated that one of the growing problems is that there is no protection for vulnerable clients. There may be someone supervising and looking at the outcome of the care, but there is no one responsible for reporting a caretaker's risky behavior.
Ms. Harris mentioned that there is a concern as to what is the definition of a caregiver.

It was noted that the high rate of turnover is directly related to the environment in which an employee works. If a person is not valued for their contribution, they move to another type of job.

Senator Cirillo pointed out that there are seriously ill people who are cared for in the home and that should not be discouraged. There is a concern that without regulating that environment, how does the caregiver acquire reasonable skills to attend to these patients.

Recently, the Board of Nursing worked on a bill that was passed by the Legislature that allows for multistate licensures. Although someone is licensed in another state, that license would be recognized in Arizona, but the caregiver needs to know the State regulations. A temporary license can be issued for a couple of weeks or for several months, depending on the status of the other state's license. It was pointed out that there is a national registry for LPNs and RNs.

Senator Yrun asked what the next steps will be. Ms. Harris replied that the workgroup members are still working on the grid, determining job titles and training requirements and noted that there are two variations that need much refining.

Mr. Vandenbosch reported on the progress of the funding, reimbursement and collaboration workgroup and distributed a handout (*Attachment C) on the subject. He pointed out that there are four primary issues: 1) registries; 2) health insurance; 3) reimbursement rate setting; and 4) new funding sources. He and several workgroup members discussed the challenges and possible solutions of each issue, which are identified in the handout.

Joe Brennan, Arizona Department of Health Services (DHS), explained that they are working at developing one common reporting requirement that would fit all nursing homes and agencies.

Senator Yrun questioned if there is a deadline identified for the reports. Mr. Brennan replied that currently it is burdensome on the industry to provide a report that no one is using. DHS first needs to identify the elements. He noted that the rule-making process takes approximately two years, unless there is an emergency provision that would streamline that time.

Senator Yrun went over the Interagency Council for Long Term Care Agency Matrix (*Attachment D). Ms. Hanley provided additional information about the matrix. Ms. Hanley noted that the Interagency Council for Long Term Care was created last session because there was not enough communication and collaboration among the agencies responsible for long-term care. The Council has been meeting since October 2001 and has been gathering data. Each agency is expected to provide information to the Council by April 17 and the Council would like to have a final product by the end of August.

Senator Yrun noted that the key items on the matrix are what are the state and federal regulatory or statutory schemes that establish obligations on the State of Arizona and who is responsible for it. It is impossible for the State to honor all of its commitments in a coordinated, efficient manner if there is no one resource that clearly outlines what all the obligations are. There may be redundancies and gaps and both can be costly. She pointed out that after the matrix is filled in, the members will be able to determine what the next steps will be to progress.

It was also discussed that the funding stream is an important issue.

Senator Yrun asked if the members could complete the matrix and return it to her by April 8.

Senator Yrun distributed the Statewide Health Care Insurance Task Force: Draft Guiding Principles (*Attachment E) and suggested it would be a guideline for the members. She asked the members to determine what six principles are necessary for developing and

retaining caregivers and to submit them to her by April 30. This will allow the legislative staff to begin formulating a draft that the Committee can work with.

It was announced that the next meeting is scheduled for May 17 at 1 p.m.

There being no further business, the meeting was adjourned at 2:50 p.m.

Respectfully submitted,

Carol Dager
Committee Secretary

*(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ARIZONA STATE LEGISLATURE

AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Friday, May 24, 2002
1:00 p.m. Senate Hearing Room 1

Members Present:

Senator Virginia Yrun, Chairman
Bonnie Danowski
Mary Lou Hanley
Ritch Steven
Senator Edward Cirillo
Gwen Dean
Guy Mikkelsen
Gene Vanderbosch

Members Absent:

Senator Susan Gerard
George Good
Senator Ruth Solomon
Patricia Harris

Staff:

Barbara Guenther, Senate Research Analyst

Tape 1, Side A

Chairman Yrun called the meeting to order at 1:04 p.m. and attendance was noted. For additional attendees, see Sign-in Sheet (*Attachment A).

REPORTS FROM WORKGROUPS SUBCOMMITTEES

Recruitment, Education and Regulation – Gwen Dean

Ms. Dean distributed a handout entitled "Workgroup on Recruitment, Education, Regulation, 3rd Report – May 24, 2002"(*Attachment B). She remarked that on March 22 the workgroup provided a report that listed issues that included the lack of a clear definition of caregivers, inconsistent titles, training, low wages, and high turnover rates. She stated that list is the first portion of the 3rd report. Referring to page 13 of Attachment B, she explained that the workgroup decided a grid was needed to outline the data collected.

Ms. Dean noted that additional columns would need to be added to include information regarding area agencies on aging, benefits, and career path providers. She noted that many of the items listed in the grid are similar and opined that it is possible that some uniformity can be made. She stated that the next step the workgroup would like to do is to

contact the regulatory bodies to bring a representative to the workgroup and have them assist with developing solutions.

In response to Senator Yrun, Ms. Dean stated that the area of training is one area in which a basic training program could be developed for caregivers. She remarked that the workgroup would like to have the regulatory bodies review and add any additional information to the grid.

Senator Cirillo remarked that certified nursing assistants (CNAs) receive three times more training and higher salaries than caregivers that are going into private homes. He commented that this does not appear to make sense, as caregivers in private homes are alone and unsupervised, whereas CNAs usually work in facilities.

Ms. Dean agreed with Senator Cirillo's remarks and commented that no one is interested in regulating caregivers. She opined that if the regulatory bodies could develop a basic training that would provide a certificate to a caregiver, it could be hand carried to the agencies, which is another possible solution. She noted that this would save money for the agencies and would also improve the image of caregivers in the community.

Senator Yrun commented that personal care attendants, personal care workers and independent care providers, who provide care in private homes, are not required to have fingerprinting as a pre-employment requirement. Ms. Dean stated that caregivers who work in facilities are the only employees that are required to have fingerprinting done as a pre-employment requirement currently.

Senator Cirillo commented that this demonstrates the balance that is trying to be maintained, yet at the same time, there is an obligation to protect the patients that the caregivers are providing care for. He stated that finding that balance is something that needs to be done.

Mr. Michelson remarked that there are liability controls with the agencies that carry insurance to provide mandatory supervision for private home caregivers. He noted that the current system does work, although many improvements can and should be made. He applauded the development of the grid and the idea to implement information obtained from the agencies. He agreed with the idea of having caregivers receive certification of basic training.

Senator Yrun commented that it would be helpful to know how many people are in each of the categories listed in the grid to quantify the workforce, relative to the population and future needs.
Ms. Dean remarked that information should be easily obtained from the agencies.

Mr. Michelson suggested that a characterization of the workforce in terms of demographics, as well as the current family structure, as this would effect the reimbursement programs, would be applicable.

Senator Cirillo suggested that a questionnaire be sent to the agencies with a request that the agencies return and make presentations with demographic information.

Funding, Reimbursement an Collaboration – Gene van den Bosch

Mr. van den Bosch distributed a handout entitled "Funding, Reimbursement and Collaboration, 3rd Report – May 24, 2002"(*Attachment C). He noted the conclusion section in the report summarizes the workgroup's suggested solutions. Referring to page 1, he noted that among the six points of agreement that the workgroup had made, point six had been highlighted because of its significance. He commented that "until the Legislature adjusts program funding levels to those required to implement SB 1322(from last year), it is unlikely that the current critical shortage of direct care workers will be able to be meaningfully addressed." Referring to page 6, he stated that one possible solution is to require state agencies that contract with a private entity to provide direct care services, including home health services and supportive care services, to require the private entity to comply with the federal Fair Labor Standards Act (FLSA).

Mr. van den Bosch, referring to page 10, New Funding, stated that the workgroup suggested soliciting new federal Temporary Assistance for Needy Families (TANF) funding to improve CNA retention and to increase the number of licensed practical nurses (LPNs) and registered nurses (RNs) available to work in long-term care. He stated that there is a model program in the State of New York that is included in the appendix section of the document.

Mr. Michelson remarked that at the St. Luke's Health Initiative's "Coming of Age" conference held yesterday new information was given that is on their website of www.slhi.org. He stated that the numbers that were brought up were staggering and stated that it was noted that family care giving is the dominant methodology. He remarked that more education and respite services are needed in this area of private home care.

Discussion on Guiding Principles

Senator Yrun distributed handouts entitled "Draft, Senate Ad Hoc Committee on Caregiver Wages and Workforce Development"(*Attachment D) and "Final Report, Statewide Health Care Insurance Plan Task Force, December 2001"(*Attachment E). She asked the members to review these documents and return to Committee with ideas for a mission statement, a statement of values, and 4-5 guiding principles as well as feed the objectives into the principles in an outline format. She requested that this information be returned in approximately two weeks.

Senator Yrun opined that a series of public hearings should be held in Maricopa, Pima, Coconino and Santa Cruz Counties for the purpose of hearing public testimony from consumers as well as provider agencies and independent providers. She commented that these meetings should be held in mid-September through mid-October so that the final report can be completed in November. Without objection, it was decided that these

meetings would be held on the first and third Tuesdays of September and October. She stated that the members would be notified of locations.

Senator Cirillo commented that an outline of proposed legislation should be included in the report.

Discussion on Matrix – Mary Lou Hanley

Ms. Hanley distributed a handout entitled "Interagency Council for Long Term Care, Arizona Department of Health Services (DHS) Matrix"(*Attachment F). She stated that the Council met in mid-April and at that time, requests were made to the agencies to develop matrices with an August deadline. She stated that this handout is an example of the start up matrix from DHS. She noted that the format for the matrix will be landscape, for easier reading and noted that in addition, the revisions that were discussed at the previous meeting will be included for the agencies to complete.

Senator Yrun announced the next meeting would be on August 12, 2002.
Without objection, the meeting was adjourned at 1:55 p.m.

Respectfully submitted,

Tracey Moulton
Committee Secretary

*(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ARIZONA STATE LEGISLATURE
AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Tuesday, August 20, 2002
10 a.m., Senate Hearing Room 1

Members Present:

Senator Virginia Yrun, Chair
Senator Ruth Solomon
Gwen Dean
Mary Lou Hanley
Guy Mikkelsen
Gene Vandenbosch
Senator Edward Cirillo
Bonnie Danowski
George Good
Patricia Harris
Ritch Steven

Members Absent:

Senator Susan Gerard

Staff:

Barbara Guenther, Senate Family Services Research Analyst
Tracey Landers, Senate Assistant Research Analyst

Chairman Yrun called the meeting to order at 10:07 a.m. and attendance was noted.

Senator Yrun mentioned that the goal of the meeting is to review the drafted workgroup reports (Attachment 1) and garner feedback. If any member determines that something is missing from the report, that information should be emailed to Barbara Guenther and Senator Yrun by September 5, 2002. She stressed that their key focus should be on the recommendations, ensuring they are clearly stated, and most importantly, prioritizing them so that a final report can be developed. She also suggested that everyone should review all meeting minutes for accuracy.

Mr. Steven questioned if there will be a final committee report that blends the data from both the workgroups. Senator Yrun explained that the integrated prioritization of recommendations would be the final report. She stated that if someone wants to integrate all the data from each of the workgroups into one report that would be acceptable. She indicated that the committee could resolve any inconsistencies in the reports.

Barbara Guenther, Senate Family Services Research Analyst, referred to the table of contents of the drafted final report, noting that Sections 1 and 2 have been completed; however, Section 3 has not yet been written. She explained that Section 3 ultimately will be the committee's final report, which will include the recommendations voted on and

passed by the committee. She pointed out that there can be a minority report that covers recommendations that do not pass the full committee.

Ms. Harris questioned if the final recommendations would be in a specific report with the workgroup reports intact. Ms. Guenther replied that the workgroup reports will remain intact as final reports of the workgroup. There also will be a final Section 3 that is devoted to the committee's consensus on the guiding recommendations for implementation.

Senator Cirillo added that normally the final report is also a documentary vehicle including all meeting agendas, minutes, reports, and final recommendations. Thus, it is a historical document and action plan.

Senator Yrun brought up that the committee had previously discussed having several public hearings in various locations to allow community members to provide input who may not have been able to travel to Phoenix. She noted that she was unable to set up those meetings due to budget constraints. She suggested that an option to the hearings would be to designate readers throughout Arizona who would read the statement of the problem, the prioritized recommendations, and the two committee reports. She asked each of the members to identify two to three individuals who would be willing to commit to and complete the task in two to three weeks. This would help ensure a statewide outreach. Each member should provide Ms. Guenther with the names, addresses, email addresses, and telephone numbers of those individuals who agree to take on this assignment.

Mr. Steven asked if the members could have a memo sent to them by email providing the details of the assignment and due dates. Senator Yrun replied that staff would provide that information to the members.

Ms. Harris questioned if there are any particular qualifications for the readers; specifically, can they include agency employees. Senator Yrun replied that she would like to see a diverse group, including consumers, providers, public, private, etc. Senator Cirillo suggested that the media should also be included.

Senator Solomon wondered if the rural issues have been identified in the reports. Senator Yrun replied that she feels the rural issues have been identified; however, if anything is missing, she would appreciate knowing that information. Ms. Harris responded that she feels that the rural issues have not been specifically identified but feel they were incorporated, because she does not feel this is just an urban issue.

Ms. Harris next discussed the final report from the Workgroup on Recruitment, Education, and Regulation. She went over the executive summary, pointing out the education/training, recruitment/retention, and accreditation/regulation major issues. She quoted from the report the workgroup's recommendation: "Our research indicates that each agency has similar, but different standards for caregiver training, education, and oversight. The development and implementation of universal standards and practices will

lead to a stable, qualified workforce, a higher quality of care and an overall reduction of costs. Due to the current shortage and increase demand for qualified caregivers, it is imperative that action be taken within 12 months. Our recommendation is that through existing interagency workgroups and or taskforces, these issues are addressed and solutions are implemented consistently statewide, thus avoiding the need for new legislation."

Senator Yrun wondered if Ms. Harris envisioned the recommendations being implemented through a rule-making process. Ms. Harris replied that she feels it could be through a rule-making process. She noted that they are aware that there are interagency taskforces currently meeting and feel the recommendations could be incorporated into their work process. Senator Yrun questioned the cooperation of the multiple accreditation organizations. Ms. Harris explained that if the organizations agree to accept each other's credentials then there is portability.

Senator Cirillo asked if the recommendations incorporated paid caregivers and volunteers. Ms. Harris responded that volunteers, independent contractors, and employees were considered.

Senator Solomon referred to the Labor Pool Shortage section of the report and pointed out that there is no mention of volunteers. Ms. Harris replied that the workgroup did consider the volunteers and would be happy to amend the report to make it clear that volunteers are included. Senator Solomon asked if the volunteers will be required to attend training. Ms. Harris explained that they would like to have the training available to everyone who provides care. Senator Solomon questioned how they can require volunteers to go through training. Mr. Steven responded that they recognized that when dealing with individual volunteer caregivers, it is very difficult to mandate that they must participate in anything. He suggested that their plan would make resources available and encourage participation at a minimal or no-cost basis, hoping that the volunteers will see that it is in their best interest to participate. He indicated that the workgroup was unable to figure out a way to mandate training for volunteers.

Senator Yrun commented that there are some models for the committee to review, specifically in California, where the training is available on websites, allowing people to review all types of educational resources. Mr. Steven explained that the workgroup had talked about volunteers being educated and having some type of reimbursement available to encourage them to spend their personal time. Senator Yrun noted that currently there is a federal prohibition against providing benefits to family members. However, she believes there is a state that has a waiver that allows a subsidy for a family member. There are creative ways to approach providing some compensation and training requirements for private caregivers.

Ms. Danowski mentioned that she believes the Arizona Health Care Cost Containment System (AHCCCS) is heading in that direction, looking at independent providers. Spouses are ineligible; however, all other family caregivers are eligible and are being paid. AHCCCS has had difficulty regulating the process and overseeing the program. She

pointed out that there is support available for family caregivers throughout the country through the National Family Caregivers Association. She suggested that they should encourage providers to make that information accessible to the caregivers.

Senator Yrun recommended a footnote be added to the report, providing information regarding resources and websites available. Senator Cirillo noted that they already have an existing policy of providing breaks for the caregivers and perhaps these breaks could be used for an education session.

Ms. Harris mentioned that one of their recommendations includes respite and suggested that they could identify the education programs available.

Senator Solomon questioned that the report does not show the resources needed to implement the recommendations. She pointed out several recommendations, noting there would be a cost and feels it is important for the committee to review those costs.

Senator Yrun acknowledged that the committee will need to review cost figures after the first prioritization cut. She emphasized that it is important not to assume money is not available, because some of these issues will have such enormous financial consequences for failure to implement, which needs to be balanced against the cost of implementing.

Senator Cirillo noted that this is a nationwide problem and if Arizona can design a good program, the federal government might provide some funds. Senator Yrun explained that some private foundations are interested in providing grants, as well. Senator Solomon cautioned that federal grants do not last forever and the State must assume the obligation when the federal grant monies cease.

Mr. Harris related that one of the recommendations from the state agencies was to separate the report into two areas: 1) facilities and 2) home and community-based services. She explained that the workgroup did strongly consider that recommendation; however, they decided that the essence of their work was to have people come together and recognize the commonality of their jobs. Therefore, they did not divide the report.

Mr. Vandenbosch next provided an overview of the Funding, Reimbursement, and Collaboration Workgroup's final report. He stressed that this is a very complicated, multidimensional problem requiring a multidimensional solution. He emphasized that until the Legislature adjusts program funding levels to those required to implement the 2001 Arizona Legislative session's SB 1322, it is unlikely that the current critical shortage of direct care workers will be able to be meaningfully addressed.

Senator Cirillo asked if the workgroup considered that the current state of the economy might free up individuals to go into this area of work. Mr. Vandenbosch replied that he has not seen any numbers, but does not feel that is the case. When given choices, most people will opt for other types of work. Caregivers are heroes and are doing the job because they deeply care, not because of the pay.

Mr. Steven suggested that direct caregivers are no different than registered nurses (RN). He referred to a recent report that indicates that by 2020 there will be a 20% vacancy rate in RN positions. He stated that he feels that will trickle on to other caregiver populations. He emphasized that if these numbers are accurate, it will radically change the way healthcare is delivered. It is a large problem and the numbers are accelerating.

Senator Cirillo noted that the average nurse providing care today is in her/his mid-40s and the average age of volunteers as caregivers is even higher.

Senator Solomon asked if they was any consideration given to shortages in the rural areas versus urban. Mr. Vandenbosch replied that he does not recall the rural/urban distinction being addressed in their report; however, he feels that is significant. He suggested that when they ask for the readers, there should be a special focus on the rural areas.

Senator Yrun questioned the prioritizing of the workgroup's recommendations. Mr. Vandenbosch suggested that he would poll his committee members for that information and get back to her in a couple of days.

Senator Cirillo referred to the eleven objectives of their report and suggested that they could be condensed into five or six categories.

Senator Yrun indicated that upon reviewing the recommendations, she felt that many of them could move forward apart from legislative action and that was the reason she suggested the formation of an implementation workgroup. She wondered if they should wait until they actually see how the recommendations are prioritized.

Ms. Hanley mentioned that Senator Yrun had asked the Long-Term Care Council to develop a matrix of the statutes and regulations each agency is obligated to fulfill. The deadline was August 16 and all data has been gathered. She explained that the information is being input into a database, which will be standardized into a presentation and submitted to Ms. Guenther.

Ms. Guenther reviewed the next steps for the committee: 1) email the workgroups' reports to the committee members to review, edit, and prioritize by September 5; 2) prepare draft of members comments and send to identified readers for review and comments to be returned within three weeks (end of September); 3) incorporate all comments (staff will need a few weeks to complete); 4) schedule a meeting in October to determine the short- and long-term goals, which can be implemented without legislation, and begin compiling them into a final form for the committee to vote on; 5) prepare final report of recommendations passed by the committee; other recommendations can be prepared in a minority report; and 6) schedule a meeting in late November to finalize the report due December 15.

Senator Cirillo asked that once all comments are received and compiled by staff, could a report be sent to the committee members to review prior to the October meeting where they will be voting on them. Ms. Guenther replied that they can do that.

Senator Yrun asked if the members have to vote on each separate recommendation.

Senator Cirillo suggested that a package could be presented and any member wanting to change something would need to offer an amendment.

Senator Yrun asked the workgroups how long it would take them to prioritize their recommendations. Mr. Vandenbosch replied that they could do it within 10 days or sooner. Senator Yrun indicated that the committee should then be able to receive all the recommendations to review by September 5, so that by September 15th they would have a list of recommendations that could be submitted to Joint Legislative Budget Committee (JLBC) for fiscal data. Senator Cirillo suggested that the agencies could provide some of the fiscal data.

Senator Solomon explained that the fiscal analysis could include both savings and cost; but generally, JLBC needs to be instructed that is what the committee is looking for.

Ms. Harris noted that their workgroup would also need to prioritize their recommendations and submit by the deadline.

Senator Yrun questioned if the timeline would change. Ms. Guenther responded that if the workgroups can get their data to her by September 1, that information can be sent to the members who should be able to get their remarks back to Barbara in a week. At that time JLBC could receive the information to provide some costs by the end of September.

Mr. Mikkelson related a story regarding the current economic environment, suggesting that the reports have wonderful ideas. However, from a business point-of-view, they would be compressing the ability of providers to respond and carry out some of these ideas, noting that the only way a provider can address any of the issues is to pay less.

There being no further business, the meeting was adjourned at 11:07 a.m.

Respectfully submitted,

Carol Dager
Committee Secretary

(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

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ARIZONA STATE LEGISLATURE
AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting

Tuesday, October 15, 2002

10:00 a.m., Senate Hearing Room 1

Members Present:

Senator Virginia Yrun, Chair
Bonnie Danowski
Guy Mikkelsen
Gene van den Bosch
Senator Edward Cirillo
Patricia Harris
Ritch Steven

Members Absent:

Senator Gerard
Gwen Dean
Mary Lou Hanley
Senator Ruth Solomon
George Good

Staff:

Barbara Guenther, Senate Research Analyst
Tracey Landers, Senate Assistant Research Analyst

Senator Yrun called the meeting to order at 10:07 a.m. and attendance was noted.

Comment on Essential Reader Feedback

Senator Cirillo stated that the Final Report should indicate that the findings and recommendations are equally applicable to all caregivers.

Senator Yrun commented that technology and long-term care are two significant areas of impact for the caregiver.

In response to Senator Cirillo, Barbara Guenther, Senate Research Analyst, stated that the State Library and Archives retain the official historical documents. She further stated that the Final Report will be on line.

Finalize Recommendations

Senator Yrun stated that the handout was a consensus of the committee with 41 recommendations in order of priority (Attachment A). The committee recessed for 15 minutes at 10:20 a.m. to study Attachment A.

Senator Yrun reconvened the meeting at 10:35 a.m. and invited general discussion from the members. After much discussion, it was decided that all recommendations and changes to the handout would be presented and adopted in the Final Report at the next meeting.

Senator Yrun commented on a letter from Timothy J. Schmaltz, Center for Spirituality and Ministry in the Marketplace, in a handout entitled "Ad Hoc Committee on Caregiver Wages and Workforce Development Statement of the Problem (Attachment B). She commented that the recommendations will be substituted with the work just completed.

Senator Yrun further commented that the committee will not only address issues and recommendations for the elderly and the disabled, but also for mental illness and childcare needs.

Mr. Gene van den Bosch agreed that the Committee's recommendations appear to apply for caregivers of all vulnerable people, but he added the Committee's original commission and proper focus on long-term care should clearly remain the focus of the Committee's final report.

Senator Cirillo suggested that a bill should be introduced in the upcoming legislature to reestablish the committee to be an implementation committee. Senator Yrun commented that this should be a recommendation and language be drafted.

Update on Fiscal Notes

Senator Yrun stated that Senator Solomon is beginning the process of requesting fiscal notes on the recommendations. She further stated that this would be presented at the next meeting.

Overview of Revenue Expectations and Budget Process

Stefan Shepherd, Joint Legislative Budget Committee (JLBC), stated that JLBC works with the Appropriations chairs in the House and Senate to develop recommendations both on the expenditure side as well as expectations on the revenue side. He further stated that budgeting is done on an incremental basis. They compare policy issues and compare them to the current budget. During session, the Governor will issue her recommendation.

The JLBC recommendation comes out the first week of session and will address the Governor's recommendation as well. Then the recommendations will be debated by the Appropriations Committees.
Mr. Shepherd stated that the current year deficit of $400 million consists of shortfalls on the revenue side and expenditures being higher than assumed in the budget. The year-to-date general fund deficit is $116 million. He stated that estimates need to be made for fiscal year 2004 which generally will grow from year to year. However, if there are revenue shortfalls from fiscal year 2003, it will effect 2004. He stated that enrollment

growth in schools is still growing and the basic state aid formula needs to be funded. He stated that the fiscal year 2003 $400 million shortfall can be solved with ongoing reductions. This will reduce the $1 billion deficit projected for fiscal year 2004.

In response to Patricia Harris, Mr. Shepherd stated that the fiscal year begins in July.

In response to Senator Cirillo, Mr. Shepherd commented that the State's economy will recover slowly.

Senator Cirillo commented that there are items upcoming on the ballot that could generate additional revenue for the State.

Richard White, East Valley Interfaith Network, encouraged the Committee to place the details in the Executive Summary. He further stated that it is critical to carry on this work.

Senator Yrun announced that the next meeting will be held on November 12, 2002.

There being no further business, the meeting was adjourned at 11:30 a.m.

Respectfully submitted,

Debbee Kennedy
Committee Secretary

(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ARIZONA STATE LEGISLATURE
AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Minutes of the Meeting
Tuesday, November 12, 2002
11:00 a.m. Senate Hearing Room 1

Members Present:

Senator Virginia Yrun, Chairman	Senator Edward Cirillo
Bonnie Danowski	Gwen Dean
George Good	Mary Lou Hanley
Patricia Harris	Guy Mikkelsen
Ritch Steven	Gene van den Bosch

Members Absent:

Senator Susan Gerard	Senator Ruth Solomon

Staff:
Barbara Guenther, Senate Research Analyst
Tracey Landers, Senate Research Assistant Analyst

Chairman Yrun called the meeting to order at 11:10 a.m. and attendance was noted. For additional attendees, see Sign-in Sheet (Attachment A).

APPROVAL OF MINUTES

Mr. van den Bosch moved the minutes of August 21, 2001, October 23, 2001, November 7, 2001, November 19, 2001, December 6, 2001, February 7, 2002, March 22, 2002, May 24, 2002, August 20, 2002, September 18, 2002 and October 15, 2002 be approved. Ms. Harris seconded the motion.

Mr. van den Bosch moved the following amendment to the October 15, 2001 minutes: Page 2, after paragraph three insert: "Mr. van den Bosch agreed that the Committee's recommendations appear to apply for caregivers of all vulnerable people, but – he added – the Committee's original commission and proper focus on long-term care should clearly remain the focus of the Committee's final report."

Ms. Harris moved the October 15, 2001 minutes as amended. The motion CARRIED by voice vote.

Without objection, the remaining minutes were APPROVED as distributed.

DISCUSSION OF EXECUTIVE SUMMARY

Without objection, the Executive Summary was ADOPTED by voice vote.

VOTE ON FINAL RECOMMENDATIONS

Senator Yrun, referring to the handout entitled Draft, Senate Ad Hoc Committee on Caregiver Wages and Workforce Development (Attachment B) explained that the proposed amendments to the recommendations begin on page 6 of the attachment.

Barbara Guenther, Senate Research Analyst explained that the recommendations had been approved by the Committee at the last meeting. The proposed amendments make final adjustments to the approved recommendations.

Ms. Danowski moved amendment #1 dated 11/12/02 (Attachment C). Ms. Harris seconded the motion.

Mr. Mikkelsen moved the following verbal amendment to amendment #1, to add the following members to the draft legislation: The Director of the Department of Economic Security or the Director's designee and the Director of Arizona Health Care Cost Containment System or the Director's designee be added to the task force. Mr. van den Bosch seconded the motion.

Ms. Harris moved amendment #1 AS AMENDED, be ADOPTED. Ms. Danowski seconded the motion. The motion CARRIED by voice vote.

Mr. van den Bosch moved amendment #2 dated 11/12/02 (Attachment D). Ms. Harris seconded the motion. The motion CARRIED by voice vote.

Mr. van den Bosch moved amendment #3 dated 11/12/02 (Attachment E). Ms. Harris seconded the motion. The motion CARRIED by voice vote.

Mr. van den Bosch moved amendment #4 dated 11/12/02 (Attachment F). Ms. Harris seconded the motion. The motion CARRIED by voice vote.

Mr. van den Bosch moved amendment #5 dated 11/12/02 (Attachment G). Ms. Harris seconded the motion. The motion CARRIED by voice vote.

Mr. Good moved amendments #6-8 dated 11/12/02 (Attachments H, I and J). Mr. van den Bosch seconded the motion. The motion CARRIED by voice vote.

Senator Yrun commented that Ms. Hanley has been chairing the effort of creating a matrix of all the programs within the state that serves anyone over the age of 65 or anyone with a developmental disability at the Interagency Council for Long-term Care.

She stated that the matrix is being mailed to the members with corrections provided by the Interagency Council for Long-term Care. She remarked that this matrix is an incredible tool that includes programs, courts cases, eligibility, and consequences for failure to provide services.

Senator Yrun noted that an initial conversation has taken place with a consultant to provide the Committee with a price for facilitating a process through the Interagency Council for Long-term Care of performing a gap analysis or redundancy review and also the cost involved with having the consultant perform the analysis.

Senator Yrun stated that the work that has begun with the Interagency Council for Long-term Care has been an exhaustive review of all the programs into information that policy makers could use to either create efficiencies or eliminate redundancies and possible stretch existing dollars through waivers to cover new groups of people. She commented that the work of the Committee would continue through the recommendations, which will be presented to the Legislature.

Senator Yrun presented all the members with letters of Legislative Commendation in appreciation of their efforts.

Without objection, the meeting was adjourned at 11:30 p.m.

Respectfully submitted,

Tracey Moulton
Committee Secretary

(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

Arizona Senate Ad Hoc Committee
on Caregiver Wages and Workforce Development

Funding, Reimbursement and Collaboration

Final Report ~ August 20, 2002

This report is for the Arizona Senate Ad Hoc Committee on Caregiver Wages and Workforce Development from its Funding, Reimbursement and Collaboration Workgroup

Workgroup Participants

Karen Barno, Executive Director
Arizona - Assisted Living Federation of America

Joe Brennan, Economist
Arizona Department of Health Services

Paul Friedlan, Administrator and Principal
Copper Mountain Inn

George Good, District Chief
Rural Metro Fire District

Larry Litman, Healthcare Consultant
Health Care Systems

Matt Luger, Executive Director
Covenant Health Network

Guy Mikkelsen, Executive Director
Foundation for Senior Living

Debra Nixon, Vice President, Corporate Development
Health Services Advisory Group, Inc.

Mary Temm, President
Temm & Associates

Gene van den Bosch, Director of Policy and Governmental Affairs
Arizona Association of Homes and Housing for the Aging

Summary

Staffing shortages within Arizona's long-term care (LTC) providers affect the cost, quality, and availability of care. Our workgroup of community stakeholders used facets of the multi-dimensional problem - i.e. the workforce crisis in the LTC sector - to form a framework for a multi-dimensional solution. This report focuses on four primary issues, their barriers, and our developing recommendations for proposed solutions. These issues are:

1. registries (temporary staffing pools)
2. health insurance
3. reimbursement rate setting
4. new funding sources.

Representatives of stakeholder groups in our workgroup agree that:

1. staffing shortages and turnover rates affect the cost, quality, and availability of care;
2. the LTC workforce crisis is a multi-dimensional problem requiring a multi-dimensional solution;
3. the most important dimension to solving this complex problem is adequate funding and reimbursement achieved more readily through collaboration;
4. this collaboration should include long-term care providers, program contractors, private foundations, plus academic and government agencies sharing information, increasing awareness and spearheading change; and
5. primary issues related to funding and reimbursement at this time are registries, health insurance, reimbursement rates and new potential sources of funding; however - and we stress -
6. **until the Legislature adjusts program funding levels to those required to implement the 2001 Arizona Legislative session's SB1322, it is unlikely that the current critical shortage of direct care workers will be able to be meaningfully addressed.**

Registries
Temporary Staffing Agencies

1. **Issues:**

- Effects of registries (temporary worker staffing agencies) include rising costs[1] and a smaller pool of critically needed full-time caregivers available for permanent employment.

- Faced with a shortage of health-care workers, Arizona's nursing homes have turned to registries for certified nurses assistants (CNAs). These agencies often have a ready supply of nurse-assistants partly because they are not limited by AHCCCS rate setting parameters, in terms of their employee compensation.

- The higher costs for utilizing temporary care workers from registries are significant. The costs are currently not reflected in AHCCCS' reimbursement rates for ALTCS nursing facilities (NFs). Seventy-five percent (75%) of the 143 NFs currently licensed in Arizona report paying nearly $23 million in FY 2001 for registry care workers. *See Appendix D.*

2. **Challenges:**

- Registries pay higher wages to temporary staff, thus attracting caregivers. Facilities desperate for caregivers (up to 20% vacancy rates for some) pay registries higher fees to bring in critically needed caregivers to offer essential care to residents. One effect is rising costs. Registry costs remains a significant percentage of the total labor costs for nursing homes and the significant increase of temporary workers in recent years has raised concerns about the impact on providers' finances as well as on the continuity and quality of care. The cost of putting a temporary worker on a shift is estimated to be two to three times the cost of using a staff employee.[2] Nursing homes cannot compete with registries on a wage-per-hour basis because nursing homes are limited by AHCCS reimbursement ranges, while registries are not.

- Temporary work can be appealing, despite the unpredictable number of hours it offers. The lack of benefits such as health insurance is not an issue because many nursing homes and HCBS providers cannot afford to offer their CNAs affordable health-care coverage.

- Two entities compete for the same workers, yet one is restricted and the other is not. The effect is a "false labor market".

- Constant turn-over of temporary caregivers makes "quality" care and experience more challenging for the caregivers and for the resident.

- Registry contracts contain a "non-compete clause" preventing post-service free movement or full-time employment with the care facility, thus preventing the facility from recruiting temporary workers into the facility workforce.

- We know little about the employment patterns and motivations of temporary workers. Most in the field contend that workers choose temporary work because of higher pay and more flexibility. Pools may also allow people to continue to work in the field as their situation changes and allow

[1] According to the Arizona Association of Homes and Housing for the Aging and the Arizona Health Care Association, some nursing home services cost more than Medicaid/AHCCCS pays and temporary workers are one of the fastest-growing costs faced by the care providers.
[2] Sources: Arizona Health Care Association and the Arizona Association of Homes and Housing for the Aging.

"permanent" workers to supplement their income. Workers, particularly nursing assistants, often alternate between temporary and "permanent" work.

3. **Proposed Solutions:**

- Further research by Arizona's universities and other members of the research community (e.g. private foundations) - in collaboration with LTC providers, program contractors, registries, and nursing professionals in LTC - to include these questions:

  1. What are the wages for nurses working in temporary pools?
  2. How much rate reimbursement would be available if registries did not exist?
  3. Are there other issues besides wages behind the growth of registries?
  4. What legislative solutions are offered in other states (e.g. MN,) and what are the outcomes in those states?
  5. How many temporary caregivers now working in nursing homes are also employed at other homes and rely on registries to supplement their income with additional work?
  6. Would statutorily capping temporary worker rates have a positive or negative effect on worker availability?
  7. What is the comprehensive portrait of LTC nursing personnel in Arizona, including basic demographic information, educational levels, racial and ethnic diversity, and their distribution across geographic areas and LTC settings?
  8. What is the wage elasticity for CNAs, LPNs and RNs in LTC?
  9. What is the relationship between LTC worker satisfaction and retention and the quality of care and quality of life for recipients of care?
  10. What are reasons CNAs leave their line of work and what would it take to keep them on the job (and for those who leave, what it would take to get them to return)?
  11. Would better training, career paths, higher wages, or improved benefits for LTC employees result in lower overall program costs, presuming AHCCCS payment practices permitted this?
  12. Consider the cost issues related to registries at a collaborative work-group comprised of representatives from AHCCCS, rural NFs, urban NFs and program contractors. Recommendations would go to AHCCCS as it develops the method for NF rate setting.[3] *(See Appendix D)*

- Research the legality of the non-compete clause for temporary health care workers through the State Attorney General's office.

- *Depending on research* with the State Attorney General's office, explore banning the "non-compete clause" for temporary health care workers through an amendment to a similar bill going through the Arizona legislature for media personnel.

- Pass legislation in the 2003 session that would limit what registries can charge for temporary workers. In Minnesota last year, legislators passed a law that effectively caps the wages of temporary workers at 150 percent of the prevailing wage. The law also stipulates that at least 30

[3] The law survived a federal court challenge in November 2001.

percent of the work hours filled by agency employees must be during weekends, holidays or night shifts.[4] *(See Appendix E)*

- Given the possible side-effect of legislation to cap wages at registries as the mass exodus of qualified care-providers from nursing homes, we should explore, educate and collaborate to find new funding to improve compensation for the regular staff and expand the number of people coming into the profession.

Health Insurance

Health insurance for caregivers

1. **Issues:**

- Health insurance provides significant benefits for caregivers and their families.

- Nurse assistants working in all types of health care settings are the least likely group of health care workers to have insurance. [5]

2. **Challenges:**

- Because of AHCCCS reimbursement shortfalls, many LTC employers cannot afford to offer health insurance to their employees.

3. **Proposed Solutions:**

- Through AHCCCS, provide health insurance for parents of children enrolled in KidsCare. Many of Arizona's caregivers are among these parents.

  Note: Although the waiver to expand Title XXI funding to parents of KidsCare children was approved by the *Centers for Medicare and Medicaid Services (CMS),*[6] the Arizona legislature must authorize the program and approve the state appropriation. While this issue was discussed at the legislature, there is no active legislation at this time.

- Explore, through the commissioned Statewide Healthcare Insurance Task Force, possibilities associated with a "group pool" for health insurance that would allow AHCCCS participating facilities to offer health insurance to employees at more affordable rates.

Reimbursement Rate Setting

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[4] The law survived a federal court challenge in November 2001.

[5] No care for the caregivers: Declining health insurance coverage for health care personnel and their children, 1988-1998 by G.S. Brady et al is published in the March 2002 issue of the American Journal of Public Health (Vol. 92, No 3). This study of health insurance coverage of health care personnel between 1988 and 1998 shows that they lost coverage more rapidly than other workers. In 1998, 1.36 million health care workers were uninsured, up 83.4 % from ten years earlier. In 1998, 23.8% of aides were uninsured, representing 37% of uninsured health care workers. When looked at by place of work, 20% of all nursing home workers were uninsured. However, workers in private nursing homes were much more likely to be uninsured (20.9%) than workers in public nursing homes (7.5%).

6 The Centers for Medicare and Medicaid Services (CMS, formerly HCFA) is a federal agency within the United States Department of Health and Human Services. CMS runs the Medicare and Medicaid programs and maintains oversight of the survey and certification of nursing homes and continuing care providers (including home health agencies, intermediate care facilities for the mentally retarded, and hospitals).

by AHCCCS for nursing facilities caring for ALTCS residents

1. **Issues:**

- Appropriate reimbursement rates for NFs and HCBS are related to the ADHS and AHCCCS collection of relevant nursing facility (NF) data to include direct care costs (nursing salaries/wages/benefits), capital costs and indirect care.

- Arizona is ranked 33rd for Average Medicaid Reimbursement Rates. Thirty-two (32) states have higher and 18 states have lower average Medicaid reimbursement rates for nursing homes than Arizona. [7] *(See Appendix F)*

2. **Challenges:**

- At the request of the Legislature, the JLBC conducted a study on the on the cost impact of requiring the State of Arizona to include competitive, fair and market wages for direct care staff in final contract rates for direct care services. Although this requirement was ultimately adopted by the Legislature, funding allocations for the program areas addressed in the legislation were not increased to the levels estimated to be required by the JLBC study.

- Our society still undervalues the work of women - tolerating poor wages for caregivers - most of whom are women.

- Unreasonable expectations in terms of data sample sizes for AHCCCS rate setting for nursing facilities providing services and care for ALTCS residents.

- Disagreements among stakeholders over AHCCCS rate setting methodologies and the data collection process required for such rate setting.

- Current data collection for AHCCCS rate setting does not reflect all costs for providing caregivers with a fair and market wages. Still, care providers can only pay what they receive. *(See Appendix C)*

- Past data collection tool not compatible with Y2K or current commonly used computer software. Statutes requiring information collection by ADHS were thus not enforced.

- Data-lag. Some costs may rise very quickly.

- Current NF rates do not yet reflect January 2002 calculations by AHCCCS using updated data that indicated a need to immediately increase payment rates by three percent (3%).

3. **Proposed Solutions:**

- Require state agencies that contract with a private entity to provide direct care services, including home health services and supportive care services, to require the private entity to comply with the federal Fair Labor Standards Act (FLSA).[8]

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[7] Source: 2001 The Guide to the Nursing Home Industry by HCIASachs/Arthur Anderson.

Note: Until the Legislature adjusts program funding levels to those required to implement the 2001 Arizona legislative session's SB1322, it is unlikely that the current critical shortage of direct care workers will be able to be meaningfully addressed.

- Require ALTCS reimbursement rates at levels sufficient for the care provider to comply with the FLSA.

- Require regular meetings between AHCCCS, ADHS, nursing facilities, HCBS providers, and program contractors to define reporting requirements for future AHCCCS rate setting efforts.

- Require a collaborative process of comprehensive data collection to set AHCCCS reimbursement rates for ALTCS residents that utilizes

  1) equitable formulas and methodologies agreed to by all of the major stakeholders (i.e. AHCCCS, program contractors, NF and HCBS providers), and

  2) the most current and accurate data possible.

- Require collaborative workgroup(s) comprised of NF and HCBS stakeholder representatives should meet with AHCCCS to coordinate the timing for data gathering, develop data collection tools, calculation methodologies and participation incentives (e.g. coordinated surveys, coordinated or joint announcements)

- Require the "cost report" to be a *single uniform cost report* for both AHCCCS and ADHS. ADHS and AHCCCS representatives should address modifications to inter-government / agency agreements to streamline reporting and clarify existing statute mandating data collection and cost reporting.[9]

- Consider and approve the AHCCCS re-calculation using updated Time and Motion study results and its recommendation to increase AHCCCS NF rates by an additional three percent (3%).[10]

- Require a collaborative study – collaboration to include stakeholders and a disinterested third party (e.g. Arizona university or another research institution, private foundation) – to include these questions:

  1. What is the current actual capacity for NFs and HCBS?
  2. How many NFs are closing?[11]

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[8] The U.S. Office of Personnel Management and the U.S. Department of Labor (USDOL) describe the FLSA as establishing minimum standards for wages, overtime entitlements, record keeping and child labor standards. Presently, covered nonexempt workers are entitled to a minimum wage of at least $4.25 per hour. Overtime pay is required for these workers at a rate of not less than one and one-half times their regular rates of pay after working 40 hours in a week. According to the USDOL, the FLSA does not require vacation, holiday, severance or sick pay; meal or rest periods, holidays off or vacations; premium pay for weekend or holiday work; pay raises or fringe benefits; and a discharge notice, reason for discharge or immediate payment of final wages to terminated employees. "Direct care services" is defined as any service directly provided to a client or recipient.

[9] A meeting between AHCCCS and ADHS on this matter took place on March 21.

[10] Annualized fiscal impact of this additional 3% NF rate increase is approximately $11.5 million total funds, which equates to $7.6 million Federal, $2.3 million State, and $1.6 million County funds. (Source: AHCCCS)

[11] According to the Arizona Department of Health Services, 1,329 nursing home beds were lost in Arizona through 19 nursing home and SNF closures, downsizing and changes of ownership between February 2000 and February 2002. During the same period, 258 beds ere added to the system through four new and three upsized facilities. The net loss of nursing care beds for Arizona is 1,071.

3. Why are NFs closing?
4. Where are these NF closings taking place?
5. What are the economic, social and health implications of NF closings?

New Funding Sources

Identify new funding sources to support caregiver wages and workforce development.

1. **Issue:**

- Realistically, existing funding sources will have to cover the overwhelming share of workforce costs, however new funding sources would help to provide additional support for increased caregiver wages and workforce development.

2. **Challenges:**

- Arizona budget crisis.

- In total, the administrative expenses for the ALTCS program are over 15%. [12] Together with the administrative costs of the program contractors, these administrative expenses total over 25%. Duplication in administrative expenses may be caused by duplication in regulatory requirements placed on the provider community by both AHCCCS and the Program Contractors. For example, quality assurance requirements imposed on nursing facilities by both AHCCCS and the Program Contractors have increased. Quality assurance studies and improvement programs are not often coordinated by AHCCCS and the Program Contractors, resulting in expenditure of valuable nursing facility workforce resources.

3. **Proposed Solutions:**

Increased Medicaid/AHCCCS payments for nursing homes using new funding sources such as:

- Solicit new federal Temporary Assistance for Needy Families (TANF) funding to improve CNA retention and to increase the number of LPNs and RNs available to work in long-term care. This program[13] could include:
  1. collaboration between ADHS, DES and groups representing NFs, HCBS providers and hospitals;
  2. hiring of TANF eligible people;
  3. recruitment goal of a designated percentage being current TANF recipients;
  4. upgrading of skills for the existing workforce;
  5. meeting the demand for additional staffing by allowing NFs, HCBS providers and hospitals to "grow their own" LPNs and RNs; and
  6. viable career path for caregiver employees.

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[12] Per the JLBC 2002 Budget report.

[13] A similar program was successfully funded in 2001 with TANF Health Worker Training Initiative dollars by the New York State Department of Health, in consultation with the New York State Department of Labor. It is now implemented by The Senior Health Alliance of Greater Rochester - The Episcopal Senior Life Community, Jewish Health Care System of Rochester, Rochester Friendly Senior Services, St. John's Senior Services, and St. Ann's of Greater Rochester. The 2000-2001 New York State Budget made available up to $80 million for grant awards supporting the recruitment, training and retention of individuals eligible for TANF funded services for jobs in hospitals, nursing homes and home health care agencies.

- Recovery of unused *Residential Personal Needs Funds* previously assigned to deceased residents. Some estimate the amount available should be between $0.8 and $1.5 million.

- Bad debt recovery. Every year, nursing facilities face uncollectible amounts of "bad debt" due to "prior period or prior quarter" ALTCS eligibility determinations. The nursing facility provided care for - presumably - a private pay patient, only to be notified of a retroactive ALTCS approval date. Such an approval date often does not "go back" to the date those residents exhausted their private funds. Consequently, the facility is forced to "write off" all charges prior to the actual date that ALTCS payment commences. This "bad debt" is a direct function of the facility's AHCCCS enrollment and the AHCCCS policy decision to change how prior period coverage is or is not funded. In previous years, providers were generally assured of receiving payment from the first day of ALTCS eligibility. In early 2001, an AHCCCS memo indicated a policy change that put the facilities at risk for some prior periods. A recent survey revealed this "bad debt" uncollectible amount, due to AHCCCS rollovers, to be significant.[14]

- Creation of a seven-member task force to help identify funding problems and design solutions.

- A more efficient use of current available funds. Undertake a to review the administrative funds allocated in the ALTCS program to the AHCCCS Administration and to the individual Program Contractors.

Conclusion

This report suggested the following Proposed Solutions to address the funding and reimbursement challenges related to Arizona's caregiver wages and workforce development.

Registries / Temporary Staffing Agencies

1) Further research on registries by Arizona's universities and other members of the research community in collaboration with LTC providers, program contractors, registries, and nursing professionals in LTC.

2) Research the legality of the non-compete clause for temporary health care workers through the State Attorney General's office.

3) Explore banning the "non-compete clause" for temporary health care workers through an amendment to a similar bill going through the Arizona legislature for media personnel.

4) Limit what agencies can charge for temporary workers. Legislation should cap the wages of temporary workers at 150 percent of the prevailing wage. The law should also stipulates that at least 30 percent of the work hours filled by agency employees must be during weekends, holidays or night shifts.

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[14] For 57 Arizona nursing facilities responding to a Joint survey by the Arizona Health Care Association and the Arizona Association of Homes and Housing for the Aging in April and May of 2002, the uncollected share of cost amounts were $745,589 (FY 1999); $557,229 (FY2000); and $273,396 (FY2001). Amounts uncollectible due to AHCCCS rollovers were $250,806 (FY 1999); $103,593 (FY2000); and $110,486 (FY2001).

5) Explore, educate and collaborate to find new funding to improve compensation for the regular staff and expand the number of people coming into the profession.

Health Insurance for Caregivers

1) Authorize AHCCCS to provide health insurance for parents of children enrolled in KidsCare.

2) Explore, through the commissioned Statewide Healthcare Insurance Task Force, possibilities associated with a "group pool" for health insurance that would allow AHCCCS participating facilities to offer health insurance to employees at more affordable rates.

Reimbursement Rate Setting

1) Require state agencies that contract with a private entity to provide direct care services, including home health services and supportive care services, to require the private entity to comply with the federal Fair Labor Standards Act (FLSA).

2) Require ALTCS reimbursement rates at levels sufficient for the care provider to comply with the FLSA.

3) Require AHCCCS, ADHS, nursing facilities, HCBS providers, and program contractors to achieve shared agreement regarding reporting requirements for future AHCCCS rate setting efforts.

4) Require a collaborative process of comprehensive data collection to set AHCCCS reimbursement rates for ALTCS residents that utilizes equitable formulas and methodologies agreed to by all of the major stakeholders, and the most current and accurate data possible.

5) Require a collaborative workgroup(s) comprised of NF and HCBS stakeholder representatives should meet with AHCCCS to coordinate the timing for data gathering, develop data collection tools, calculation methodologies and participation incentives (e.g. coordinated surveys, coordinated or joint announcements).

6) Require the "cost report" to be a single uniform cost report for both AHCCCS and ADHS.

7) Consider and approve the AHCCCS re-calculation using updated Time and Motion study results and its recommendation to increase AHCCCS NF rates by an additional three percent (3%).

8) Require a collaborative study – to include stakeholders and a disinterested third party (e.g. Arizona university or another research institution, private foundation) on NF and HCBS capacity, closures and the economic, social and health implications of NF and HCBS closures.

New Funding

1) Solicit new federal Temporary Assistance for Needy Families (TANF) funding to improve CNA retention and to increase the number of LPNs and RNs available to work in long-term care.

2) Recover unused *Residential Personal Needs Funds* previously assigned to deceased residents.

3) Recover share-of-costs (bad debt).

4) Create a seven-member task force to further identify funding problems and design solutions.

5) Use current available AHCCCS and program contractor administration funds more efficiently.

The challenge to locate funding and provide appropriate reimbursements rates to support LTC workers providing care to our state's most vulnerable citizens is made more complicated by the looming workforce crisis (shortages and turn-over rates) and Medicaid crisis. We also have an opportunity to more carefully examine possible causes of the current problem and to affect system changes to provide both short-term relief and long-term solutions. Despite its urgency, the crisis may also present an opportunity for major changes in long-term care. It may provide incentives for taking steps that have been difficult for policy makers and the long-term sector to take. Assuring adequate staffing across long-term care settings in Arizona will require both short-term actions to alleviate the immediate crisis and long-term strategies that address its roots.

Since public programs such as ALTCS will likely remain the major payor of LTC in Arizona, public policy will continue its fundamental role in shaping the LTC sector. We believe significant improvement in caregiver wages and workforce development requires collaborative mechanisms that promote a comprehensive approach, build and maintain momentum, and provide a direct conduit to public policy changes.

We believe effective solutions are within reach - as long as long-term care, academic and government officials work together to gather and share information, increase awareness and spearhead change.

Appendix A

Report

The *Arizona Senate Ad Hoc Committee on Caregiver Wages and Workforce Development* directed our Funding, Reimbursement and Collaboration Workgroup to meet at least six times and to present interim reports before April 11, 2002. We met seven times as a workgroup from January through April of 2002.

Our report is based upon:

- national and state dialogues regarding caregiver and workforce funding and reimbursement;
- discussions with various stakeholders at meetings convened by AHCCCS or by our workgroup; and
- policy issues regarding caregiver and workforce funding and reimbursement raised in the literature.

Findings and recommendations presented in this report are based on:

- Materials submitted upon invitation from identified stakeholders. Invitations to submit relevant information on this topic were sent to individuals and organizations recognized as opinion leaders or researchers in the area of nursing home care and home and community based care within Arizona or nationally. *See Appendix I.*
- Selected reports and articles published in the last decade about funding and reimbursement for caregivers working for nursing homes and home and community based services, consequences of low funding and low staffing, and other related quality of care concerns.
- Financial and utilization data on nursing homes and home and community based services from the American Health Care Association; Arizona Health Care Association; American Association of Homes and Services for the Aging; Arizona Association of Homes and Housing for the Aging, AHCCCS, and ADHS.
- Information drawn from surveys completed by 143 skilled nursing facilities completed between April 1, 2001 and May 10, 2002.
- Data from the Arizona Department of Health's Licensing and Certification Office and the federal On-line Survey Certification and Reporting System (OSCAR).
- ALTCS Program cost data.

Appendix B

National Context

A growing disparity between available caregivers and the number of dependent older adults is the "sleeper issue for the next 20 years," according to the Future of Aging Services. While most national studies on this issue point out the complicated multi-faceted approach required for solutions,[15] they also clearly state that the most important solution to reduce this disparity is through additional compensation for the caregivers.

Yet, even with this realization, the task for our nation is challenging. Two national crises especially affect Arizona's funding and reimbursement for its caregivers. One is related to the workforce and the other to Medicaid.

Workforce Crisis

Compounding the caregiver supply problem is the fact that caregivers in paraprofessional positions are not paid very well and the positions are considered by many to be "really crummy." Indeed, experts say the only aspect of caregiver jobs in long-term care our society has upgraded is the qualifications.[16]

Although Centers for Medicare and Medicaid Services (CMS) has not officially released the second phase of its epic study on nursing home staffing, a draft of the report has appeared on the Web site of the Minority Office of the House Committee on Government Reform, under the direction of Rep. Henry Waxman (D-Calif.). An executive summary of Phase II was leaked and has given rise to reports that the study shows "nine out of 10 nursing homes are understaffed."

Associations representing LTC providers report a staffing crisis of epidemic proportions which could seriously threaten future access to quality care if not addressed immediately.

Nursing and assisted living facilities, home health agencies and intermediate care facilities for persons with mental retardation or developmental disabilities all require sufficient numbers of qualified staff to provide quality care and services. The staffing crisis in LTC has developed and worsened over time, influenced by social, economic and demographic factors, generally beyond the providers' control.[17]

LTC providers across the continuum are struggling to fill staffing positions due to a combination of factors, including non-competitive wage and benefit levels limited by current low Medicare and Medicaid rates, public information and negative public perceptions of the profession and limited opportunities for career advancement.[18]

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[15] Most studies site needed improvements such as additional compensation and training; improving the workplace; increased use of existing and emerging technologies; resolving issues related to temporary workers; recruiting New Americans; and making changes within the practices of LTC providers.

[16] Bruce Vladeck, Ph.D., professor of health policy and geriatrics, Mount Sinai School of Medicine, New York, and former administrator for the Health Care Finance Administration (now the Centers for Medicare and Medicaid Services).

[17] William L. Minnix & Charles H. Roadman. *A Comprehensive Plan to Create a Healthy, Affordable and Ethical Long-Term Care Program for America.* Submitted to The Honorable Tommy Thompson, Secretary, U.S. Department of Health and Human Services.

[18] Ibid.

Medicaid Crisis

While lawmakers receive reports related to nursing home staffing and quality of care, they are also considering Medicaid reimbursement. Indeed, many states may actually cut back on Medicaid coverage of home and community-based services and assisted living, since these services are optional.

At their February annual meeting, our nation's governors were unanimous in declaring Medicaid's cost the most urgent crisis they face. Just how grave the problem is became clear earlier this month, when Mississippi's Medicaid program went broke. Lawmakers there were unable to come up with the money to pay for medical care for the poor.[19]

Some are suggesting a total rethinking of Medicaid and to whom it's intended to serve. And, according to the *Los Angeles Times*, the rethinking has begun.[20]

While originally intended to meet the health care needs of the poor, the joint federal-state Medicaid program has become America's long term care payment system by default because the nation lacks a comprehensive long term care program. Today, two out of three nursing facility residents rely on Medicaid to pay for their long-term health care.[21] With increased use of medically intensive services, Medicaid spending as a share of gross domestic product is expected to double over the next thirty years under current policy. While this growth might be sustainable at the national level, coming demographic shifts mean that the burden will be very unevenly distributed among states. The states that are currently spending the least on long-term care are the very states expected to see the greatest increase in their elderly populations and, presumably, in the demand for long-term care services. They will face a choice between significantly increasing tax burdens on working-age adults or limiting access or quality of care. One consequence may be the increasing pressure to federalize the program.[22]

Across the nation, state lawmakers and Medicaid administrators say it is not possible for Medicaid to do so much for so many. Meanwhile providers argue that nursing homes and hospitals will close if Medicaid fees fall too low. Medicaid is the single biggest budget item for many states--and thus an easy target for cuts. Medicaid is vulnerable as well because so much of the program is discretionary. Nearly two-thirds of all Medicaid spending is for benefits defined by the federal government as "optional"--that is, outside the mandated package of health insurance for the indigent. The federal government helps pay for Medicaid, so for every dollar a state puts into the program, Washington sends up to $3.31 in matching funds.[23]

Some lawmakers want the federal government to take over a bigger share of the costs, especially for the elderly. (The federal insurance program for senior citizens, Medicare[24], does not now cover long

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[19] *The Clarion Ledger.* March 7, 2002

[20] *Los Angeles Times.* March 5, 2002.

[21] Senate Special Committee on Aging, *Cash Crunch: The Financial Challenge of Long Term Care for Baby Boomers*, March 9, 1998: 2.

[22] Financing Long-Term Care in the Twenty-First Century: The Public and Private Roles. Mark Merlis, Georgetown University Institute for Health Policy Solutions, September 1999.

[23] This varies state to state.

[24] Medicare was originally intended to care for America's sick, while Medicaid was created to meet the health care needs of the poor. Medicare covers the first 20 days of care in a skilled nursing facility and only under certain conditions. For days 21 through 100, the beneficiary must share the cost of care by paying a nationally set rate of $92 per day in 1997. Medicare does not cover stays in an intermediate care facility. Following day 100, beneficiaries are no longer eligible for Medicare and must then seek coverage under Medicaid. In order to receive benefits from Medicaid, residents are forced to "spend down" and liquidate their entire savings and other assets. American Health Care Association, *What You Need To Know About Private Long Term Care Insurance.*

nursing-home stays or prescription drugs--though changes are debated--so much of that burden has fallen to Medicaid.) States also are demanding more flexibility.

The Bush administration is making bolder experimentation possible through a waiver program that lets states design new Medicaid packages--including, for the first time, offering different benefit packages for different populations--as long as the revisions don't cost the federal Treasury any extra money.

California, Arizona and Michigan are using their waivers to expand Medicaid so that both children and parents in low-income households have coverage.

Appendix C

State Context

Conflicting Trends, Attempted Solutions

Like our nation, Arizona also faces conflicting trends. Although the state provides a network of long-term care, the population of older adults is increasing. This, though the pool of workers is diminishing and the costs to provide care is rising. Last year (2001), several stakeholder groups responded to this crisis by advocating for the passage of new legislation. Arizona Senate Bill 1322 (SB1322) would have required state agencies that contract with a private entity to provide direct care services, including home health services and supportive care services, to require the private entity to comply with the *Federal Fair Labor Standards Act* (FLSA).[25]

Scope of Long-Term Care

Long-term care (LTC) in Arizona is a network of health and supportive services that helps chronically impaired persons and their caregivers manage their situations over time, place and provider in the least restrictive setting they call home. Components in the LTC continuum include adult day care; non-medical home and community based services (NMHCBS); home and community-based services (HCBS)[26]; assisted living (AL); intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR); nursing homes; and skilled nursing facilities (SNFs)[27].

On an average day in Arizona, approximately:

- 97 citizens rely on adult day care;[28]
- 347 rely on Non-Medical Home and Community Based Services (NMHCBS) adult day health services;[29]
- 11,921 rely on NMHCBS home delivered meals;[30]
- 583 utilize NMHCBS home health aids;[31]
- 1,226 utilize NMHCBS home nursing services;[32]

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[25] The U.S. Office of Personnel Management and the U.S. Department of Labor (USDOL) describe the FLSA as establishing minimum standards for wages, overtime entitlements, record keeping and child labor standards. Presently, covered nonexempt workers are entitled to a minimum wage of at least $5.15 per hour. Overtime pay is required for these workers at a rate of not less than one and one-half times their regular rates of pay after working 40 hours in a week. According to the USDOL, the FLSA does not require vacation, holiday, severance or sick pay; meal or rest periods, holidays off or vacations; premium pay for weekend or holiday work; pay raises or fringe benefits; and a discharge notice, reason for discharge or immediate payment of final wages to terminated employees. Direct care services are generally defined as any service directly provided to a client or recipient.

[26] State law defines *Home health* as the provision of nursing services or home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on a physician's orders and in accordance with federal law. A.R.S. Title 36-2939, subsection B, paragraph 2 and subsection C.

[27] State law defines a SNF as Nursing care institution" means an institution or other place, however named, whether for profit or not, including facilities operated by the state or a subdivision of the state, which is advertised, offered, maintained or operated for the express or implied purpose of providing care to persons who need nursing services on a continuing basis but who do not require hospital care or care under the daily direction of a physician. A.R.S. Title 36 chapter 4 article 2 paragraph 5.02.

[28] Source: Arizona Adult Day Care Association. 2002.

[29] Source: *Arizona's Community Based Services and Settings Report* (3rd Biennial). Published by the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Department of Economic Security (ADES), and the Arizona Department of Health Services (ADHS). May 2002

[30] Source: *Arizona's Community Based Services and Settings Report* (3rd Biennial). May 2002.

[31] Source: *Arizona's Community Based Services and Settings Report* (3rd Biennial). May 2002.

- 6,708 utilize NMHCBS housekeeping services;[33]
- 1,919 utilize NMHCBS personal care services;[34]
- 508 receive NMHCBS respite care services;[35]
- 22,000 live in assisted living facilities[36];
- 166 reside in large MR/DD facilities; [37]
- 14,000 reside in 139 licensed nursing homes and three (3) SNFs that operate as a distinct part of a general acute care hospital;[38]

For many, these services are temporary only. However, residents with serious or chronic health conditions may reside in a skilled nursing facility for several years. The average cost of stay within a nursing facility is $41,000/year, and the average length of stay is 2.3 years.[39]

The Arizona Long-Term Care system (ALTCS) is the state's alternate system to Medicaid. Arizona has operated this system since the late 1980s. By 2001, the system was serving more than 29,000 people at a cost to the state of about $568 million. ALTCS is comprised of two populations: elderly and physically disabled (EPD) and developmentally disabled (DD). Each population is contracted for separately. ALTCS is a managed care program that pays its contractors by member month capitation. The capitation amount includes payments for all covered services, including nursing facilities, acute care, and home and community based services (HCBS).

Expenditures for nursing homes for the elderly population totaled $231.5 million in 2002, rising to about $253 million in 2001, and projected to increase to $267 million in 2002. For the developmentally disabled population, nursing home spending remained at about $2 million throughout this period. Combined expenditures for HCBS for the elderly and for developmentally disabled people totaled more than $200 million in FY 2001, with more than 80 percent of the total allocated to DD services. Spending on services for the elderly rose from $45.1 million in 2000 to $61.5 million in 2001, and was projected to increase further in 2002 to almost $71 million.[40]

Arizona's long-term housing and care facilities employ caregivers at these estimated levels: [41]

- 8,474 by elderly and continuing care retirement communities;
- 3,220 by services for the elderly and disabled persons;
- 8,139 by home health care services; and
- 15,574 by nursing care facilities.

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[32] Ibid.
[33] Ibid.
[34] Ibid.
[35] Ibid.
[36] Source: Arizona Assisted Living Federation of America. 2002
[37] Source:
[38] Approximately 8,921 of these people reside in Metro Phoenix. Arizona SNF beds total 16,206. Metro Phoenix SNF beds number 10,583. Source: Davis Appraisal, 3rd Quarter 2001.
[39] Statement by Senator Michael B. Enzi, Senate Aging Committee Hearing on Long Term Care, March 9, 1998. Health Care Finance Administration.
[40] Source: State Long-Term Care: Recent Developments and Policy Directions. National Conference of State Legislatures. 2002.
[41] Source: County Business Patterns, 1999.

Older Adult Population Increasing

Of special significance is the trend of Arizona people over 65 increasing from 13% in 2000 to 17% in 2010. And, by the year 2030, over 21% of our population will be over 65. Arizona's population over 85 is increasing more rapidly than any other group. This age cohort should increase anywhere from 94% to 200% by the year 2010.[42] At least 55% of those people will likely live in the Greater Phoenix area. To meet the care and housing needs of these citizens, Arizona will need its struggling long-term care system.

Long-Term Care Costs Will Explode

The cost of LTC, which is already financially devastating to most of Arizona's older adults, will only become more expensive as our population ages and people live longer with the assistance of expensive drugs, therapies and medical technologies.

Caregivers Will Shrink Dramatically

While demographics and costs will explode, the pool of paid and unpaid caregivers will shrink dramatically. This is due to small size, families living further apart and two-wage earner families. Arizona's paid caregiver workforce is unlikely to keep up with the exploding need because capped, inelastic and under-funded government payment systems do not allow providers to be competitive in a tight labor market. The AHCCCS/Medicaid system pays - on average - about $100 per patient-day[43] for 70% of the 14,000 residents in Arizona's nursing homes. These funds are expected to cover room, board, three meals a day, some therapies, overhead, social activities, linens, mortgage and caregiver salaries, among other things.[44]

The inability to offer competitive wages and benefits has created the most serious professional and paraprofessional LTC labor shortage. The labor shortage causes remaining workers to shoulder unrealistic workloads. In addition, many caregivers are required by government regulation to focus on paperwork instead of resident care. This compounds the difficult environment in which both providers and caregivers are finding it more unappealing and intolerable to work.

Staffing shortages experienced nationwide are a reality for Arizona's LTC providers and their residents as well. According to a recent trade association surveys, the *average* vacancy rates for nursing care in Arizona's nursing facilities range from 10.4% to 17% within the not-for-profit facilities,[45] and range from15.6% to 20.2% within the for-profit facilities.[46]

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[42] Sources: Arizona Department of Economic Security. Research Administration, July 2001, and *Long-Term Care Services in Arizona*, St. Luke's Charitable Trust, 1998.

[43] Average: $96.70. High: $122.26. Low: $85.79. Year 2000 Rates. Source: *2001 The Guide to the Nursing Home Industry* by HCIASachs/Arthur Anderson

[44] William L. Minnex & Charles H. Roadman. *A Comprehensive Plan to Create a Healthy, Affordable and Ethical Long-Term Care Program for America*. Submitted to The Honorable Tommy Thompson, Secretary, U.S. Department of Health and Human Services.

[45] Average vacancy rates for CNAs at 10.4%, for LPNs 15.1% and for RNs 17%. Source: Joint Survey to 37 Nursing Facilities by the Arizona Association of Homes and Housing for the Aging and Southwest Institute on Aging. September 2001

[46] Average vacancy rates for CNAs at 15.6%, for LPNs 18.7% and for RNs 20.2%. Based on *Results of the 2001 AHCA Nursing Position Vacancy and Turnover Survey* published by the American Health Care Association. Survey results from 67 facilities in Arizona. February 7, 2002.

Another workforce risk factor compromising the quality of LTC in Arizona *is turnover rate.* A recent trade association survey reports *average* annualized turnover rates for Arizona nursing homes positions range from 71% to 95%.[47]

Fair and Market Wages Bill Proposed

Last year, Arizona Senate Bill 1322 (SB 1322) would have required state agencies that contract with a private entity to provide direct care services, including home health services and supportive care services, to require the private entity to comply with the federal Fair Labor Standards Act (FLSA).[48]

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[47] Average annualized turnover rates in 2001 for CNAs at 95.2%, for LPNs 71.4% and for RNs 86.5%. Based on *Results of the 200[illegible] AHCA Nursing Position Vacancy and Turnover Survey* published by the American Health Care Association. Survey results from 6[illegible] facilities in Arizona. February 7, 2002.

[48] The U.S. Office of Personnel Management and the U.S. Department of Labor (USDOL) describe the FLSA as establishing minimum standards for wages, overtime entitlements, record keeping and child labor standards. Presently, covered nonexempt workers are entitled to a minimum wage of at least $4.25 per hour. Overtime pay is required for these workers at a rate of not less than one and one-half times their regular rates of pay after working 40 hours in a week. According to the USDOL, the FLSA does not require vacation, holiday, severance or sick pay; meal or rest periods, holidays off or vacations; premium pay for weekend or holiday work; pay raises or fringe benefits; and a discharge notice, reason for discharge or immediate payment of final wages to terminated employees. Direct care services are generally defined as any service directly provided to a client or recipient. Arizona Senate Fact Sheet prepared by Prepared by Senate Staff. February 1, 2001

Appendix D

Arizona NF Costs for Registries

Total Licensed Arizona NFs	143
N = Surveys[49] Returned	83
Surveys not returned	60
% Open NFs Responding	72.3%
Average (mean) with N = 83	$270,846
Total Registry Costs for N = 83	**$22,480,259**

Rank Listing of Costs for Registries / Supplemental Staffing for 83 of 143 Licensed Arizona Nursing Facilities in FY 2001

[49] *Source: Joint Survey conducted by Arizona Association of Homes and Housing for the Aging and Arizona Health Care Association, March 2002.*

$2,232,335	50,000
1,490,023	37,273
1,357,976	36,000
1,200,000	34,115
1,015,516	29,559
893,000	27,604
886,096	22,581
848,663	20,705
806,060	20,000
733,735	19,119
680,000	17,615
650,000	15,000
523,798	12,880
523,798	7,976
484,573	7,975
476,912	7,000
468,382	5,500
455,250	1,780
453,190	1,572
433,670	1,200
418,686	1,057
381,699	143
375,453	0
314,552	0
302,613	0
260,644	0
259,635	0
255,491	0
251,157	0
220,770	0
220,501	0
188,804	0
185,809	0
165,000	0
165,000	
154,224	
150,546	
137,044	
120,000	
112,000	
103,126	
101,339	
86,824	
82,847	
77,350	
74,110	
73,782	
71,007	
68,149	
60,500	
53,166	

Appendix E

Minnesota's Supplemental Nursing Services Agency Model[50]

I. Purpose:

A new law enacted by the 2001 MN Legislature requires registration with the MN Department of Health (MDH) of Supplemental Nursing Services Agencies (SNSA) – i.e. temporary employment agencies or registries - effective august 31, 2001 and the responsibility for the health care facilities / agencies to comply with the law.

II. Responsibilities:

1. SNSAs will be responsible for providing health care facilities with proof of SNSA registration before the agency providing temporary nurses, nursing assistants, nurse aides or orderlies. An SASA located outside MN, which provides supplemental nursing services to health care facilities in MN must also meet these requirements.

2. Health Care Facilities/Agencies in MN should verify that the SNSA is registered with MDH.

3. A person who operates a SNSA shall register the agency and each separate location of the business with the commissioner.

III. Key Provisions:

The SNSA must:

1. submit background studies on controlling persons and all employees who will be sent to health care facilities licensed by MDH and maintain documentation to show compliance;

2. maintain documentation showing that each employee meets the minimum licensing, training and continuing education requirements for his/her position;

3. comply with health requirements for employees such as TB testing;

4. supply, at the request of the facility, 30 percent of the total personnel hours during the night, holiday, and weekend shifts;

[50] Minnesota Department of Health. Information Bulletin 01-22.

5. carry medical malpractice insurance for incidents related to death or injury because of negligence or malpractice caused by supplemental agency staff (Workers' Comp. insurance required).

The SNSA is:

1. prohibited from having policies that restrict employment opportunities for SNSA's employees or require the payment of liquidated damages, employment fees or other compensation if the employee is hired as a permanent employee of the health care facility;

2. prohibited from charging or receiving payments from nursing homes more than 150% of the average wage for an employee classification. The Commissioner of Human Services determines average wage. The charge of not more than 150% of the average wage for the classification shall include all charges and the SNSA must not charge any additional fees.

MDH will:

1. establish a system for investigating complaints against supplemental nursing services agencies;

2. impose a fine on the SNSA equal to 200 percent of the amount billed or received in excess of the maximum permitted under the provisions of the law and shall subject the SNSDA to revocation or non-renewal of its registration for a "pattern of failure" to comply with the requirements of the law;

3. submit an annual report to the MN legislature on the use of supplemental training services, including the number of hours worked by SNSA personnel and payments to the SNSA.

4. Maintain a listing of currently registered SNSAs at a website (www.health.state.mn.us.divs/fpc/directory/fpcdir.html)

IV. Contact:

Tempool@health.state.mn.us
Minnesota Department of Health
Facility and Provider Compliance Division
Licensing and Certification Program
85 East Seventh Place, Suite 300
PO Box 64900, St. Paul, MN 55164-0900
(615) 215-8701

V. Weighted Average[51] Wage Rates in MN NFs

Sorted by Rule 50 Geographic Groups
Based on Data from Reporting Year Ending 9/30/00

Weighted Average Wage Rates

Employee Group Class	Rural (83 facilities)	Semi-Rural (175 facilities)	Metro (163 facilities)
Registered Nurse (RN)	$18.24	$18.67	$20.87
LPN	12.89	13.38	15.91
Nursing Assistant (CNA)	9.15	10.17	11.38

Allowable Maximum Supplemental Nursing Service Charge (150%)

Employee Group Class	Rural (83 facilities)	Semi-Rural (175 facilities)	Metro (163 facilities)
Registered Nurse (RN)	$27.36	$28.01	$31.31
LPN	19.34	20.07	23.87
Nursing Assistant (CNA)	13.73	15.26	17.07

[51] Weighted by the number of employees in each job classification.

VI. Average Wage Rates in Arizona Nursing Facilities

- As of March 1, 2002 and based on Arizona Long Term Care nursing hourly rates of pay.
- Total of 70 facilities (or approximately 50% of 143) facilities participated in the survey.
- Collected throughout Arizona in seven counties.
- Includes for-profit and not-for-profit nursing facilities of all sizes.
- Data collected on May 31, 2001 by Flikirs Professional Services (of Maine).
- Data adjusted for inflation by a factor of the national "medical CPI" of 7% annualized (9 months - 5.25%)
- Hourly rates do not include payroll-related costs such as taxes, employer-paid insurance premiums, sick-time, vacation-time, education/training costs, recruitment costs, bonuses, retirement & 401(k) plans, certification/licensure fees, child day care, transportation reimbursement, fingerprinting/background checks, etc.

Average Wage Rates

Employee Group Class	Rural	Semi-Rural	Urban
RN - Director of Nursing	$26.50	N/A	$29.70
RN - Assist. D.O.N.	24.30	N/A	24.84
RN - Charge	22.00	N/A	22.70
RN - Staff	21.10	N/A	21.88
MDS Coordinator	19.95	N/A	22.22
LPN - Charge	17.50	N/A	17.91
LPN - Staff	17.10	N/A	17.71
Nursing Assistant (CNA)	9.90	N/A	10.37
restorative CNA	11.00	N/A	11.53

- These average wage rates do not include other employee-related costs such as the cost for insurance, and registries. These additional costs are estimated by the Arizona Health Care Association to range between 17% to 32% and the average additional costs are 25% of the wage rate for a nursing facility in Arizona.[52]

[52] Arizona Health Care Association (AHCA) survey of its members in April 2002.

Appendix F

2000 Medicaid Rates for Nursing Homes

State	Average	Highest	Lowest	Level/Year	Multi Rates	Included within Medicaid Rate		
						Therapy	DME	Drugs
Alabama	$ 108.53	$ 130.28	$ 77.40			no	no	no
Alaska	$ 233.80	$ 585.23	$ 192.49	freestanding	1	yes	no	no
Alaska	$ 370.11	$ 585.23	$ 192.49	combined	2	yes	no	no
Arizona	$ 96.70	$ 122.26	$ 85.79			yes	yes	no
Arkansas	$ 69.35	$ 75.58	$ 58.42			yes	yes	no
California	$ 70.69	$ 77.64	$ 59.40	Level A R/B	1	no	no	no
California	$ 94.28	$ 107.22	$ 85.93	Level B R/B	2	no	no	no
Colorado	$ 106.72	$ 139.87	$ 69.55	1999 rates		yes	yes	no
Connecticut	$ 151.59	$ 207.13	$ 113.69			yes	yes	no
DC						yes	yes	no
Delaware	$ 124.85	$ 277.59	$ 75.98			yes	yes	no
Florida	$ 111.27	$ 146.67	$ 77.11			yes	no	no
Georgia	$ 88.50	$ 155.30	$ 58.42			yes	yes	no
Hawaii	$ 158.80	$ 283.85	$ 107.87			no	no	no
Idaho	$ 116.67	$ 144.03	$ 86.33	freestanding	1	yes	yes	no
Idaho	$ 138.24	$ 155.88	$ 121.12	hosp.-based	2	yes	yes	no
Illinois	$ 87.05	$ 121.88	$ 55.37			yes	yes	no
Indiana	$ 92.88					yes	no	no
Iowa	$ 113.57	$ 583.00	$ 59.00			no	yes	no
Kansas	$ 83.12	$ 151.46	$ 50.76			yes	yes	no
Kentucky	$ 104.30					yes	no	no

Louisiana	$ 69.32	$ 250.76				no	yes	no
Maine	$ 115.77	$ 269.96	$ 83.11	$ 1999 rates		no	yes	no
Maryland	$ 111.93			1999 rates		yes	no	no
Massachusetts	$ 126.00					no	no	no
Michigan	$ 110.00	$ 140.95	$ 100.75			no	yes	no
Minnesota	$ 111.13	$ 283.71	$ 57.73			no	yes	no
Mississippi	$ 87.42	$ 116.11	$ 64.95			no	yes	no
Missouri						yes	yes	no
Montana	$ 96.97	$ 107.26	$ 83.60			no	no	no
Nebraska	$ 65.89	$ 311.22	$ 42.94			no	no	no
Nevada	$ 102.54	$ 257.71	$ 59.22			no	no	no
New Hampshire	$ 118.91					yes	yes	no
New Jersey	$ 110.24			1997 rate		yes	yes	no
New Mexico	$ 105.32	$ 204.39	$ 95.65	$ low NF	1	yes	no	no
New Mexico	$ 167.71	$ 257.09	$ 184.47	$ High NF	2	yes	no	no
New York	$ 171.60	$ 600.80	$ 75.16			yes	no	no
North Carolina	$ 88.35	$ 93.60		intermediate	1	yes	yes	no
North Carolina	$ 116.27	$ 124.78		skilled.	2	yes	yes	no
North Dakota	$ 97.68	$ 219.88	$ 66.28	$ 1999 rates		yes	yes	no
Ohio	$ 121.34	$ 406.26	$ 66.98			yes	yes	no
Oklahoma	$ 66.75			Basic NF		yes	yes	no
Oregon	$ 93.52			Basic rate	1	yes	no	no
Oregon	$ 130.77			Basic+complex	2	yes	no	no
Pennsylvania	$ 126.47	$ 476.70	$ 86.28			yes	yes	no
Rhode Island	$	$	$			yes	no	no

South Carolina	$ 114.00	$ 136.17	$ 79.43			yes	no	no
South Dakota	$ 91.00	$ 112.91	$ 67.56	1999 rates		yes	yes	yes
Tennessee	$ 78.92	$ 91.11	$ 96.11	$ 65.85 Level I	1	yes	no	no
Tennessee	$ 91.18	$ 141.68	$ 156.55	$ 66.96 Level II	2	yes	no	no
Texas	$ 81.22	$ 138.89	$ 63.64			yes	yes	no
Utah	$ 89.11	$ 98.64	$ 77.36			yes	yes	no
Vermont	$ 113.19					yes	no	no
Virginia						yes	no	no
Washington	$ 121.48					yes	no	no
West Virginia	$ 115.50			100+ beds	1	yes	no	no
West Virginia	$ 117.40			1-99 beds	2	yes	no	no
Wisconsin	$ 111.23	$ 159.00	$ 39.98			no	yes	no
Wyoming	$ 96.76	$ 117.41	$ 77.19			yes	yes	no

Source: 2001 The Guide to the Nursing Home Industry by HCIASachs/Arthur Anderson

2000 Medicaid Rates for Nursing Homes Ranked

State	Average	Highest	Lowest	Level/Year	Multi Rates	Included within Medicaid Rate	Therapy	DME	Drugs
Nebraska	$ 65.89	$ 311.22	$ 42.94				no	no	no
Oklahoma	$ 66.75			Basic NF			yes	yes	no
Louisiana	$ 69.32	$ 250.76					no	yes	no
Arkansas	$ 69.35	$ 75.58	$ 58.42				yes	yes	no
California	$ 70.69	$ 77.64	$ 59.40	Level A R/B	1		no	no	no
South Dakota	$ 78.92			1999 rates			yes	yes	yes
Texas	$ 81.22	$ 138.89	$ 63.64				yes	yes	no
Kansas	$ 83.12	$ 151.46	$ 50.76				yes	yes	no
Illinois	$ 87.05	$ 121.88	$ 55.37				yes	yes	no
Mississippi	$ 87.42	$ 116.11	$ 64.95				no	yes	no
North Carolina	$ 88.35	$ 93.60		intermediate	1		yes	yes	no
Georgia	$ 88.50	$ 155.30	$ 58.42				yes	yes	no
Utah	$ 89.11	$ 98.64	$ 77.36				yes	yes	no
South Carolina	$ 91.00	$ 112.91	$ 67.56				yes	no	no
Tennessee	$ 91.18	$ 96.11	$ 65.85	Level I	1		yes	no	no
Indiana	$ 92.88						yes	no	no
Oregon	$ 93.52			Basic rate	1		yes	no	no
California	$ 94.28	$ 107.22	$ 85.93	Level B R/B	2		no	no	no
Arizona	$ 96.70	$ 122.26	$ 85.79				yes	yes	no
Wyoming	$ 96.76	$ 117.41	$ 77.19				yes	yes	no
Montana	$	$	$				no	no	no

	96.97	107.26	83.60					
North Dakota	$ 97.68	$ 219.88	$ 66.28	1999 rates		yes	yes	no
Nevada	$ 102.54	$ 257.71	$ 59.22			no	no	no
Kentucky	$ 104.30					yes	no	no
New Mexico	$ 105.32	$ 204.39	$ 95.65	low NF	1	yes	no	no
Colorado	$ 106.72	$ 139.87	$ 69.55	1999 rates		yes	yes	no
Alabama	$ 108.53	$ 130.28	$ 77.40			no	no	no
Michigan	$ 110.00	$ 140.95	$ 100.75			no	yes	no
New Jersey	$ 110.24			1997 rate		yes	yes	no
Minnesota	$ 111.13	$ 283.71	$ 57.73			no	yes	no
Wisconsin	$ 111.23	$ 159.00	$ 39.98			no	yes	no
Florida	$ 111.27	$ 146.67	$ 77.11			yes	no	no
Maryland	$ 111.93			1999 rates		yes	no	no
Vermont	$ 113.19					yes	no	no
Iowa	$ 113.57	$ 583.00	$ 59.00			no	yes	no
Rhode Island	$ 114.00	$ 136.17	$ 79.43			yes	no	no
West Virginia	$ 115.50			100+ beds	1	yes	no	no
Maine	$ 115.77	$ 269.96	$ 83.11	1999 rates		no	yes	no
North Carolina	$ 116.27	$ 124.78		skilled	2	yes	yes	no
Idaho	$ 116.67	$ 144.03	$ 86.33	freestanding	1	yes	yes	no
West Virginia	$ 117.40			1-99 beds	2	yes	no	no
New Hampshire	$ 118.91					yes	yes	no
Ohio	$ 121.34	$ 406.26	$ 66.98			yes	yes	no
Washington	$ 121.48					yes	no	no
Delaware	$	$	$			yes	yes	no

	124.85	277.59	75.98					
Massachusetts	$ 126.00					no	no	no
Pennsylvania	$ 126.47	$ 476.70	$ 86.28			yes	yes	no
Oregon	$ 130.77			Basic+complex	2	yes	no	no
Idaho	$ 138.24	$ 155.88	$ 121.12	hosp.-based	2	yes	yes	no
Tennessee	$ 141.68	$ 156.55	$ 66.96	Level II	2	yes	no	no
Connecticut	$ 151.59	$ 207.13	$ 113.69			yes	yes	no
Hawaii	$ 158.80	$ 283.85	$ 107.87			no	no	no
New Mexico	$ 167.71	$ 257.09	$ 184.47	High NF	2	yes	no	no
New York	$ 171.60	$ 600.80	$ 75.16			yes	no	no
Alaska	$ 233.80	$ 585.23	$ 192.49	freestanding	1	yes	no	no
Alaska	$ 370.11	$ 585.23	$ 192.49	combined	2	yes	no	no
DC						yes	yes	no
Missouri						yes	yes	no
Virginia						yes	no	no

Source: 2001 The Guide to the Nursing Home Industry by HCIASachs/Arthur Anderson

Appendix G

VACANCY AND TURNOVER RATES

Table 1.
Vacancy Rate Estimates for Arizona Nursing Home Positions (based on six months ending June 30, 2001.

	Total Number of Facilities	Number of Facilities with Usable Data	Percent of Facilities with Usable Data	Established Positions in Responding Facilities	Vacant Positions in Responding Facilities	Vacancy Rate	Total Estimated Number of Vacancies
DONs	144	73	50.7%	73	1	1.4%	2
Adm. RNs	144	64	44.4%	183	23	12.3%	51
Staff RNs	144	65	45.1%	391	79	20.2%	175
LPNs	144	66	45.8%	909	170	18.7%	371
CNAs	144	67	46.5%	2,592	403	15.6%	866

Table 2.
Annualized Turnover Rate Estimates for Arizona Nursing Home Positions (based on six months ending June 30, 2001).

	Total Number of Facilities	Number of Facilities with Usable Data	Percent of Facilities with Usable Data	Established Positions in Responding Facilities	Terminations in Responding Facilities	Annualized Turnover Rate
DONs	144	76	52.8%	77	52	67.5%
Adm. RNs	144	65	45.1%	190	115	60.7%
Staff RNs	144	61	42.4%	369	319	86.5%
LPNs	144	59	41.0%	844	603	71.4%
CNAs	144	60	41.5%	2,369	2,255	95.2%

Based on *Results of the 2001 AHCA Nursing Position Vacancy and Turnover Survey* published by the American Health Care Association. February 7, 2002.

Appendix H

Collaboration

The following state reports[53] provide sample methods for stakeholder collaboration to gather and process data for Medicaid reimbursement rate setting.

FL

In Florida, nursing homes are penalized if a cost report is not filed timely. They can also be fined, although that has yet to be used. The NF association gets its data from the state, and the association verifies the rate setting, including all ceiling calculations. They work pretty well together. There is no charge for the data, and the state does not expect the associations to produce data.

IA

In Iowa, wage data is collected with the regular cost reports on a separate schedule. Facilities report annually to the state's CPA firm which is contracted to collect and analyze the data for the Medicaid agency but makes it available to the public.

MN

In Minnesota the two nursing home associations share the cost of purchasing a rate tape from the Medicaid agency every year. The rate tape includes several data-sets of varying interest. Before MN moved off of cost-based reimbursement, this information all came from the annual cost reports and
included the calculated per diems and rates. Most facilities are now on a system under which each year their rates are simply inflated forward, but about one-fourth of the industry remains on a cost-based system for property. Three-fourths of the facilities do not report any cost data (they do report census data, however). Consequently, the data the State gets is much less useful than it used to be simply because most of it is irrelevant--when facilities are not paid on the basis of their costs and most facilities don't even report their costs, the data has glaring weaknesses.

NY

New York has had a pricing methodology in place since 1986 that still relies on costs incurred in 1983 for most facilities. It also relies on the RUG-II classification system, which dates from the mid-80s as well. The only changes to the methodology are authorized in legislation. Neither the administrative agency, the Department of Health nor the state legislature proactively reaches out to providers on methodology issues.

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[53] Based on an Arizona Association of Homes and Housing for the Aging survey sent to affiliate associations of the American Association of Housing Services for the Aging in April 2002.

OH

In Ohio, stakeholders use a cost-based system. All Medicaid certified facilities must file annual cost reports which are used for rate setting. Once the state computes ceilings, it e-mails the NF associations the zipped cost data and calculations, so they can verify everything before publication. The associations haven't found significant errors in the state's calculations, and they collaborate with each other to estimate the effects of any proposed changes to the payment system. Ohio's entire reimbursement formula is in law, so any changes must be proposed and enacted by the legislature. Such shared-use of the cost data has prevented serious reductions. Ohio's cost reports include all cost and wage and hour data, they must be notarized, and they are subject to state audit, so everyone is confident that they are accurate.

WA

In Washington, stakeholders frequently collaborate. Washington's regulatory agency holds a stakeholders meeting to get input on changes in legislation. The cost report data is available for a nominal fee, but is difficult to work with because of its format. The for-profit association
has a very good rates analyst that the non-profit association works with and both share information.
All in all, stakeholders are able to work out most differences ahead of publication of rates and regulations. If nothing else, when LTC associations disagree with the regulatory agency, they can always say that they gave the stakeholders a chance for input. This often works in the agency's favor with Washington's state legislature.

For rate setting, it is all in statute. Very little can be changed without an act of the legislature. (But of course, an act of the legislature is always subject to interpretation.) When stakeholders are looking at a potential change in the statute, both associations run the numbers based on the most recent cost report data from the regulatory agency to see how it will impact their members. The agency doesn't want to make facility specific projections because there are too many assumptions involved. But they always do a system wide projection as do the analysts from the budget committees for a total dollar figure. And often, everyone has different numbers.

Appendix I

STAKEHOLDERS

The following organizations and/or individuals were invited to submit materials for consideration in the preparation of this report.

- American Association of Housing Services for the Aging - affiliate member associations
- Arizona Assisted Living Federation of America
- Arizona Association of Homes and Housing for the Aging
- Arizona Department of Health Services (ADHS) Office of Assurances and Licensure
- Arizona Health Care Association
- Arizona Health Care Cost Containment System (AHCCCS) Office of Managed Care
- Foundation for Senior Living
- Future of Aging Services
- Health Services Advisory Group

Workgroup on Recruitment, Education, Regulation

FINAL REPORT
August 20, 2002

Participants:

Clinco, Judy - Direct CareGiver Association

Danowski, Bonnie - Arizona Interfaith Network

Dante, Donna - Native American Community Health Center, Inc.

Dean, Gwen - AZ Bridge for Independent Living

Hanley, Mary Lou - DES-DACS

Harris, Patricia - Maricopa Community Colleges

Lindley, Pam - DES-AAA

Steven, Ritch - AARP

Executive Summary

The Arizona Senate Ad Hoc Committee on Caregiver Wages and Workforce Development was divided into two workgroups for the purposes of completing its charge. The workgroup on Recruitment, Education, Regulation identified numerous issues related to caregiver shortages, workforce development and retention. The major issues identified are:

EDUCATION/TRAINING

- Inconsistent Job Titles and Job Descriptions (p. 3)
- Inconsistent Standardized Education/Training Curriculum (p. 3)
- No ongoing Education Training Requirements (p. 4)
- Minimal Support during Education Programs (p. 5)

RECRUITMENT/RETENTION

- Labor Pool Shortage (p. 5)
- Lack of a Living Wage and Supportive Benefits (p. 5)
- Poor Caregiver Image in Society (p. 5)
- High Attrition and Turnover (p. 6)
- Inadequate and Potentially Unsafe Working Conditions in Home and Institutional Settings (p. 7)

ACCREDITATION/REGULATION

- Multiple Accrediting/Licensing Agencies without Mutual Recognition of Credentials (p. 8)
- Lack of Protection for Vulnerable Clientele (p. 8)

Arizona Department of Health Services (ADHS), Arizona Health Care Cost Containment Services (AHCCCS), Area Agency on Aging, and the Department of Economic Services (DES) were invited to a meeting for the purposes of collaboration in this project. Input and recommendations were received from ADHS, AHCCCS, and DES. A commitment was made by these agencies to provide information, and all received was considered and /or incorporated into this document.

Recommendation:

Our research indicates that each agency has similar, but different standards for caregiver training, education, and oversight. The development and implementation of universal standards and practices will lead to a stable, qualified workforce, a higher quality of care and an overall reduction of costs. Due to the current shortage and increased demand for qualified caregivers, it is imperative that action be taken within 12 months. Our recommendation is that through existing inter-agency workgroups and/or task forces, these issues are addressed and solutions are implemented consistently statewide, thus avoiding the need for new legislation.

EDUCATION/TRAINING

Issues:

Inconsistent Job Titles and Descriptions
Inconsistent Standardized Education/Training Curriculum
No Ongoing Education Training Requirements
Minimal Support during Education Programs

Inconsistent Job Titles and Descriptions

1. **Issues:**

- Lack of uniformity in job titles results in confusion, inefficiency, and discrepancies in training/qualifications when naming entry level jobs (i.e., home health aids, caregivers, personal care assistants, housekeepers, nurse assistants, direct care workers, etc.)
- Certified Nursing Assistants have a regulated scope of practice and a protected job title, making it easier for the consumer to know the skill level of the caregiver. However, there is no regulated scope of practice and consistent job title for caregivers in Home and Community Based Services and Assisted Living Facilities.
- Lack of common job titles/descriptions raises barriers to worker mobility between settings.
- Inconsistent job titles and training requirements result in loss of income for the employee and increased cost to the employer.

2. **Recommendations:**

- Standardize job titles and duties.
- Require public and private agencies to utilize the standardized titles and duties within their organizations for contracting and marketing.
- Standardize job titles/descriptions so that minimal competencies and educational requirements are consistent.

Inconsistent Standardized Education/Training Curriculum

1. **Issues:**

- Caregiving curriculum is fragmented, and minimal training hours do not prepare the worker for safe practice. There is no comprehensive, integrated core curriculum, which can be delivered in multiple settings, serving as the base for a career pathway.
- Not all employers comply with existing mandated training.
- There is inconsistent routine oversight of training delivery compliance.

2. **Recommendations:**

- Determine the content of a core curriculum for each job title, including interpersonal and life skills, and establish hours needed.
- Institute standardized testing to be completed at end of training.
- Educate the community regarding which worker is certified/trained to do the job

required.

- Develop high school career education for workers in various care settings.
- If State agencies fail to address these concerns in twelve months, enact legislation to ensure universal standards for caregivers.

No Ongoing Education Training Requirements

1. **Issues:**

- Inconsistent ongoing training requirements among governmental agencies and accrediting bodies.
- Lack of established career ladder for advancement of the direct caregiver.

2. **Recommendations:**

- Require an annual assessment of skills and didactic curriculum for all workers.
- All ongoing training shall be monitored, and consequences shall be applied for noncompliance.
- Develop a program for the annual assessment of continued competency and professional development needs.

Minimal Support during Educational Programs

1. **Issues:**

- Lack of affordable, available childcare facilities or health services.
- Lack of reliable, consistent transportation to training.
- Language, study, and work stills are often lacking.
- Lack of adequate income to pay for training.
- Lack of adequate income during training programs.

2. **Recommendations:**

- State agency collaboration to develop programs to provide needed financial, health, transportation, and childcare support for this worker population.
- Establish a mentor program through the community.
- Stage agencies coordinate efforts to seek grant funding and incentive monies for creative workforce development programs.
- Place new trainees into GED/ESL programs, if desired or needed.

RECRUITMENT/RETENTION

Issues:

Labor Pool Shortage
Lack of a Living Wage and Supportive Benefits
Poor Caregiver Image in Society
High Attrition and Turnover
Inadequate and Potentially Unsafe Working Conditions in Home and Institutional Settings

Labor Pool Shortage

1. **Issues:**

- The average age of a caregiver today is 44. Caregivers of this age will not be able to continue to work at such physically intensive jobs.
- Population shift: Rapidly aging population with increasing chronic care needs contrasted by a significantly smaller population of younger workers.
- Caregiver positions are dead end jobs filled primarily by women who are economically disadvantaged and have low levels of education.
- Competition between other service industries that recruit for entry-level positions further reduces the workforce.

2. **Recommendations:**

- Design current programs that empower consumer to be less reliant on caregivers by offering Independent Living Skills Training, Peer Mentoring and Home Modifications.
- Continue to develop programs that will allow persons to care for their own family member, which include a livable wage, health benefits, respite, retirement plan, training and support.
- Explore recruiting workers through INS.
- Incorporate caregiver training /curriculum at the high school level, including; basic life skills related to attitude, appearance, personal health and work ethic.
- Establish a career ladder with advanced training and job opportunities for the caregiver.
- Utilize technology to enable the direct caregiver to be more efficient.
- Create alternative methods of work to allow the older caregiver to continue in the role.

Lack of a Living Wage and Supportive Benefits

1. **Issues:**

- Caregivers are not being paid fair market value.
- Lack of affordable health insurance.
- Lack of competitive benefits such as: sick days, vacation pay, and holiday pay.
- Lack of caregiver retirement plans.
- From time of application, caregivers may not receive a wage for five weeks or longer from the time they interview because of training time, placement, workweek and payroll processing.

2. **Recommendations:**

- Develop a pay and benefit structure for public and private agencies who hire caregivers that will be consistent with the level of care they are providing, competitive to market wages, and consistent with training and education requirements.
- Develop a special program that allows workers without other means for health benefits to enroll in a government supported health plan.
- Establish guidelines for agency administrative costs dependent upon type of service provided.
- Continue to develop programs that will allow persons to care for their own family members, include a livable wage, health insurance, retirement plan, training and support.

Poor Caregiver Image in Society

1. **Issues:**

- Society has stigmatized caregiver positions to be employment for economically disadvantaged people with low levels of education.

2. **Recommendations:**

- Develop a campaign strategy to educate the general public as to the value of direct caregivers and the importance of their work.
- Develop and implement a statewide workforce recruitment and retention plan continuing to attract the traditional worker, plus strategies directed at men and younger workers.
- Designate a week during which a Governor's Proclamation is issued annually in recognizing the valuable role served by caregivers.

High Attrition and Turnover

1. **Issues:**

- Attrition is anecdotally reported in all phases of hiring and training: If 100 people are interviewed, providers will accept 75 into training, 50 will show up for training, 25 will complete training and 15 will go to work.
- Community-based care experiences a turnover of thirty-five to forty-five percent. Turnover in Skilled Nursing facilities is reported to be sixty-two to one hundred percent annually.
- Caregivers find higher paying jobs in other industries.
- Jobs are physically and emotionally demanding with little or no respect or support from providers, supervisors, or consumers.

2. **Recommendations**

- Supervisor and consumer training.
- Evaluate the adequacy of existing staffing ratios and adjust where appropriate based upon quality outcomes.

- Develop incremental pay increases based on time in service and performance evaluations (let consumer be part of the evaluation)
- Employers develop caregiver awards for exceptional services, along with other personalized awards.
- Pre-screen for individual's appropriateness for this career prior to training and hiring.

Inadequate and Potentially Unsafe Working Conditions in Home and Institutional Settings

1. **Issues:**

- Inadequate training on use of equipment.
- Limited supplies to complete task; cleaning supplies, food, etc.
- Lack of appropriate equipment; shower chair, lifts, etc. Frequently broken or ill maintained.
- High Worker's Compensation costs in this caregiver population.
- High utilization of supplemental staff frequently leads to safety and quality issues.

2. **Recommendations:**

- Research funding sources for medical supplies and equipment.
- Provide adequate training regarding the use and maintenance of equipment.
- Provide in-depth training on OSHA requirements, personal safety.
- Satisfactory orientation of supplemental staff.

Accreditation/Regulation

Issues:

Multiple Accrediting/Licensing Agencies without Mutual Recognition of Credentials
Lack of protection of vulnerable clientele

Multiple Accrediting/Licensing Agencies without Mutual Recognition of Credentials

1. **Issues:**

   - Multiple agencies (ADHS, DES, and AHCCCS and private service providers) "certify" caregivers using different criteria.
   - Job Titles with like certification criteria are different.
   - Lack of mutual recognition of training or certification among all parties which limits portability of credentials.
   - Lack of title recognition/protection.
   - Lack of defined scope of practice or limitation of service.
   - Lack of career pathway.

2. **Recommendations:**

   - Standardization across caregiving continuum:
     - Standardization of credential requirements
     - Title standardization and protection
     - Training requirement and standardization of curriculum
   - Mutual recognition within Arizona
   - Standardize existing service specifications/scope of practice, including limitations, of providers for Home and Community Based Services, and other settings excluding licensed nursing facilities.

Lack of Protection of Vulnerable Clientele

1. **Issues:**

   - No common criteria across continuum of background, drug, or security information requirements.
   - Lack of common requirements to report inappropriate or unprofessional conduct of caregiver.
   - Inadequate training on reporting situations of abuse, neglect or exploitation.

2. **Recommendations:**

   - Create a standardized State database for background check, drug screening and fingerprinting information for all caregivers.
   - All providers who receive State funding shall utilize the database to verify credentials

to pre-screen employees or contractors.

- The collaboration of State agencies shall determine which agency shall develop and maintain the integrity of the database.
- Establish mandatory reporting criteria of other information to be maintained in the database.
- Provide training and informational materials from Protective Service Agencies on an ongoing basis.

PARAPROFESSIONAL CAREGIVER MATRIX

(August 20, 2002)

	Certified Nursing Assistant (C N A)	Personal Care Assistant or Attendant	Personal Care Worker	Independent Provider (Used by On-Reservation Tribes and DD/ALTCS)	Supervisory, Personal Care, Directive	Home Health Aide
Settings: (Where Care is provided)	In-home, Alternative Settings, Nursing Facility (Hospitals, Home Health Agencies, Assisted Living Facilities.)	In-home (Client's Residence)	In-home (Client's Residence), Assisted Living Facility	In-home (Client's Residence)	Assisted Living Facilities (ALF), Supervisory Care Centers (SCC), Adult Day Care Facilities (ADC)	In-home
Training Times:	Assisted Living Caregiver Training Requirements (120 hrs.)	Determined by Agency Based on Criteria in AHCCCS policy (24-40 hrs.)	Determined by Agency based on Criteria in AHCCCS policy (24-40 hrs.)	Varies from none to whatever meets contracted agency requirements.	ALF/20 hours SCC/30 hours ADC/62 hours	Unknown
Scope f Work/Services Provided:	Vital signs, assistance with Activities of Daily Living (ADL), such as dressing, bathing and grooming, walking, and eating, prepare light meals, light housekeeping, laundry (Personal Care)	Assist with ADLs, such as dressing, bathing and grooming walking, and eating, prepare meals, housekeeping, laundry, grocery shopping (Personal Care, Supervision, Attendant Care)	Assist with ADLs, such as dressing, bathing and grooming walking, and eating, prepare light meals, housekeeping, laundry (Personal Care, Safety, Feeding, Transfers)	Assist with ADLs, such as dressing, bathing and grooming walking, and eating, prepare meals, housekeeping, laundry, grocery shopping (Personal Care, Supervision, Attendant Care)	Personal Care Medication and Recreation, Daily living skills, Rehabilitative activities, Supervision	Health Maintenance, Personal Care, Vital Signs, Dressing Changes, Bowel and Bladder Care
Caregiver Work Status:	Employee	Employee	Employee	Self-employed (Independent Contractor, Employee)	Employee	Employee
Salary Ranges:	Driven by Contract negotiations between the Program Contractor, the Agency and industry	Driven by Contract negotiations between Program Contractor, Agency and industry standards	Driven by Contract negotiations between Program Contractor, Agency and industry standards	**For ALTCS EPD:** Cap Rate for Personal Care is $19.01/hr and Cap rate for Attendant Care is $13.50/hr.	ALF/ $7 to $8 SCC/ $8.00 ADC/ $8.00	Unknown

PARAPROFESSIONAL CAREGIVER MATRIX

(August 20, 2002)

	Certified Nursing Assistant (C N A)	Personal Care Assistant or Attendant	Personal Care Worker	Independent Provider (Used by On-Reservation Tribes and DD/ALTCS)	Supervisory, Personal Care, Directive	Home Health Aide
	standards ($8.50 to $10.75)	($8.60 with Medical, $8.99 with no Medical benefits, $9.00-$10.25 without Medical Benefits)	($8.00 to $10.25)	**For ALTCS DD:** DD Administration would establish rate. ($7.00 to $9.45, up to 70% of cap)		
Family Salary Ranges:	Driven by Contract negotiations between Program Contractor, Agency and industry standards	Driven by Contractor negotiation between Program Contractor, Agency and industry standards ($7.22 with Medical $7.88 without Med, $9.00-$10.25 without Medical)	**Driven by Contractor negotiation between Program Contractor, Agency and industry standards**	Unknown	Unknown	Unknown
Benefits:	Agency decision	Agency decision (Med Coverage, Vacations)	Agency decision	Unknown	Unknown	Unknown
Career Paths:	Determined by Agency if any	Determined by Agency if any	Determined by Agency if any	Unknown	Unknown	Unknown

PARAPROFESSIONAL CAREGIVER MATRIX

(August 20, 2002)

	Certified Nursing Assistant (C N A)	Personal Care Assistant or Attendant	Personal Care Worker	Independent Provider (Used by On-Reservation Tribes and DD/ALTCS)	Supervisory, Personal Care, Directive	Home Health Aide
Regulatory Bodies:	Arizona State Board of Nursing	DES/Aging and Adult Administration via contracts (ALTCS-AHCCCS)	DES/Aging and Adult Administration via contracts (ALTCS-AHCCCS)	AHCCCS	DHS	DES/AAA
Continuing Education Requirements:	Established by ADHS (Renewal every 2 yrs.)	CPR/First Aid (Agency Discretion Annually)	CPR/First Aid (Agency discretion annually)	Unknown (CPR/First Aid)	12 Hours	CPR/First Aid
Supervisors:	LPN/RN (Mgr/Owner, Administrator)	Agency Supervisor (Contracted Agency Field Supervisor)	Agency Supervisor (Contracted Agency Field Supervisor)	ALTCS Case Manager	ALF/Manager SCC/Manager ADC/Manager of Contracted Facilities	RN/LPN
Pre-Employment Requirements:	16 yrs. of age, finger-printing (18 yrs of age, PPD screening, finger-printing)	References, CPR/First Aid, other requirements as determined by the Agency (18 yrs of age, PPD screening, Personal work references)	References, CPR/First Aid, other requirements as determined by the Agency (18 yrs of age, PPD screening, Personal work references)	18 yrs of age, 3 references/non-family	18 yrs of age, 16 yrs of age as assistant, CPR/First aid, PPD screening, Fingerprinting, Personal/work references	References, CPR/First Aid
Service Monitoring:	90, 180, 270 day evaluation by case manager	90, 180, 270 day evaluation by case manager (30, 60, 90 day evaluations, quarterly thereafter)	90, 180, 270 day evaluation by case manager (Quarterly Evaluations)	Quarterly Reassessment	Daily	60, 90 and 120 Day Evaluations

INTERAGENCY COUNCIL FOR LONG-TERM CARE MATRIX

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ACUTE CARE
AHCCCS MATRIX

The AHCCCS acute care program is a statewide, managed care system that delivers acute care services through prepaid, capitated health plans. The major Medicaid groups covered through AHCCCS are listed below. Services include: Inpatient, Outpatient, Physician, Pharmaceutical, Laboratory, Radiology, Medical Imaging, Emergency Services, Transportation, Transplants, Behavioral Health, and Emergency Dental Services, and Long Term Care Services (in lieu of hospitalization).

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
AHCCCS' Acute Medicaid (Title XIX)	Aged, blind, and disabled members, including individuals whose income is under 100% of the Federal Poverty Level. For 2002, the rate is $739 per month for an individual.	Section 1902(a)(10)(A) of the Social Security Act (USC 42-1383c A.R.S. §36-2901 and §36-2934	Established in October 1, 1982 at 36% FPL. Effective October 1, 2001 the FPL was raised to 100%.	Funded with a combination of a federal match and a state match, In FFY 2002 the federal matching assistance program is 64.98% federal and 35.02% state. Of the state match the county pays 15.34%.	Enrollment figures as of August 1, 2002 totaled 93,912 members.	Eliminating the Acute Care program will leave approximately 800,000 Arizonans without health care. There would be an increase in uncompensated care.	*Elizabeth Salgado & Pima County v. AHCCCS* In 1994 the Arizona Supreme Court determined that the AHCCCS statute excluding coverage of liver transplants for adults was unconstitutional. Status Closed The AHCCCS statute was amended.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ACUTE CARE
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
	Family Coverage, which includes families and children who's income is under 100% FPL (the largest of the groups).	Families whose income is under 100% of the FPL were included under the State's 1115 Demonstration Waiver, and implemented with Senate Bill 1577 (Prop 204) and A.R.S. §36-2901.	Family coverage for persons whose income is under 100% of the FPL became effective October 1, 2001.	Same as above	Enrollment figures as of August 1, 2002 totaled 425,226 members.		*J.K., et al. v. Griffith, et al. & AHCCCS* Class action lawsuit filed regarding the provision of behavioral health services, concluded approximately 10 years of litigation. Status Closed In 2001, a Settlement Agreement was reached.
	Childless couples and single adults whose income is under 100% FPL.	This population was included through the State's 1115 Demonstration Waiver, and implemented with Senate Bill 1577 (Prop 204) and A.R.S. §36-2901.	This population was established effective October 1, 2001.	Acute Care is funded with a combination of federal match and a state match, In FFY 2002 the federal matching assistance program is 64.98% federal and 35.02% state.	Enrollment figures as of August 1, 2002 totaled 79,937 members.		

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ACUTE CARE
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
	Medical Expense Deduction Program for persons whose income is over 100% FPL and who use medical bills to "spend down" their income to 40% of the FPL.	The Medical Expense Deduction Program was established with Arizona's 1115 Demonstration Waiver, and implemented with A.R.S. §36-2901.04	Medical Expense Deduction, in its current form, was established October 1, 2001.	Funded with a combination of federal match and a state match. In FFY 2002 the federal matching assistance program is 64.98% federal and 35.02% state. Of the state match the county pays 15.34%	Enrollment figures as of August 1, 2002 totaled 3,833 members.		*Abortion Services of Phoenix (Simat Corp.) et al. v. The State of Arizona & AHCCCS* <u>Status</u> Open At present, the AHCCCS Administration is awaiting a decision from the Arizona Supreme Court regarding the provision of medically necessary abortion. In 2001, the Arizona Court of Appeals upheld the existing statutory and regulatory limitations regarding abortion services,
	Pregnant women whose income is under 140% of the FPL.	Section 1902(a)(10)(A) & 1902 (l)(1)(A) and (B) of the Social Security Act as amended by section 4603 of the omnibus Budget Reconciliation Act of 1990.	Expansion of SOBRA eligibility from 133% FPL to 140% FPL for pregnant women and infants effective October 1, 1990. (HB 2351, Chapter 333, Laws of 1990) and implemented with A.R.S. §36-2901	Same as above	Enrollment figures as of August 1, 2002 totaled 8,858 members.		

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ACUTE CARE
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
	Children Only Coverage which includes: Children - under age 1 whose family income is under 140% FPL.	Section 1902(a)(10)(A) & 1902 (l)(1)(A) and (B) of the Social Security Act as amended by Section 4603 of the Omnibus Budget Reconciliation Act of 1990.	Same as above	Same as above	Enrollment figures as of August 1, 2002 are estimated at a total of 10,962 members.		determining that AHCCCS is not required to cover medically necessary abortions. *Perry vs. AHCCCS* Imposed specific notice and continuation of Benefit requirements relating to the denial, reduction, or termination of medical services Status Closed The AHCCCS Program substantially modified its notification process to members.
	Children ages 1 thru 5 whose family income is under 133% FPL.	Sections 1902(a)(10)(A)(i)(VI) and 1902(l)(1)(C) of the Social Security Act and implemented with A.R.S. §36-2901.	Same as above	Same as above	Enrollment figures as of August 1, 2002 are estimated at a total of 24,846 members.		
	Children 6 and older who's family income is under 100% FPL.	Section 1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D) of the Social Security Act as amended by Section 4601 of the Omnibus Budget Reconciliation Act of 1990. Implemented with A.R.S. §36-2901.	Effective October 1, 1988, eligibility age limits for SOBRA children with incomes to 100% FPL raised from under 5 years of age to under 6 years of age. (SB 1182, Chapter 3, Laws of 1988).	Same as above	Enrollment figures as of August 1, 2002 are estimated at a total of 37,270 members.		

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ACUTE CARE
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
	Federal Emergency Services (FES) for persons who are non-citizens and non-qualified aliens whose income is under 40% FPL.	Federal Emergency Services was established under Section 1903(A) of the Social Security Act and implemented with ARS 36-2901.06.	Section 1903(v) of the Social Security Act and implemented with ARS 2903.03.	Same as above	Enrollment figures as of August 1, 2002 totaled 11, 555 members. 9,420 are pregnant, non-citizen women.		
	Family Planning Services - A woman who is eligible and who is not otherwise enrolled in the system is eligible to receive voluntary family planning services for one year after her AHCCCS enrollment ends. T+here is no income limit for this group. Services are covered by AHCCCS on a fee-for-service basis.	Section 1902 (a)(10)(A) of the Social Security Act and A.R.S §36-2907.04	On August 1, 1995, the Family Planning Services Extension Program was implemented.	Same as above	Enrollment figures as of August 1, 2002 totaled 9,430 members.		
	Young Adult Transitional Insurance (YATI) is a person under age 21 in foster care on their 18th birthday. There is no income limit for this group.	Section 1902 (a)(10)(A) of the Social Security Act and A.R.S. §36-2901.06.	Same as above	Same as above	Enrollment figures as of August 1, 2002 totaled 87 members.		

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Medicare Cost Sharing Program
AHCCCS MATRIX

The Medicare Cost Sharing (MCS) programs provide help with Medicare expenses for people who are aged, blind, or disabled. A member may apply and be deemed eligible for any one of the following six Medicare Cost Sharing Groups: (1) Qualified Medicare Beneficiary-Only, (2) Qualified Medicare Beneficiary-Dual, (3) Specified Low-Income Beneficiary (4) Qualified Individual-1, (5) Qualified Individual-2, and (6) Qualified Disabled Working Individual.

All applicants must meet general eligibility criteria: A. Must be a resident of Arizona B. Must be a citizen of the United States or a qualified non-citizen, and C. Are required to have a social security number.

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
Qualified Medicare Beneficiary (QMB)	Qualified Medicare Beneficiary are members whose income is up to 100% of the FPL ($739 for an individual and $995 for a couple). AHCCCS pays: Medicare Part B Premium and Medicare Part A (hospital insurance) premium (if not free), Medicare Coinsurance, Medicare Deductibles and Co-payments.	The Medicare Catastrophic Coverage Act of 1988	Coverage of the QMB population became effective July 1, 1989.	QMB is funded through the federal and state governments by the current federal matching assistance percentage FMAP which is 64.98 for 2002. The remaining amount is paid by the State.	As of August 1, 2002, enrollment figures totaled 1,097 members.	Some QMB members who chose to apply for other Medicaid programs and who are found eligible due to their low income, could receive services under other mandatory groups such as the Proposition 204 group. Individual would be responsible for payment of Part A and Part B Medicare premiums, deductibles, and coinsurance.	There has been no litigation involving any of the groups under served under this program.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Medicare Cost Sharing Program
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
Qualified Medicare Beneficiaries Dual	Qualified Medicare Beneficiaries Dual - Members whose income is up to 100% of the FPL ($739 for an individual and $995 for a couple). Qualified Medicare Beneficiaries determined eligible are entitled to all AHCCCS and Medicare Part A and B covered services and can therefore benefit from either system. AHCCCS pays: Medicare Part B Premium and Medicare Part A premium (if not free), Medicare Coinsurance, Medicare Deductibles and Co-payments as well as the cost for prescription drugs.	Same as above	Same as above	Same as above		Individual would be responsible for payment of Part A and Part B Medicare premiums, deductibles, and coinsurance. Also, there would be no coverage under Medicaid unless individual applies and is deemed eligible for a Title XIX group. Potential loss of prescription coverage.	N/A

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Medicare Cost Sharing Program
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	C nsequences Of NOT D ing Program	Court Cases
Specified Low Income Beneficiary	Specified Low Income Beneficiary_ - Income between 101% to 120% of the FPL ($739.01 to $886 for an individual and $995.01 to $1,194 for a couple). AHCCCS pays the Medicare Part B Premium of $54/mo.	The Omnibus Budget Reconciliation Act of 1990 created the SLMB group.	This group became effective January 1, 1993.	SLMB members are funded through the Federal & State governments by the current FMAP which is 64.98% for 2002. The remaining amount is paid by the State.	As of August 1, 2002, enrollment figures totaled 7,377 members.	Individual responsible for payment of the Medicare Part B premium of $54/mo.	N/A

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Medicare Cost Sharing Program
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
Qualified Individual-1	Qualified Individual-1 - Income between 121% to 135% of the FPL ($886.01 to $997 for an individual and $1,1941.01 to $1,344 for a couple). AHCCCS pays the $54 Medicare Part B premium.	This group was created by the Balanced Budget Act of 1997. 42 USC, Chapter 7, Subchapter XIX, Section 1396d Arizona Revised Statute Title 36, Chapter 29, Article 3	Effective July 1, 1998.	Funded 100% by annual block grants from the federal government. These block grants were authorized by the Balanced Budget Act of 1997 for calendar years 1998 through 2002. These are not entitlement programs. When the block grant funds are depleted, eligibility cannot be approved for any more people. Applicants are approved on a first-come, first-served basis.	Enrollment figures as of August 1, 2002, totaled 3,345 members.	Individual would be responsible for payment of Medicare Part B premium of $54/mo.	N/A

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Medicare Cost Sharing Program
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population S rved	Consequences Of NOT Doing Program	C urt Cases
Qualified Individual-2	Qualified Individual-2 - Income between 136% to 175% of the FPL ($997.01 to 1,293 for an individual and $1,344.01 to 1,742 for a couple). A one-time payment for partial reimbursement of Medicare Part B premium which equaled $3.91/mo. for 2002.	Same as above	Same as above	Same as above	Enrollment figures as of August 1, 2002 totaled 1,992 members.	Minimal	N/A

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Medicare Cost Sharing Program
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
Qualified Disabled Working Individuals	Qualified Disabled Working Individuals - Income up to 200% of the FPL ($1,477 for an individual and $1,990 for a couple). There is also a resource limit for this group of $4,000 for an individual and $6,000 for a couple. To be eligible, the QDWI member must be: disabled; under the age of 65; have lost Title II disability benefits; and not otherwise be entitled to Medicare benefits. AHCCCS pays premiums for Medicare Part A.	This group was established with the passage of the Omnibus Budget Reconciliation Act of 1989.	Coverage of the QDWI became effective July 1, 1990.	Funded through the Federal & State governments by the current FMAP which is 64.98 for 2002. The remaining 35.02% is paid by the State.	There are currently no members receiving assistance under this group.	Individual would be responsible for payment of Medicare Part A premium.	N/A

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Medicare Cost Sharing Program
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
State Emergency Services Program (SESP)
AHCCCS MATRIX

SESP provides services for those qualified aliens or non-citizens who do not meet Federal Title XIX Medicaid requirements, but who are eligible according to Arizona Revised Statute. Legislation was passed in Special Session authorizing persons eligible on or before November 1, 2001 for SESP to receive continued coverage through FY 01-02

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
AHCCCS' State Emergency Services Program (SESP) *End Stage Renal Disease and Cancer Treatment*	Subject to the availability of monies, persons who were determined eligible on or before November 1, 2001, continue to receive treatment if it is medically necessary and the service does not meet the federal definition of an emergency medical condition as defined in section 1903(v) of the social security act. Individuals must also meet the following eligibility criteria: • Non-citizen and non-qualified alien • Have an adjusted gross income of not more then 40% of the FPL, • Meet income and resource requirements.	Laws 2001, 2nd S. S., Ch. 8	This program was established July 1, 1993.	100% State funded Funding was not continued for this program for FY 02-03 AHCCCS has been given approval from the Department of Administration to continue using unspent funds (about $1 million) appropriated this year	As of August 1, 2002, enrollment figures totaled 990 members.	Providers will have increased uncompensated care and may be at an increased risk of closing their emergency departments because of economic losses due to uncompensated care. Qualified patients will go without necessary medical services.	*Scottsdale Healthcare, Inc. v AHCCCS* In May of 2002 argued that the rehabilitation-related services provided to undocumented aliens constitutes an emergency services Status The Arizona Court of Appeals determined that the rehabilitation-related services provided to the undocumented alien did not constitute emergency services. The Court also

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
State Emergency Services Program (SESP)
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
	Services are limited to the following conditions: 1. Treatment for end stage renal disease that requires ongoing dialysis. 2. Radiation and chemotherapy to treat a diagnosed cancer that was found as the result of an emergency condition that was related in an inpatient hospital setting. Treatment does not include transplantation services.						determined that any care rendered after the patient was stabilized, while perhaps medically necessary, was not emergency care under the statute. The Supreme Court accepted review on 9/24/02. *Padilla v. Diebess* The U.S. District Court for Arizona ordered a preliminary injunction on 9/24/02 that will allow persons with ESRD who don't qualify for Medicaid coverage to continue to receive dialysis services.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
State Emergency Services Program (SESP)
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
AHCCCS' State Emergency Services Program	SESP provides emergency services for those qualified aliens or non-citizens who do not meet Federal Title XIX Medicaid requirements, but who are eligible according to Arizona Revised Statute Individuals must also meet the following eligibility criteria: • Have an adjusted gross income of not more then 40% of the FPL, • Meet income and resource requirements, and • Meet non-citizen and non-qualified alien status. • Not categorically eligible for Medicaid. Services are provided only if Services necessary to treat the sudden onset of a medical condition, including emergency	Section 1903(v) of the Social Security Act and A.R.S. §36-2901.06 and 36-2903.03	Same as above	100% State funded		Hospitals will have increased uncompensated care and may be at an increased risk of closing their emergency departments because of economic losses due to uncompensated care.	*Mercy Healthcare v. AHCCCS* In 1994 the plaintiff claimed that legislation does not limit coverage to services for treatment while acute symptoms continue. <u>Status</u> Closed The Arizona Court of Appeals decision required the Agency to analyze each case individually. The Court also concluded that undocumented aliens were entitled to treatment of emergency care-not long

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
State Emergency Services Program (SESP)
AHCCCS MATRIX

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
	labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: • 1. Placing the patient's health in serious jeopardy, • 2. Serious impairment to bodily functions, or • 3. Serious dysfunction of any bodily organ or part. Services are not covered unless all of the criteria are met at the time the service is rendered. An emergency medical condition shall be determined on a case-by-case basis.						term care.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
PROGRAM DESCRIPTION
Arizona Long Term Care System

Long term care refers to ongoing services for members who require care equivalent to that in a skilled nursing facility or ICF/MR. ALTCS offers a complete array of acute medical care services, institutional services, behavioral health services, home-and-community-based services (HCBS) and case management services for all eligible persons.

Division Program	Program Description	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
AHCCCS' Arizona Long Term Care System (ALTCS)	AHCCCS contracts on a prepaid, capitated basis with eight Program Contractors to provide services to elderly, physically disabled, or developmentally disabled members. Primary Care Physicians and case managers act as gatekeepers to coordinate member care. ALTCS Services In addition to acute care services, an ALTCS members may receive these services: ▪ Case Management; ▪ HCBS; ▪ Behavioral Health; and	Federal Medicaid law requires states to provide nursing facility services. Home and community - based services (HCBS) are optional. In 1987, the Legislature passed legislation to establish a comprehensive long term care program that included home and community based services and case management. The authority for the program is found at: Arizona Revised Statute, Title 36, Chapter 29,	The ALTCS program began in two phases: • The DD population began receiving services on December 19, 1988; and • The EPD population was added on January 1, 1989. The ALTCS Program, under Arizona's 1115 Waiver, has been extended through September 30, 2006.	Funding from federal, state and county sources for SFY '02: Long Term Care is split between Federal and State by the current FMAP. In FY 2002 the FMAP is 64.98% Federal and 35.02% State. For the FFY 2002 Appropriation the 35% State Match is then split between the County Fund and the General Fund at 77.74% for the County Fund and 22.26% for the	As of August 1, 2002, enrollment figures totaled 34,963 members. Of this total there are 13,503 DD members and 21,460 EPD members. Eligibility is based on financial criteria, medical criteria, and being "at risk" of immediate institutionalization Financial A monthly income of up to $1,635 and resources up to $2,000 Medical The person must be at immediate risk of institutionalization.	If the State were to eliminate the Title XIX program entirely, providing comparable NF (not including administrative expenses) is estimated to be at least $1.4 billion annually to cover the current ALTCS population (33,635). Following is a description of the impact on various parties if the ALTCS program were eliminated: Hospitals Forces the healthcare system to respond to acute/chronic needs left unattended for those individuals choosing not to enter a NF. Increases emergency room visits. Other State Agencies Increases demand on other state agencies for	*Shea and Lacy v AHCCCS.* Required Pre-Admission Screening to be part of regulation. Status AHCCCS agreed and modified rule. *Ball et al. v Biedess, AHCCCS and the State of Arizona.* Maintains that AHCCCS is in violation of federal law due to the alleged lack of home care services

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
PROGRAM DESCRIPTION
Arizona Long Term Care Syst m

Division Program	Program Descripti on	Statute Establishing Program	Current Status Year Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
	▪ Nursing Facility.	Article 2; Arizona Administrative Code, Title 9, Chapter 28; and Arizona's 1115 Waiver under Section 1115 of the Social Security Act.		General Fund.		services such as DES, Aging and Adult Services, and DHS. HCBS Providers Dismantling of the HCBS network has the potential of increasing unemployment in the field. Nursing Facilities If HCBS were eliminated and AHCCCS only covered mandatory services (NF and ICF/MR) there would not be enough NF capacity.	available to HCBS recipients. Status Open Cross motions for Summary Judgments have been filed.

MEDICARE COST SHARING GROUP SUMMARY PAGE

The Medicare Cost Sharing (MCS) programs provide help with Medicare Part A (hospital insurance) or Part B (medical insurance) expenses for people who are aged, blind, or disabled. A member may apply and be deemed eligible for any one of the Medicare Cost Sharing Groups listed below.
All applicants must meet general eligibility criteria: ● Must be a resident of Arizona ● Must be a citizen of the United States or a qualified non-citizen, and must apply for pension, disability, or retirement benefits if potentially available.

Eligibility Groups	FPL Income	Specific Requirements	Benefit	Statute	Year Established	Funding '02	Enrollment Figures
Qualified Medicare Beneficiary-Only	100% $739 individual $995 couple	Receiving or conditionally eligible for Medicare Part A	Payment of Part A and Part B Medicare premiums, deductibles, and coinsurance.	Medicare Catastrophic Coverage Act of 1988	July 1, 1989	64.98% federal matching assistance percentage and 35.02 State match	TBD
Qualified Medicare Beneficiary-Dual	100% $739 individual $995 couple	Receiving or individually eligible for Medicare Part A	Payment of Part A and Part B Medicare premiums, deductibles, and coinsurance. Also eligible to receive Medicaid services.	Medicare Catastrophic Coverage Act of 1988	July 1, 1989	64.98% federal matching assistance percentage and 35.02 State match	TBD
Specified Low-Income Beneficiary	101%-120% $739.01-$866 individual $995.01-$1,194 couple	Eligible for and covered by Medicare Part A	Payment of the Medicare Part B premium of $54/mo.	Omnibus Budget Reconciliation Act of 1990.	January 1, 1993	64.98% federal matching assistance percentage and 35.02 State match	TBD
Qualified Individual-1	121%-135% $866.01-$997 individual $1,194.01-$1,344 couple	Eligible for and covered by Medicare Part A	Payment of Medicare Part B premium of $54/mo.	Balanced Budget Act of 1997	July 1, 1998	100% federal funding thru annual block grants. Applicants are approved on a first-come-first served basis	TBD
Qualified Individual-2	136%-175% $997.01-$1293 individual $1,344.01-$1,742 couple	Eligible for and covered by Medicare Part A and receipt of Medicare Part B.	A one-time payment for partial reimbursement of Medicare Part B premium which equaled $3.91/mo. for 2002.	Balanced Budget Act of 1997	July 1, 1998	100% federal funding thru annual block grants. Applicants are approved on a first-come-first served basis	TBD
Qualified Disabled Working Individual	Up to 200% $1,477 individual $1,990 couple	Under age 65 and lost Title II Social Security Disability Benefits due to earnings.	Payment of Medicare Part A premium.	Omnibus Budget Reconciliation Act of 1989	July 1, 1990	%64.98 federal matching assistance percentage and 35.02 State match.	TBD

Interagency Council for Long Term Care
Department of Economic Security
Aging and Adult Administration Matrix

Division-Program	Program Description	Statute/ Regulation Establishing Program.	Current Status-years established	Funding Stream	Population Served	Consequences of NOT doing Program	Court Cases
DACS/A&AA	Long-Term Care Ombudsman	OAA (Older Americans Act) Title 7, Chapter 2, Section 711 through 713 and A.R.S.§ 46-402.	Authorized by Older Americans Act in 1965 and as amended; re-authorized in 2002.	Older Americans Act, Title 7 and Title 3; also state funding Funding is currently 85% Federal and 15% state funding.	Vulnerable adults residing in long-term care facilities.	The consequence of not having an ombudsman program would be the loss of current funding sources, resulting in the loss of paid staff to recruit, train and supervise volunteer ombudsmen as well as the inability to provide federally mandated services to Long-term care residents.	There are no known court cases.
DACS/APS	Adult Protective Services	A.R.S.§ 46-451; A.R.S.§ 46-454 through 457; A.R.S.§ 41-1959.	A.R.S.§ 46 statutes were established in 1980; A.R.S.§ 41 was established in 1981.	Federal SSBG; (Social Security BlockGrants); State Funds; and DOL (Department of Labor) pass-through.	Age 18 and older	The consequence of not having an APS program is loss of funding for mandated protective services for vulnerable adults.	There are no known court cases.
DACS/A&AA	In-home services (now known as non-medical home and community based services (HCBS).	A.R.S.§ 46-191 through 193.	Statute was established in 1980.	Older Americans Act, Title 3; State SPP (Suplemental PaymentProgram) and SSBG.	The statute states: "frail, older individuals."	The consequence of not having an HCBS program would result in increased numbers of senior citizens needing nursing home placement.	There are no known court cases.

Interagency Council for Long Term Care
DIVISION OF DEVELOPMENTAL DISABILITIES MATRIX

Division-Program	Program Description	Statute establishing Program	Current Status-years established	Funding Stream	Population Served	Consequences of NOT doing Program	Court Cases
DES/ DDD **State-Only**	Services/ Support coordin-ation for people with eligible conditions of mental retardation, epilepsy, cerebral palsy, autism & 3 or more areas of major life impairment.	ARS 36-552.C Subject to annual legislative appropriation and other available funding, the department shall provide a wide variety of developmental disability programs and services throughout the state in response to the wide range of developmental disability conditions	Established in Approx. 1952 (Dept. of MR)	General Fund Appropriatio n; Title XX; client contribu-tions; LTC System fund interest; 3rd Party Liability; foster care trust fund account; PASARR ——— Targeted Case Mgt.: Title XIX match for support coordian-tion	7264 DDD eligible consumers (state- only funded) 3444 Targeted case management consumers (Subcom-ponent of state-only funded population) (June 2002)	Loss of services/ placements and support coordination to eligible individuals No Room & Board funding or non – LTC funded services for Medicaid eligible consumers	

Interagency Council for Long Term Care
DIVISION OF DEVELOPMENTAL DISABILITIES MATRIX

Division-Program	Program Description	Statute establishing Program	Current Status-years established	Funding Stream	Population Served	Consequences of NOT doing Program	Court Cases
DES/ DDD **Arizona Long Term Care**	Program Contractor for AHCCCS providing acute care,, home & community services, & support coordination to eligible individuals with developmental disabilities who are at risk of institutionalization; Intermediate Care Facilities/Institution. The Division subcontracts with 3 health plans and over 3000 individual & agency providers.	36-2940. Program contractors; The administration shall contract with program contractors ... The department shall be a program contractor and provide services ... either directly or through subcontracts with providers or through noncontracting providers to members who are defined as developmentally disabled pursuant to section 36-551 and who are enrolled with the program contractor by the system.	December 1988	Federal Match: 66.69% State Match: 33.31%	13,315 Arizona Long TermCare eligible consumers (June 2002)	No Medicaid program would result in loss of services to over 13,000 people with developmental disabilities or use of 100% general fund; increased demand on other social service agencies	

Interagency Council for Long Term Care
ARIZONA DEPARTMENT OF INSURANCE MATRIX

Division-Program	Program Description	Statute/Regulation establishing Program/Obligation	Current Status-years established	Funding Stream	Population Served	Consequences of NOT doing Program	Court Cases
Long Term Care Insurance	ADOI regulates the transaction of insurance and enforces the specific requirements for Long Term Care Insurance Companies.	A.R.S. § 20-1691 – 1691.08 and A.A.C. R20-6-1001 – 1016.	LTC insurance was created in the late 1960s – early 1970s. The bulk of current laws & regs were enacted in 1992. Sales for the product are increasing at a rapid pace.	The ADOI budget comes from the state's General Fund.	All purchasers & prospective purchasers of LTC insurance.	There would be no consumer protection in the transaction of LTC insurance.	N/A
Liability insurance for LTC facilities & providers, including Errors & Omissions insurance and Medical Malpractice insurance.	ADOI regulates the transaction of insurance.	Various statutes in Title 20.	Unknown.	The ADOI budget comes from the state's General Fund.	All purchasers & prospective purchasers of Liability insurance.	There would be no consumer protection in the transaction of Liability insurance.	N/A

Interagency Council for Long Term Care
Arizona Department of Health Services Matrix

Division-Program	Program Description	Statutes Establishing Program	Current Status-Years Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
Assurance and Licensure: Office of Long Term Care	Licensing of Nursing Care Institutions, which provide inpatient beds and nursing services on a continuing basis.	A.R.S. § Title 36, Chapter 4, Articles 1, 2, and 7	Statute Established: 1977	25% State General Fund 50% CMS Title 19 50% CMS Title 18	Adults who require inpatient beds and nursing services on a continuing basis.	If licensing of Nursing Care Institutions were no longer mandated facilities would not be required to meet minimum standards, putting patients at risk.	
Assurance and Licensure: Office of Assisted Living	Licensing of Assisted Living Homes and Centers, which provide supervisory, personal, and directed care services on a continuing basis.	A.R.S. § Title 36, Chapter 4, Articles 1 and 2	Statute Established: 1987 (Formerly in Article 8; repealed and replaced in 1989)	75% State General Fund 25% AHCCCS Title 19	Adults who require a residential setting and supervisory, personal, or directed care services on a continuing basis.	If licensing of Assisted Living Facilities were no longer mandated facilities would not be required to meet minimum standards, putting patients at risk.	
Assurance and Licensure: Office of Medical Facilities Home Health	Licensing of Agencies that provide home health services.	A.R.S. § Title 36, Chapter 4, Articles 1 and 2	Statute Established: 1983	40% State General Fund 60% CMS Title 18	Adults or children who require in-home nursing care.	If licensing of Home Health Agencies were no longer mandated facilities would not be required to meet minimum standards, putting patients at risk.	
Assurance and Licensure: Office of Medical Facilities Hospice	Licensure of agencies that provide palliative and supportive care for terminally ill persons and their families or caregivers.	A.R.S. § Title 36, Chapter 4, Articles 1 and 2	Statute Established: Between 1971 and 1989	40% State General Fund 60% CMS Title 18	Adults or children who are terminally ill and require...	If licensing of Hospice agencies and inpatient facilities were no longer mandated, facilities would not be required to meet minimum standards, putting patients at risk	

Division-Program	Program Description	Statutes Establishing Program	Current Status-Years Established	Funding Stream	Population Served	Consequences Of NOT Doing Program	Court Cases
Assurance and Licensure: Office of Assisted Living Adult Day Health Care	Licensing of Adult Day Health Care Facilities, which provide planned care supervision and activities, personal care, personal living skills training, meals and health monitoring.	A.R.S. § Title 36, Chapter 4, Articles 1 and 2	Statute Established: Between 1987 and 1989	75% State General Fund 25% AHCCCS Title 19	Adults who benefit from planned care, supervision, and activities in a social setting.	If licensing of Adult Day Health Care Facilities were no longer mandated, facilities would not be required to meet minimum standards, putting participants at risk	
Cost Reporting & Rate Review	Reports annually the cost of services, registers rate increases and reports the utilization of services provided at long term care facilities.	A.R.S. § 36-436 for Rate Review and A.R.S. §36-125.04 for the Financial & Utilization Review.	Statute Established: 1970's (Last Revised: 1996, currently under revision)	100% State	General Public; AHCCCS (for rate setting purposes)	The financial status of LTC facilities and the cost of services offered at the facilities would not be known.	
Healthy Aging 2010	The Development of a Statewide Plan for health promotion and disease prevention	None	N.A.	100% State funded	All Arizonans over the age of 65 years.	Collaboration on statewide health promotion and disease prevention activities would not exist.	
Behavioral Health Prevention	Provides the following Services; 1. Gate openers 2. Prevention and Education for Senior Citizens 3. Home based prevention 4. Peer counseling	None	N.A.	Block Grant Federal Funds Tobacco Tax	Arizonans over the age of 60 years.	Increased hospitalizations; crisis, nursing home admissions	

Sources used for this document:

"The 21st Century Workforce Shortage and Implications for Health and Human Services Agencies", APHSA State Government Summit on the Workforce Crisis

"Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis, Stone, Robert Wood Johnson Foundation, Institute for the Future of Aging Services, and The Urban Institute.

Personnel from State Agencies contributing to the report:

Alvarez, Georgia – Division of Developmental Disabilities/DES
Larson, Lynn – Aging and Adult Administration/DES
Tomlinson, Cheri – AHCCCS
Winter, Anne – AHCCCS
Wynn, Lisa – AZ Department of Health Services

PUBLIC PARTICIPATION
September 30, 2002

Arizona Senate Ad Hoc Committee on Caregiver Wages and Workforce Development

FINDINGS

[Arizona has a caregiver crisis.] A growing disparity between available caregivers and the number of dependent older adults is the "sleeper issue for the next 20 years," according to the Future of Aging Services. While most national studies on this issue point out the complicated multi-faceted approach required for solutions, they also clearly state that the most important solution to reduce this disparity is through additional compensation for the caregivers. (Page 21 of 63)

We believe effective solutions are within reach - as long as long-term care, academic and government officials work together to gather and share information, increase awareness and spearhead change. (Page 19 of 63)

Staffing shortages within Arizona's long-term care (LTC) providers affect the cost, quality, and availability of care. The LTC workforce crisis is a multi-dimensional problem requiring a multi-dimensional solution. The most important dimension to solving this complex problem is adequate funding and reimbursement achieved more readily through collaboration. (Page 10 of 63)

The inability to offer competitive wages and benefits has created the most serious professional and paraprofessional LTC labor shortage. The labor shortage causes remaining workers to shoulder unrealistic workloads. In addition, many caregivers are required by government regulation to focus on paperwork instead of resident care. This compounds the difficult environment in which both providers and caregivers are finding it more unappealing and intolerable to work. (Page 26 of 63)

Of special significance is the trend of Arizona people over 65 increasing from 13% in 2000 to 17% in 2010. And, by the year 2030, over 21% of our population will be over 65. Arizona's population over 85 is increasing more rapidly than any other group. This age cohort should increase anywhere from 94% to 200% by the year 2010.54 At least 55% of those people will likely live in the Greater Phoenix area. To meet the care and housing needs of these citizens, Arizona will need its struggling long-term care system. (Page 25 of 63)

Nursing and assisted living facilities, home health agencies and intermediate care facilities for persons with mental retardation or developmental disabilities all require sufficient numbers of qualified staff to provide quality care and services. The staffing crisis in LTC has developed and worsened over time, influenced by social, economic and demographic factors, generally beyond the providers' control. (Page 21 of 63)

LTC providers across the continuum are struggling to fill staffing positions due to a combination of factors, including non-competitive wage and benefit levels limited by current low Medicare and Medicaid rates, public information and negative public perceptions of the profession and limited opportunities for career advancement. (Page 21 of 63)

Since public programs such as ALTCS will likely remain the major payor of LTC in Arizona, public policy will continue its fundamental role in shaping the LTC sector. We believe significant improvement in caregiver wages

and workforce development requires collaborative mechanisms that promote a comprehensive approach, build and maintain momentum, and provide a direct conduit to public policy changes. (Page 17 of 63)

Arizona's universities and other members of the research community should do further research by (e.g. private foundations) - in collaboration with LTC providers, program contractors, registries, and nursing professionals in LTC to resolve the caregiver workforce crisis. Many questions must be addressed. (Page 12 of 63)

Nurse assistants working in all types of health care settings are the least likely group of health care workers to have insurance. Health insurance provides significant benefits for caregivers and their families. (Page 13 of 63)

Arizona is ranked 33rd for Average Medicaid Reimbursement Rates. Thirty-two (32) states have higher and 18 states have lower average Medicaid reimbursement rates for nursing homes than Arizona. (Page 13 of 63) (See Appendix F)

The cost of LTC, which is already financially devastating to most of Arizona's older adults, will only become more expensive as our population ages and people live longer with the assistance of expensive drugs, therapies and medical technologies. (Page 26 of 63)

While demographics and costs will explode, the pool of paid and unpaid caregivers will shrink dramatically. This is due to small size, families living further apart and two-wage earner families. Arizona's paid caregiver workforce is unlikely to keep up with the exploding need because capped, inelastic and under-funded government payment systems do not allow providers to be competitive in a tight labor market. The AHCCCS/Medicaid system pays - on average - about $100 per patient-day for 70% of the 14,000 residents in Arizona's nursing homes. These funds are expected to cover room, board, three meals a day, some therapies, overhead, social activities, linens, mortgage and caregiver salaries, among other things. (Page 26 of 63)

Staffing shortages experienced nationwide are a reality for Arizona's LTC providers and their residents as well. According to a recent trade association surveys, the average vacancy rates for nursing care in Arizona's nursing facilities range from 10.4% to 17% within the not-for-profit facilities,55 and range from15.6% to 20.2% within the for-profit facilities.

The average age of a caregiver today is 44. Caregivers of this age will not be able to continue to work at such physically intensive jobs. Population shift: Rapidly aging population with increasing chronic care needs contrasted by a significantly smaller population of younger workers. Caregiver positions are [viewed as] dead end jobs. Jobs which are filled primarily by women who are economically disadvantaged and have low levels of education. Society has stigmatized caregiver positions. Competition between other service industries that recruit for entry-level positions further reduces the workforce. (Page 48 of 63)

Another workforce risk factor compromising the quality of LTC in Arizona is turnover rate. A recent trade association survey reports average annualized turnover rates for Arizona nursing homes positions range from 71% to 95%. (Page 27 of 63) [High] attrition is anecdotally reported in all phases of hiring and training: If 100 people are interviewed, providers will accept 75 into training, 50 will show up for training, 25 will complete training and 15 will go to work. Community-based care experiences a turnover of thirty-five to forty-five percent. (Page 49 of 63)

Turnover in Skilled Nursing facilities is reported to be sixty-two to one hundred percent annually. Caregivers find higher paying jobs in other industries. Jobs are physically and emotionally demanding with little or no respect or support from providers, supervisors, or consumers. (Page 49 of 63)

Our research indicates that each funding agency has similar, but different standards for caregiver training, education, and oversight. The development and implementation of universal standards and practices will lead to a stable, qualified workforce, a higher quality of care and an overall reduction of costs. Due to the current shortage and increased demand for qualified caregivers, it is imperative that action be taken within 12 months. (Page 45 of 63)

Caregiving curriculum is fragmented, and minimal training hours do not prepare the worker for safe practice. There is no comprehensive, integrated core curriculum, which can be delivered in multiple settings, serving as the base for a career pathway. Not all employers comply with existing mandated training. There is inconsistent routine oversight of training delivery compliance. (Page 46 of 63)

RECOMMENDATIONS

Until the Legislature adjusts program funding levels to those required to implement the 2001 Arizona Legislative session's SB1322, it is unlikely that the current critical shortage of direct care workers will be able to be meaningfully addressed. Require state agencies that contract with a private entity to provide direct care services, including home health services and supportive care services, to require the private entity to comply with the federal Fair Labor Standards Act (FLSA). (Page 10 etc of 63)

Depending on research with the State Attorney General's office, explore banning the "non-compete clause" for temporary health care workers through an amendment to a similar bill going through the Arizona legislature for media personnel. (Page 13 of 63)

Pass legislation in the 2003 session that would limit what registries can charge for temporary workers. In Minnesota last year, legislators passed a law that effectively caps the wages of temporary workers at 150 percent of the prevailing wage. The law also stipulates that at least 30 percent of the work hours filled by agency employees must be during weekends, holidays or night shifts. (Page 13 of 63) (See Appendix E)

Given the possible side-effect of legislation to cap wages at registries as the mass exodus of qualified care-providers from nursing homes, we should explore, educate and collaborate to find new funding to improve compensation for the regular staff and expand the number of people coming into the profession. (Page 13 of 63)

Require the "cost report" to be a single uniform cost report for both AHCCCS and ADHS. ADHS and AHCCCS representatives should address modifications to inter-government / agency agreements to streamline reporting and clarify existing statute mandating data collection and cost reporting.

Require a collaborative study – collaboration to include stakeholders and a disinterested third party (e.g. Arizona university or another research institution, private foundation). (Pages 15/16 of 63)

Increase Medicaid/AHCCCS payments for nursing homes using new funding sources. (Page 16 of 63)

Consider legislation similar to a A new law enacted by the 2001 Minnesota Legislature requires registration with the MN Department of Health (MDH) of Supplemental Nursing Services Agencies (SNSA) – i.e. temporary

employment agencies or registries - effective august 31, 2001 and the responsibility for the health care facilities / agencies to comply with the law. (Page 30 of 63)

Exiting job requirements be standardize across all funding agencies. "Our recommendation is that through existing inter-agency workgroups and/or task forces, these issue of [the lack of standardized job requirements and standards] are addressed and solutions are implemented consistently statewide, thus avoiding the need for new legislation." (Page 45 of 63)

Require on going training and education for all caregivers based on a standardized core curriculum. State agency collaboration to develop programs to provide needed financial, health, transportation, and childcare support for this worker population. Establish a mentor program through the community.
State agencies coordinate efforts to seek grant funding and incentive monies for creative workforce development programs. (Page 47 0f 63)

[We recommend improved] supervisor and consumer training. We recommend that evaluation the adequacy of existing staffing ratios and adjust where appropriate based upon quality outcomes. Develop incremental pay increases based on time in service and performance evaluations (let consumer be part of the evaluation) Employers develop caregiver awards for exceptional services, along with other personalized awards. Pre-screen for individual's appropriateness for this career prior to training and hiring. (Page 50 of 63)

Standardize existing service specifications/scope of practice, including limitations, of providers for Home and Community Based Services, and other settings excluding licensed nursing facilities. [This should include:] Create a standardized State database for background check, drug screening and fingerprinting information for all caregivers. All providers who receive State funding shall utilize the database to verify credentials to pre-screen employees or contractors. The collaboration of State agencies shall determine which agency shall develop and maintain the integrity of the database. Establish mandatory reporting criteria of other information to be maintained in the database. Provide training and informational materials from Protective Service Agencies on an ongoing basis. (Page 52 of 63)

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September 26, 2002

The Honorable Virginia L. Yrun
Arizona State Senate
1700 West Washington
Phoenix, AZ 85002

Dear Senator Yrun:

I was asked by Bonnie Danowski to serve as one of the Essential Readers for the draft report of the Senate Ad Hoc Committee on Caregiver Wages and Workforce Development. I understand that my role is to "make comments" which will assist the Committee in completing the Report. I am familiar with the issues and with how the Committee came into existence.

My experience with Study Committee Reports is that three ingredients are necessary for the report to have impact:

- Clear concise writing
- Well stated recommendations
- Assigned responsibility for implementation

In the form in which I received the draft report, all three ingredients are lacking.

Clear concise writing

The errors in the committee members' affiliations, the grammar and the outline format are too numerous to enumerate here. A staff person with professional editing skills needs to review the entire draft and make the necessary corrections.

Well stated recommendations

The Final Recommendations need to be grouped by category, perhaps as they came from the two Workgroups, and written in a consistent format that describes the issue, explains the actions needed, and identifies the responsible parties for implementation. As an example, " 41. Supervisor and consumer training," deserves further explanation!

Assigned responsibility for implementation

I understand that it has been the desire of at least some committee members that responsibility for implementation be directed at specific agencies and that they be given one year to address the issue, after which legislation would be introduced to require implementation. Such a proviso makes good sense and should be clearly stated at the head of any section with recommendations. However, teeth need to be added to the recommendations so that the responsible parties are clearly identified in all cases so that they can be held accountable.

I hope that these comments, even though brief, will be of use to you and to the Committee.

Sincerely yours,

Art Evans, Ph.D.
Research and Evaluation Coordinator

Some of my comments are very general, others more specific.

1) There is a lot of duplication of items (reasons for turnover, education, retention, wages, etc. I believe that these need to be consolidated.

2) Unless it is required by custom, there are several pieces of the document that, for reading purposes, should be in another order. The section on meeting agendas and minutes, page 7, is an example of that. I know it is chronological, but makes more sense at the end for reference.

I think that the order should be an Executive Summary of the whole document, followed by the Final Recommendations, with back-up data and supporting reports of subgroups as the final pieces.

3) For the balance of my comments I have numbered the pages of the report for easier reference. I printed out 63 pages of the Draft, including pg 29 according to my numbering with only the word "Draft" on it. If your numbers are different please let me know so that I can clarify any references.

4) On page 10, the second #3: "the most important..." : what does "more readily" mean? It is not readily clear.

5) Page 13: the first bullet at top of page. I believe that the legislation referenced actually was passed by the Legislature already, and so this should not reference something as "going through" when it has already gone through.

6) Page 13: the second bullet "Pass legislation..." should provide the more effective format of attaching or referencing proposed solutions by using legislation, programs, etc. from other states. That one bullet is more effective than all the other 12 solutions on page 12, because it is an answer rather than a question. Granted that some questions need to be addressed, if all that comes out of this is "more study needed," then we haven't gotten very far. In fact the process will have been thwarted.

7) Page 14: The first bullet under Issues: Sentence is unclear; "reimbursement rates...are related" What does that mean--dependent upon for accuracy; these factors are needed to make them accurate? Needs to be cleaned up so that it is readable and evident.

8) page 14: first bullet under Challenges: The second sentence says that "this requirement was ultimately adopted." I believe that to be inaccurate. As a matter of fact, language in the then existing law already requiring this was removed in the Omnibus Bill of 2001. This in fact means that departments in the state had been in violation of state law as indicated by AHCCCS's own study and the Mercer study which showed rates 15-30% behind market wages.

9) page 15: third to last bullet ("Require collaborative...") last word of first line I believe ought to be "to" instead "should" to read properly.

10) page 17: last bullet before "Conclusion": "Undertake a review of the administrative funds..." instead of existing wording.

11) page 17: I believe that this "Conclusion" section is sufficiently covered in the Final Recommendations and also is already mentioned in the previous pages and so is duplicative here. I believe that this whole section from the bottom of pg 17 thru pg 19 should be removed, for the stated reason, or at least moved to the end and only

referenced here.

12) page 18: re the first bullet, please reference my previous note about this already being in law now, I believe.

13) pages 20-43 should, per my earlier comment, should be moved to the end as references and back up support.

14) page 23: "The Bush administration..." sentence may be accurate, but needs to be balanced by the fact that this administration has consistently cut back on funding by rules changes etc, such as redefining dialysis treatments for undocumenteds as not emergency any more. There may be money for some new waiver but only at a cost to other important things.

15) Page 15, page 24, and page 27: these each have an almost identical footnote, except that the one on page 27 says "$4.25 per hour" whereas the other two (correctly I think) say "$5.15 per hour" These should be consistent.

16) page 27: "Fair and Market Wages Bill Proposed": the FLSA is not the same as Market Wages. This sentence confuses the two. They are two different issues. And see the earlier note #8 that shows that the intention of SB1322 was defied by the action of the legislature in actually removing language from the law that required state agencies to do what they had not been doing.

17) the section starting on page 44 is in much preferable format than the earlier section. This section is clearer, much more succinct, and will be read, whereas the other section will be glossed over because too wordy. I highly recommend that the prior section be rewritten in this format. Again the other sections should be referenced and moved to the end for back up and support.

18) page 59: I have no idea what Guiding Principle #1 is trying to say. What does it mean?
Under "Objectives" I feel that these should be prioritized or reordered even if not specifically as prioritized. I would suggest the order of 1-11 should (with the current numbering) be #7, 9, 10, 11, 2, 6, 3, 4, 5, 1, 8.

19) page 61: #13 as is, and then add "...FLSA and to implement market level wages."
#14 as is, and then add ",,,FLSA and to implement market level wages."

20) pages 60-63: I believe that these should be prioritized. Particular items that I think should be higher are #13, 17, 19, 22,26, 28, 30, 35, 36, and especially #27, 31, 33, and 37

Thank you for your patience with this. Again, if I can help with any questions this has raised for you, please contact me.

I reiterate that I believe that this needs a strong, hard-hitting Executive Summary to lead it off, followed by a priority list of recommendations. The back up and support material are very helpful but should be there for supportive arguments to the Recommendations.

Peace

Dick White
AZ Interfaith Network
480-510-9071

Tracey,

I apologize for the delay in my response. I had some unexpected travel and this put me behind in getting this to you. I have two levels of comments. One on the approach and direction of the information gathered and the other on the format and nature of the recommendations.

Overall Impression: The report seems to focus on the issues within the nursing home sector of long term care and the issues faced by that part of the continuum. I am not certain if this is a consequence of the resources available for information are more reliable in this sector or that because of the financial and political power of that sector their issues seem to have more emphasis. Areas that do not seem to have been given equal weight are:

1. Rural Communities: The approach of the committee clearly states the preference for in-home care and use of alternatives to nursing home or group care as the final option. At the same time the lack of care givers in rural communities, the inherent inefficiencies of the use of staff when the people being supported in their homes are great distances from each other, the use of personal transportation as the means for the caregiver to go to their clients, the costs and barriers associated with this system are not addressed. This system or in-home support is a threat to the stated goal of using caregiver resources to assist persons to remain in their homes.
2. Persons with Developmental Disabilities: Since the report seems to focus on the nursing home industry and persons in long term care with DD are not in nursing homes for the most part there is little mention of the shortage issue, training issues (which in some ways are more significant than for those of the aging population) and turnover challenges and how these are different from the aging programs.
3. Affordability of Benefits for employees: I think a distinction should be made between the for-profit sector and the not-for profit sector on this issue and the definition of affordability. The definition of affordability should be contrasted to the rate and the nature of the provider rather than an issue of the cost of health insurance. Some of us figure out how to provide it and pay for it in our long term care programs.
4. Cost of registries and on-call staff: This cost issue seems to be a catch-22. The pay differentials and wage and hour issues seem to prevent the use of staff who then also work for registries who then are not available for staffing hours in their primary jobs etc...

Recommendations: The body of the report makes some fairly specific recommendations regarding some of the issues. For example the report suggests that Arizona duplicate the Minnesota Model for Nursing services yet the recommendations are not as specific and do not make such a recommendation. The recommendations are also repetitive. For example I do not know if there is a real difference between items 4 and 8. Both deal with the issue of relating the type of work done and pay structure Items 35 and 37 are really the same thing with one going to AG and one to legislature.

1. Philosophy or standards of care: For example items 23, 25, 9, 5, 39, 41
2. Rate Setting and Funding: Items 2, 3, 6,.
3. Workforce Development: This would include recruitment and training. Examples are Items 24,29, 32, 30, 39, 40, 41
4. Employment conditions: 1, 2, 4, 5. 8, 28, 33
5. Resource Development: Items that relate to funding and database sharing, research. Examples are Items 7, 26, 36, 34, 38

This sort of categorization might make the list shorter and add value for the reader in understanding the scope of the recommendations.

I hope these brief observations are helpful. Please contact me if additional clarification would be helpful

Marguerite D. Harmon, CEO
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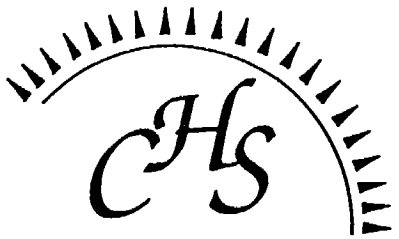

Cochise Health Systems

A program contractor for Arizona Long Term Care System and
A division of Cochise Aging & Social Services

September 26, 2002

Ms. Tracey Landers
Senate Research Staff
Email to: tlanders@azleg.state.az.us

RE: Caregiver Wages Report

The following comments are submitted, per your request:

1. Requirements for caregiver salaries or other benefits should be based on an incentive program, not specific pass-through requirements. Each provider may have specific market issues that need to be addressed, and each area may be different. Requiring the contractors to "pass-through" specific amounts to employees may serve to put private providers out of business, thus creating a more limited market of contractors.

   In combination with a standardized certification and training incentive program, perhaps variable rates could be offered, thus encouraging the training. However, there will still be services that may be performed by employees with less training and education, such as housekeeping. This level of worker should not be "excluded from the market" if they choose not to pursue additional education.

2. The idea of allowing personal care agencies to participate in a state health plan would significantly improve the abilities of our care-giving agencies to provide health care to their employees. This would serve to encourage new employees coming into the field as well as improve turnover rates.

3. The example of duplicative quality assurance studies (cited in the section on New Funding Sources, #2 Challenges) by AHCCCS and the Program Contractors does not appear accurate. The studies required by AHCCCS (currently Influenza/ Pneumonia; and two diabetic studies) are collected by the Program Contractors and the data then given to AHCCCS. The Program Contractors may choose to do other quality assurance studies themselves in order to measure quality outcomes in other areas of care, but we are unaware of "separate" studies done by AHCCCS.

   With regard to administrative expenses, the Program Contractors (by contract requirement) are only allowed 8% for administrative expenditures (2% is allowed for
   risk). In view of the many specific requirements of the contract in terms of required employees (i.e., Case Managers, Fraud and Abuse Coordinator, Cultural Competency Coordinator, etc.), even County Program Contractors (whose salaries are low in comparison to private companies) are struggling to meet these standards. If administrative allocations are changed, then administrative requirements should also be changed.

4. Share of Cost "bad debt" may be a continuing problem for nursing facilities. Part of the problem; however, is a result of the facilities' unwillingness to put stronger policies in place to require timely payment from the member/family. The Program Contractors assist with this issue, when we are notified; however, many times the nursing facility does not even notify us until many thousands of dollars are owed. Recovery, at that point, may be difficult, if not impossible.

5. The "highest" rate listed for Medicaid Rates for Nursing Homes in Arizona (Appendix F) appears low. The highest rates (even in 2000) were well above the $122.26 amount listed, including rates of $400 or more for ventilator dependent members. With regard to the inclusion of Therapy in the rate, this is only the case when a member is ventilator dependent and in need of respiratory therapy, or in a specific rehabilitation facility that also has significantly higher per diem costs. In all other nursing facility rates, therapies are paid separately.

6. Issues such as lack of protection for vulnerable clients should also include the development of rules regarding abuse or violence toward the caregivers. Currently, ALTCS members can abuse staff from one agency, then another agency is found and the staff from that agency is subsequently abused by the same member. There is no recourse in rule for these types of members.

Please call me if you have any questions regarding the comments.

Sincerely,

Denise Pederson
Director
Cochise Health Systems

Phone (520) 432-9481
Email: dpederson@co.cochise.az.us
Fax: (520) 432-9478

Dear Senator Yrun:

It has been my pleasure to serve on the Funding, Reimbursement and Collaboration Subcommittee to the Senate Ad Hoc Committee on Caregiver Wages and Workforce Development. As an essential reader to the draft report, I would like to offer the following comments relating to the final recommendations.

1. *Standardization and mutual recognition across caregiver continuum: Credential requirements, Title protection, Scope of practice including limitations.*

Comments: Who would create the standardization? Who would be responsible for monitoring the compliance with these standards? How would private pay (non-Medicare and Medicaid) services be monitored? What would be the results of noncompliance? The creation of the standardization and the ongoing monitoring are additional oversight functions which could be costly to the efforts of caregiver workforce development. In light of the State budget crisis, I would suggest further research and clarification on this recommendation.

5. *Fund and create standardized State database for training/credential, background check, drug screening and fingerprinting information regarding paid caregivers to be utilized by all providers who receive state funding.*

Comments: With various State agencies involved in funding caregiver services, it is critical to identify which agency would be responsible for the oversight of the database. What would be the results of noncompliance? Is there a potential for violation of privacy rights related to the caregivers?

8. *Standardize job titles and duties so that minimal competencies and educational requirements are consistent and provide for a career ladder and require agencies to use them.*

Comments: Who will create the standardization and how will private-pay agencies be involved in this process? Can a single State agency be responsible for compliance if the funding of the caregiver services are not provided directly by that agency? Who will monitor the use of the standardized job titles and duties? What are the consequences of noncompliance? The State budget crisis may affect an agencies ability to provide oversight.

10. *Develop strategies to educate the general public as to the value of direct caregivers and implement a workforce recruitment and retention plan. For example, designate a week annually recognizing the direct caregiver.*

Comments: Who will develop the strategies? Will private sector agencies be involved in the development of strategies?

11. *Determine the content of a core curriculum for each job title, including interpersonal and life skills, and establish hours needed and institute standardized testing to be completed at end of training. Place new trainees into GED/ESL programs, if desired or needed.*

Comments: Who will determine the core curriculum for each job title? A cost analysis should be performed to determine the cost to providers of implementing a mandated training curriculum. The cost to implement this training could be significant. Would any provision be made for current caregivers; would there be a "grandfather" clause to the implementation?

18. *State agencies shall have oversight authority over training program certification.*

Comments: Will each State agency monitor only the caregivers reimbursed through that agency? There could be a duplication of oversight if a caregiver is reimbursed through multiple programs.

19. *State agency collaboration to seek grant funding and incentive monies to develop programs to provide needed financial, health, transportation and childcare support for this worker population.*

Comments: What role, if any, will the private sector play in this collaboration?

29. *Require an annual assessment of skills, continued competency and professional development needs for all workers. All ongoing training shall be monitored and consequences shall be applied for noncompliance.*

Comments: Who will perform the monitoring? If a caregiver provides services through multiple programs, which agency will be responsible for the monitoring or will both agencies be responsible? There could be a duplication of monitoring if a caregiver is reimbursed through multiple programs. Are there any projections for the increase in expenses for the monitoring agencies? With the State budget crisis, this should be reviewed.

Overall, I feel the recommendations are a strong beginning to developing realistic solutions to the shrinking pool of caregivers working in the long-term care industry. I appreciate the opportunity to provide input into this process.

Sincerely,

Mary Temm
President
Temm & Associates, Inc.
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Phoenix, AZ 85003

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Re: Report

I have read the report and think that is an excellent summary of the issues concerning caregiving in Arizona. The material from Minnesota is particularly useful. From my perspective, University involvement in addressing the research needs is critical. We need to sit down with the players and determine how university faculty can collect the data necessary to demonstrate the needs. The next step is to prioritize what needs to be done and begin doing it. Different stakeholders can provide input to the process. We know the crisis will increase as the boomer retires. We also know that the number of people who follow the boomer are much less [77 million to 55]. We need to look at alternatives.
The report does not address the role of technology in caregiving and what role it can play. There are model programs that have infused technology into caregiving. We should address technology early on as a potential solution to personnel crisis.

If you have comments or questions, let me know.

William E. Arnold, Ph.D.
Director, Gerontology Program
Arizona State University

NURSING PROGRAMS

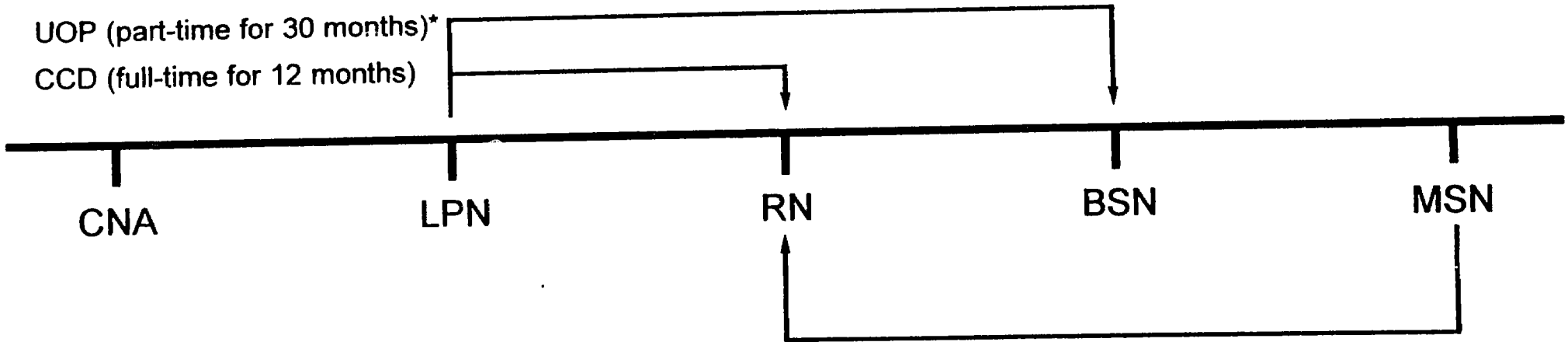
JANUARY 2002

College of Health Sciences and Nursing

Attachment A

NURSING EDUCATION CONTINUUM

Private and public educators coming together to meet the needs of the community.



*After one year at UOP and one course at CCD a student can become an RN.

BSN's enrolled in UOP MSN program qualify to teach for CCD

COMMUNITY COLLEGE OF DENVER

University of Phoenix℠
Colorado Campus
You can do this.℠

Addressing the Nation's Nursing Shortage

A Public-Private Partnership Model

The University of Phoenix

UNIVERSITY OF PHOENIX
College of Nursing & Health Sciences

A Nursing Continuum Program

A solution to the nation's nursing shortage problem draws from the strengths of the University of Phoenix adult education model and our successful working relationships with community colleges and vocational education schools. Individuals seeking to enter the nursing profession are not the typical 18-year-old high school graduate. They are more likely to be in their late twenties working full time to support families. The University of Phoenix/ Community College Partnership Model recognizes that this adult student brings life experience to the learning environment and is more likely to succeed in the modular learning context.

We are actively partnering with community college nursing programs to substantially increase the number of one-year licensed practical nursing (LPN/ LVN) graduates. The community college faculty is shifting its focus to the intensive clinical training that allows graduates to assume jobs paying $14-21/ hour as an LPN. The University then enrolls the student into a 30-month degree program, which allows the student to work, have benefits for their families, and graduate with a bachelors of science in nursing (BSN) degree. Many community college programs report 2-3 year waiting lists for nursing programs and see this model as a way to expand capacity in the most expedient fashion possible within the constraints of community and state budgets.

Hospital systems are willing to offer employment and tuition while the student continues in the nursing continuum program. In addition, this 30-month model allows the 911,335 practicing LPN's in the US, as well as over 120,000 active duty medics in the military to continue their education and become registered nurses. The University of Phoenix program is accredited by the National League for Nursing Accrediting Commission.

The Crisis

Health care is a $1.4 trillion dollar industry, consistently claiming about 14% of the Gross Domestic Product. Health continues to grow more rapidly than the overall economy because of the aging population's increasing need for services and the effective subsidy of care provided by federal, state, and private insurance plans. Health care is the second largest industry in the world, with over 25% of the international labor force tied to it.

Labor costs account for between 60-70% of overall health care costs. Department of Labor statistics document a current workforce of 5,116,000 hospital and 6,388,00 non-hospital employees. This is expected to increase to 12,620,000 by the year 2006. There are over 5100 accredited hospitals, 6200 home care agencies, 12,000 nursing / assisted living facilities, and 7000 other health facilities in the US.

A beleaguered health care industry is looking for innovative solutions to staffing hospitals, long-term care communities, home care, and freestanding medical facilities. Many health care organizations are changing their mix and types of workers, often cross-training personnel to create multi-skilled jobs and using the lowest-cost qualified workers to perform needed talks. As this happens, educational programs need to adapt their curriculum and degree programs to prepare students for these jobs.

Most evident is the nursing shortage being reported in every state, forcing hospitals to close to new admissions. The causes of the current nursing shortage are complex, ranging from an aging workforce (average age of US nurse is 41.4) to the more appealing range of career options for young women today. The nursing shortage is manifesting across the country, with hospitals scrambling to cover beds with minimum staffing levels.

Nursing: 794,00 Nurses Needed by 2008

By the year 2020, when today's baby boomers enter retirement age in force, the RN workforce will be 20% below projected workforce needs. The percent of working RN's under age 30 has dropped from 30% to 12% of the total workforce from 1983 to 1998, while the average age has been steadily increasing.

Over the last twenty years, nursing education has moved away from the traditional one year LPN/LVN and two-year associate degree programs towards a four-year baccalaureate education for nursing. While few argue that this move towards a more academic model is appropriate for those assuming the responsibilities of complex patient of today, the reality is that a continuum of trained personnel is necessary to provide care within today's fiscally restrained environment.

Today's direct patient care worker is most likely to be a high school graduate with a six-week training program run either by the hospital or local allied health professional schools. The certified nursing assistant (CNA) is a graduate of a three-month program and is licensed by the individual states in order to meet Medicare guidelines. A majority of these individuals work in the home care and long-term care industry. The Licensed Practical Nurse (LPN/ LVN) curriculum is a one-year program, producing a graduate for state licensure and who has medication administration responsibilities. There is resurgence in employment opportunities for LPN's due to the restructuring of the workforce in hospitals and nursing homes, as well as the need to compensate for the nursing shortage.

Associate degree nursing programs for registered nurse preparation are now predominately located at the community campus level and are two-year academic/ clinical programs. The curriculum is very procedural oriented, geared towards getting the nurse to the bedside as quickly as possible. The four-year BSN programs are predominately located within state and private university systems. The enrollment in these four-year programs has declined substantially over the last several years, reflecting the movement of college-bound women towards other career options and the need for many nursing applicants to work full time to support families.

The University of Phoenix has been successful in transitioning the RN to the BSN and moving them onto MSN status necessary for management roles and more complex patient care modalities. The reality is that our students are often proceeding with their degree to open up options outside of the hospital environment: home care, health plans, pharmaceutical sales, etc. Only 11% of our current students get employer reimbursement, reflecting the commitment of our students to move ahead with their careers. The University of Phoenix is the largest college of nursing in the US, with on-line students increasing by 25% per year.

Philosophy

"As employed nursing care providers and adult learners, nurses need access to educational alternatives that are congruent with their personal and professional career objectives."

The College's terminal outcomes (BSN) continue to be consistent with the American Nurses' Association (ANA) Standards of Clinical Practice. This program is an expansion of our curriculum to allow the LPN to achieve the BSN/ RN license in an adult learning environment, consistent with the overall mission of the University of Phoenix.

The Curriculum Model

The curriculum is designed to follow the competency based – differentiated practice model as outlined by the AACN-AONE Task Force on Differentiated Competencies for Nursing Practice (1995) and as further developed by the states of California, South Carolina, and Colorado. The expanded model developed by the California Strategic Planning Committee for Nursing Colleagues in Caring and reported as the California Framework for Competency Based Role Differentiation in Nursing (1999), incorporates the use of Benner's (1984) ground-breaking work on nursing role development from novice to expert.

The curriculum design is complete and supported by substantial web based resources and virtual laboratory experiences. It is estimated that students with the minimum transfer credits from the vocational schools will require 30 months to complete the BSN. Students who have additional college credit or who meet proficiency testing in the clinical courses could complete the degree in a shorter period of time. The clinical component uses a preceptor model rather than the traditional student clinical model.

Accreditation

The National League for Nursing Accreditation Council has determined that this particular track falls within the accreditation of our BSN program. Therefore, no new accrediting process is necessary.

Legal counsel has determined that this program represents less than a 25% change in our curriculum and therefore does not require separate approval from the Higher Learning Commission or the various State Boards of Higher Education.

For More Information, Contact

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University of Phoenix Can Help Solve The Nursing Shortage

Investment In Retention

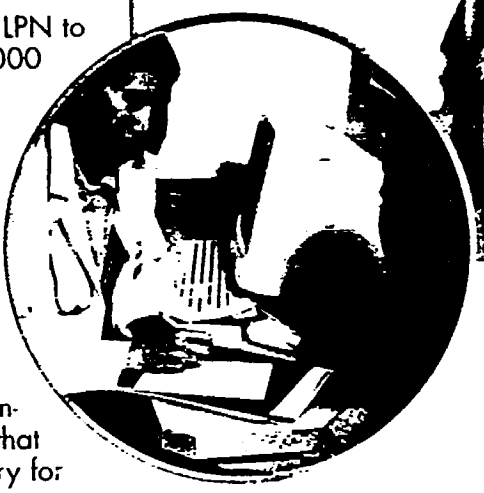
Finding and retaining RNs has never been more difficult. Faced with the worst nursing shortage in history, hospitals and health care agencies are struggling to fill their RN ranks. And, without question, today's nursing administrators face unprecedented challenges.

- Current RN vacancy rates average 10-12%*
- 418,000 additional RNs will be needed by 2006**

One strategy, however, can help you beat the odds – an investment in career education.

The LPN TO BSN Solution

University of Phoenix has developed an innovative LPN to BSN program to encourage the more than 900,000 LPNs in the U.S. to move forward in their nursing careers in as little as 30 months or less while continuing to work full-time.



The LPN to BSN Program recognizes the wealth of clinical experience that enables the LPN to achieve RN licensure and a college degree in the least amount of time possible. Specifically designed to provide a smooth, time-efficient transition from LPN to RN to BSN, the curriculum embodies participative, collaborative, and problem-solving strategies. And, practitioner faculty insure that students develop the critical thinking skills necessary for success in today's challenging health care environment.

The University of Phoenix Advantage

- Classes held just one night a week
- Clinicals in the workplace
- Competency validation with a preceptor model
- Credit for prior college courses
- Completion in 30 months or less
- Meet once a week with your learning team

University of Phoenix Programs

- Bachelor of Science in Nursing
- Bachelor in Health Sciences
- MBA/Health Care Management
- Master of Science in Nursing
- E-Health Certificate
- Clinical Trials Research Associate Certificate

All University of Phoenix programs are accredited by the National League for Nursing Accrediting Commission***

University of Phoenix can help you retain and attract nurses. Call today.

UNIVERSITY OF PHOENIX®

*American Hospital Association 2001 ** Department of Labor

***National League for Nursing Accrediting Commission 61 Broadway, New York, NY 10006. 212-363-5555

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Workgroup on Recruitment, Education, Regulation

2nd Report - March 22, 2002

Participants:

Anagnostou, Susan-Southwest Institute on Aging

Barno, Karen-Arizona Assisted Living Association

Clinco, Judy-Direct CareGiver Association

Danowski, Bonnie-Arizona Interfaith Network

Dante, Donna-Native American Community Health Center, Inc.

Dean, Gwen-AZ Bridge for Independent Living

Hanley, Mary Lou-DES-DACS

Harris, Patricia-Maricopa Community Colleges

Kneisi, Paula-Prescott Samaritan Village

Pyatskowit, Beverly-Native American Community Health Center, Inc.

Steven, Ritch-AARP

Attachment B

Summary

This work-group was tasked to look at three areas: education/training, accreditation/regulation and recruitment/retention of caregivers. We identified numerous issues related to caregiver wage and workforce development. Challenges have been identified and possible solutions for further consideration are listed. Further research is required in all areas in order to verify the statistics and practices, evaluate the ideas for discussion, and determine who needs to participate in planning solutions; this is a document of work-in-progress.

The major issues identified are:

EDUCATION/TRAINING

- Inconsistent Job Titles
- Inconsistent Job Descriptions
- No Standardized Education Requirements
- No On-going In-services Training Requirements
- Minimal Support During Education Period

RECRUITMENT/RETENTION

- Labor Pool Shortage
- Low Wages and Lack of Benefits
- Poor Caregiver Image in Society
- High Attrition
- High Turnover
- Inadequate Working Conditions

ACCREDITATION/REGULATION

- Multiple Accrediting Agencies without Mutual Recognition
- Lack of Protection Program for Vulnerable Clientele
- No Standard Definition of Caregiver

EDUCATION/TRAINING

Issues:

Inconsistent Job Titles
Inconsistent Job Descriptions
No Standardized Education Requirements
No On-going In-services Training Requirements
Minimal Support During Education Period

Job Titles

1. **Issues:**

   - There seems to be no uniformity in job titles resulting in confusion, inefficiency, and discrepancies in training/qualifications when naming entry level jobs, i.e., home health aids, caregivers, personal care assistants, housekeepers, nurse aides, direct care workers, etc.
   - Certified Nursing Assistants have a regulated scope of practice and protected job title, but cannot be excluded from these discussions as long as care within licensed skilled nursing facilities are included in the scope/task of this subcommittee.

2. **Challenges:**

   - Agreement among numerous agencies/parties on consistent job titles and duties.

3. **Ideas for discussion:**

   - Further research.
   - Look at other State's practices and legislative activity
   - Standardize job titles and duties, minimally those used by state agencies
   - Standardize titles and duties, as possible, for Home and Community Based Services (HCBS) and institutional care

Job Descriptions

1. **Issues:**

   - Each HCBS agency/nursing facility has its own definition of health care jobs resulting in confusion and additional expense when a worker goes from one facility to another. Agencies may have different training requirements for the same job titles/descriptions, which can prevent a new worker from starting work immediately and adds to the expense of the employer.
   - In other cases where previous training is not recognized, the worker may endure redundant educational programs. This results in loss of pay for the employee and loss of work time and cost to the employer.

2. **Challenges:**

- Convincing providers that standardized job descriptions would be advantageous to their workforce.
- Agreement among numerous agencies/parties on consistent job descriptions.

3. **Ideas for discussion:**

- Further research.
- Look at other State's practices and legislative activity.
- Standardize job descriptions so that minimal competencies and educational requirements are consistent.

Standardized Education Requirements

1. **Issues:**

- Various institutions, including employers, private schools, community colleges, etc, provide education and training from different standards, required hours and varied curriculum.
- Not all agencies comply with existing mandated training.
- Reportedly, there is no oversight of training delivery compliance.

2. **Challenges:**

- Bringing together all interested parties: agencies, facilities, AHCCCS.
- Successful completion of education program is dependent on good screening techniques.

3. **Ideas for discussion:**

- Determine what needs to be in a curriculum for each job title to fulfill description for a particular job.
- Carefully consider legislation for the regulation of caregivers.
- Develop a standardized curriculum that includes direct patient care skills, interpersonal skills, and personal management skills for the worker.
- Standardize hours needed to train for each job that will be recognized as fulfilling requirements for both HCBS and nursing facility jobs.
- Institute standardized test to be completed at end of training
- Educate the community regarding which worker is certified/trained to do the job required.
- Promote/broker private sector support for workers.
- Develop high school career education for caregivers as done with CNA training.

Ongoing In-service Training Requirements

1. **Issues:**

- Inconsistent ongoing training requirements among DES and agencies.

- Ongoing training helps to retain the employee.
- Lack of established career ladder for advancement.

2. **Challenges:**

- Some providers are reported to be out of compliance with DES's 12 hours CE requirement
- Often, the worker is required to attend training, but not paid for hours spent in continuing education.
- Turnover is so great that there is no time for the employer to do ongoing training.
- Transportation to educational programs is an issue for the entry-level worker.
- Employers may provide one-on-one training by the supervisor, but documentation of outcomes is not present.
- DHS requires 12 hours of continuing education (CE) for caregivers who work in licensed home health, hospice, assisted living facilities and nursing homes; other agencies do not.

3. **Ideas for discussion:**

- Consider a requirement that employers must provide a designated number of hours of training per year or documentation of worker competency.
- If requirement established, determine who would monitor and what would be done if agency or individual (if regulated) were found to be out of compliance?
- Seek sources for financial incentives for employers to provide innovative training.

Support During Educational Programs

1. **Issues:**

- Many entry-level trainees lack study/language/work skills that are required to complete education.
- Childcare is often needed.
- Healthcare may be inadequate.
- Transportation can be a problem.

2. **Challenges:**

- Costs would be added during a time of budget shrinkage.
- The infrastructure of community support that would be required may be non-existent.

3. **Ideas for discussion:**

- Further research.
- Establish a mentor program through the community.
- Seek grant funding.
- Seek incentive monies for creative workforce development programs
- Engage the employer during the training to provide salary or stipend. Facilities can justify these costs by determining their cost per employee turnover. It is reported that each new employee costs at least $3000 to train.

- Get new trainees into GED/ESL programs if needed.
- Determine feasibility of modeling training requirements after Nurse Assisting requirements.

RECRUITMENT/RETENTION

Issues:

Labor Pool Shortage
Low wages and lack of benefits
Poor caregiver image in society
High Attrition
High Turnover
Inadequate working conditions

Labor Pool Shortage

1. **Issues:**

   - The unemployment rate in Arizona and Nationally is less than 6 percent.
   - The average age of a caregiver today is 44 (includes all workers). Caregivers of this age will not be willing to continue to work at such labor-intensive jobs.
   - Society has stigmatized caregiver positions to be employment for individuals who are economically disadvantaged and have low levels of education. This image discourages educated individuals from applying for work.
   - Competition between other service industries that recruit for entry-level positions, further reduces the workforce.
   - Caregivers may not receive a wage for up to five weeks from the time they interview because of training time, placement, workweek and payroll processing.

2. **Challenges:**

   - Limited workforce to supply needs.
   - 47.5 percent of today's long term care workforce is estimated to be part of the baby-boom generation who will either have aged parents to care for in the near future and/or need support themselves.
   - The supply of workers has been and will continue to decline due to declining birth rates among the baby boom generation.
   - Competition between other service industries that recruit for entry-level positions, and offer less demanding jobs, higher wage and often provide on the job training or paid training. This allows employees to begin earning a wage immediately.

3. **Ideas for discussion:**

   - Design current programs that empower consumer to be less reliant on caregivers by offering Independent Living Skills Training, Peer mentoring and Home Modifications.
   - Continue to develop programs that will allow families to care for their own family, include a livable wage, health insurance, retirement plan, training and support. This will reduce turnover, liability and allow the limited available workforce to care for those that don't have family or prefer not to provide full time care to their family member.

- Explore recruiting from INS
- Incorporate a health care curriculum at the high school level, including; basic life skills related to attitude, appearance, personal health and work ethic.

Low Wages and Lack of Benefits

1. **Issues:**

   - The caregivers wage ranges from $6.50 to $9.00.
   - Providers and caregiver are unable to afford to pay the their portion of health insurance with current reimbursement rates and wages.
   - Providers are unable to afford to offer benefits such as: sick days, vacation pay, and holiday pay with current reimbursement rate.
   - Lack of caregiver retirement plans.

2. **Challenges:**

   - Adequate reimbursement rates for providers.
   - Arizona budget crisis.

3. **Ideas for discussion:**

   - Develop a pay structure for state agencies who hire caregivers that will be consistent with the level of care they are providing.

Poor Caregiver Image in Society

1. **Issues:**

   - Society has stigmatized caregiver positions to be employment for people who are economically disadvantaged and have low levels of education.

2. **Challenges:**

   - Educating society to understand and value caregivers.

3. **Ideas for discussion:**

   - Develop a campaign strategy to educate the general public on caregiving.
   - Seek funding sources.

High Attrition

1. **Issues:**

   - Attrition is anecdotally reported in all phases of hiring and training: If 100 people are interviewed, providers will accept 75 into training, 50 will show up for training, 25 will complete training and 15 will go to work.
   - Applicants find jobs that offer paid, on-the-job-training.
   - Some applicants are afraid of training due to limited reading and writing abilities.

- Some applicants are afraid they may have to work with a young adult with a disability.
- Some applicants will apply only to satisfy his/her government assistance requirement.
- During training program, some decide the position is not what they expected.
- Often, there is a lack of dependable childcare and transportation.

2. **Challenges:**
   - Improving screening techniques when hiring and selecting employees for training to reduce "no show" and dropout applicants
   - Ensuring childcare will not be an issue during or after training
   - Ensuring transportation will not be an issue during or after training
   - Accommodating students with limited academic abilities by providing remediation sources

3. **Ideas for Discussion**

   - Review tools and techniques used in other states and companies.
   - Collaborate with DES Childcare Administration to develop a simple strategy to enroll into their service program.
   - Collaborate with ADOT and cities on information on bus schedules, pursue feasibility of bus vouchers during training.
   - Research daycare centers that could provide transportation of child to and from home or school.
   - Collaborate with or research methods utilized by schools and/or county programs and state agencies such as Department of Rehabilitative Services and Development Disabilities.

High Turnover

1. **Issues:**

   - 35% to 45% turnover in HCBS, nursing facilities. Nursing facilities have generally 10% higher turn over. Some studies indicate turn over being as high as 62% to100 percent annually in NF.
   - Caregivers find higher paying jobs.
   - Physically and emotionally demanding jobs with little or no support from consumer families.
   - Lack of concern and/or support from employers.
   - Burn out

2. **Challenges:**

   - Poor wages and benefits.
   - Few employers offer vacations, holiday pay, paid sick days to prevent burn out.
   - Identifying new technology to assist with the physical aspect of the job.
   - Identifying ways to improve relationships between employee and employer when employees work off site.

3. **Ideas for discussion:**

- Develop incremental pay increases based on time in service and performance evaluations (let consumer be part of the evaluation)
- Communicate with companies that have employees who telecommute to learn how they develop good employee relationships.
- Employers develop awards for exceptional services, along with other personalized awards.

Inadequate Working Conditions

1. **Issues:**

- Limited supplies to complete task; cleaning supplies, food, etc.
- Lack of appropriate equipment; shower chair, lifts, etc.
- Lack of respect from consumers and/or family members.
- Lack of good management and/or management development.
- Work schedule not available in advance.

2. **Challenges:**

- Difficulty in obtaining supplies when consumers are on limited income.
- Appropriate equipment can be difficult to obtain in order to prevent both consumer and caregiver injuries.
- Lack of funding to provide supervisory training to consumers/family representative in areas such as: developing a work schedule,
- Over site of caregiver, improved attitudes of consumers towards caregivers.

3. **Ideas for discussion:**

- Research funding sources for medical supplies and equipment
- Provide avenue for adequate supervision of caregivers
- Develop sensitivity and educational materials for consumer and consumer's family regarding the role of the formal caregiver

Accreditation/Regulation (Excluding CNA)

Issues:

Multiple accrediting agencies
Lack of protection of vulnerable clientele
No standard recognizable definition of caregiver
CNAs frequently added to unregulated "caregiver" group, thus confusing issues

Multiple Accrediting Agencies

1. **Issues:**

   - Multiple agencies "certify" caregivers: ADHS, DES, and AHCCCS and Private
   - Different criteria used to establish certification by job title
   - Private agencies and Public entities use different criteria
   - Lack of mutual recognition of training or certification
   - Lack of portability of certificate

2. **Challenges:**

   - Development of universal credential, criteria for credential
   - Development and acceptance of title recognition

3. **Ideas for discussion:**

   - Title standardized/protection
   - Training requirement standardization of curriculum
   - Standardization of credential requirement
     - CPR
     - First Aid Training
   - Mutual recognition within Arizona

Lack of Protection of Vulnerable Clientele

1. **Issues:**

   - Lack of requirement for expeditious background checks or fingerprints
   - No established mechanism for reporting unsatisfactory/risky performance -i.e. theft, abandonment, fraud, falsification of records
   - No requirement/duty to report inappropriate or unprofessional conduct of caregiver

2. **Challenges**

   - Expand regulations while maintaining balance/ease in use of family caregivers

- Link between certifying agencies and reported misconduct of providers

3. **Ideas for discussion:**

- Low cost availability of services to meet certification requirement: Fingerprinting, Background checks, CPR and First Aid
- Utilization of reporting guidelines possibly those of APS, in conjunction with established mechanism of reporting to certifying agencies
- Policy of Certifying agencies or expand requirements of law to report inappropriate conduct of providers
- Pursue training or obtaining informational materials from Adult Protective Service

No Standard Recognizable Definition of Caregiver

1. **Issues:**

- No title recognition/protection
- No career pathway
- No defined scope of practice or limitations of service

2. **Challenges:**

- Buy-in of Title recognition between State and Private Agencies
- Identification of existing training requirements by certifying agencies
- Identification and integration of existing but separate standards

3. **Ideas for discussion:**

- Universal AZ Title Recognition
- Recognition of Standardized Training Requirement and equivalency
- Standardize existing service specifications/scope of practice, including limitations, of providers for HCBS and other settings excluding licensed nursing facilities.

Sources used for this document:

"The 21st Century Workforce Shortage and Implications for Health and Human Services Agencies", APHSA State Government Summit on the Workforce Crisis

"Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis, Stone, Robert Wood Johnson Foundation, Institute for the Future of Aging Services, and The Urban Institute.

Arizona Senate Ad Hoc Committee
on Caregiver Wages and Workforce Development

Funding, Reimbursement and Collaboration

2nd Report ~ March 22, 2002

This report is for the Arizona Senate Ad Hoc Committee on Caregiver Wages and Workforce Development from its Funding, Reimbursement and Collaboration Workgroup

Attachment C

Workgroup Participants[1]

Karen Barno, Executive Director
Arizona - Assisted Living Federation of America

Joe Brennan,
Arizona Department of Health Services

Paul Friedlan, Administrator and Principal
Copper Mountain Inn

George Good, District Chief
Rural Metro Fire District

Edward Hannan, Executive Director
Arizona Health Care Association

Larry Litman,
Health Care Systems

Matt Luger, Executive Director
Covenant Health Network

Guy Mikkelsen, Executive Director
Foundation for Senior Living

Debra Nixon, Director, Corporate Development
Health Services Advisory Group, Inc.

Mary Temm, CEO
Evercare Select / Lifemark Health Plans

Gene van den Bosch, Director of Policy and Governmental Affairs
Arizona Association of Homes and Housing for the Aging

[1] Sara Harper and Anne Winter of the Office of Managed Care at AHCCCS also participated in this workgroup's first three meetings.

Summary

Staffing shortages within Arizona's long-term care (LTC) providers affect the cost, quality, and availability of care. Our workgroup of community stakeholders used facets of the multi-dimensional problem - i.e. the workforce crisis in the LTC sector - to form a framework for a multi-dimensional solution. This report focuses on four primary issues, their barriers, and our developing recommendations for possible solutions. These issues are:

1. registries (temporary staffing pools)
2. health insurance
3. reimbursement rate setting
4. new funding sources

Report

The *Arizona Senate Ad Hoc Committee on Caregiver Wages and Workforce Development* directed our Funding, Reimbursement and Collaboration Workgroup to meet at least six times and to present interim reports before April 11, 2002. We met as a workgroup on January 23, February 6 and 20, March 4 and 20.

Our second report is "a work in progress" and some of the information required is *"not yet received"*. We intend to proceed with additional meetings knowing the Senate Committee process may provide opportunities and incentives for additional information collection and sharing.

This report is based upon:

- national and state dialogues regarding caregiver and workforce funding and reimbursement;
- discussions with various stakeholders at meetings convened by AHCCCS or by our workgroup; and

- policy issues regarding caregiver and workforce funding and reimbursement raised in the literature.

Findings and recommendations presented in this report are based on:

- Materials submitted upon invitation from identified stakeholders. Invitations to submit relevant information on this topic were sent to individuals and organizations recognized as opinion leaders or researchers in the area of nursing home care and home and community based care within Arizona or nationally.

- Selected reports and articles published in the last decade about funding and reimbursement for caregivers working for nursing homes and home and community based services, consequences of low funding and low staffing, and other related quality of care concerns.

  Financial and utilization data on nursing homes and home and community based services from the American Health Care Association; Arizona Health Care Association; American Association of Homes and Services for the Aging; Arizona Association of Homes and Housing for the Aging, AHCCCS, and ADHS.

- Information drawn from surveys completed by 138 skilled nursing facilities completed between April 1, 2001 and March 22, 2002.

- Data from the Arizona Department of Health's Licensing and Certification Office and the federal On-line Survey Certification and Reporting System (OSCAR).

- ALTCS Program cost data.

National Context

A growing disparity between caregivers and older adults is the "sleeper issue for the next 20 years," according to the Future of Aging Services. While most national studies on this issue point out the complicated multi-faceted approach required for solutions,[2] they also clearly state that the most important solution to reduce this disparity is through additional compensation for the caregivers.

Yet, even with this realization, the task for our nation is challenging. Two national crises especially our national and our state's funding and reimbursement for its caregivers. One is related to the workforce and the other to Medicaid.

[2] Most studies site needed improvements such as additional compensation and training; improving the workplace; increased use of existing and emerging technologies; resolving issues related to temporary workers; recruiting New Americans; and making changes within the practices of LTC providers.

Workforce Crisis

Compounding the caregiver problem is that caregivers in paraprofessional positions are not paid very well and the positions are considered by many to be "really crummy." Indeed, experts say the only aspect of caregiver jobs in long-term care our society has upgraded is the qualifications.[3]

Although Centers for Medicare and Medicaid Services (CMS) has not officially released the second phase of its epic study on nursing home staffing, a draft of the report has appeared on the Web site of the Minority Office of the House Committee on Government Reform, under the direction of Rep. Henry Waxman (D-Calif.). An executive summary of Phase II was leaked a couple of weeks ago and has given rise to reports that the study shows "nine out of 10 nursing homes are understaffed."

Yet, associations representing LTC providers report a staffing crisis of epidemic proportions which could seriously threaten future access to quality care if not addressed immediately.

Nursing and assisted living facilities, home health agencies and intermediate care facilities for persons with mental retardation or developmental disabilities all require sufficient numbers of qualified staff to provide quality care and services. The staffing crisis in LTC has developed and worsened over time, influenced by social, economic and demographic factors, often beyond providers' control.[4]

LTC providers across the continuum are struggling to fill staffing positions due to a combination of factors, including non-competitive wage and benefit levels limited by current low Medicare and Medicaid rates, public information and negative public perceptions of the profession and limited opportunities for career advancement.[5]

Medicaid Crisis

While lawmakers receive reports related to nursing home staffing and quality of care, they are also considering Medicaid reimbursement. Indeed, many states may actually cut back on Medicaid coverage of home and community-based services and assisted living, since these services are optional.

At their February annual meeting, our nation's governors were unanimous in declaring Medicaid's cost the most urgent crisis they face. Just how grave the problem is became clear earlier this month, when Mississippi's Medicaid program went broke. Lawmakers there were unable to come up with the money to pay for

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[3] Bruce Vladeeck, Ph.D., professor of health policy and geriatrics, Mount Sinai School of Medicine, New York, and former administrator for the Health Care Finance Administration (now the Centers for Medicare and Medicaid Services).

[4] William L. Minnex & Charles H. Roadman. *A Comprehensive Plan to Create a Healthy, Affordable and Ethical Long-Term Care Program for America*. Submitted to The Honorable Tommy Thompson, Secretary, U.S. Department of Health and Human Services.

[5] Ibid.

medical care for the poor.[6]

Some are suggesting a total rethinking of Medicaid and to whom it's intended to serve. And, according to the *Los Angeles Times*, the rethinking has begun.[7]

While originally intended to meet the health care needs of the poor, the joint federal-state Medicaid program has become America's long term care payment system by default because the nation lacks a comprehensive long term care program. Today, two out of three nursing facility residents rely on Medicaid to pay for their long-term health care.[8] With increased use of medically intensive services, Medicaid spending on long term care is expected to double by 2004.[9]

Across the nation, state lawmakers and Medicaid administrators say it is not possible for Medicaid to do so much for so many. Meanwhile providers argue that nursing homes and hospitals will close if Medicaid fees fall too low.

Medicaid is the single biggest budget item for many states--and thus an easy target for cuts. Medicaid is vulnerable as well because so much of the program is discretionary. Nearly two-thirds of all Medicaid spending is for benefits defined by the federal government as "optional"--that is, outside the mandated package of health insurance for the indigent.

The federal government helps pay for Medicaid, so for every dollar a state puts into the program, Washington sends up to $3.31 in matching funds.

Some lawmakers want the federal government to take over a bigger share of the costs, especially for the elderly. (The federal insurance program for senior citizens, Medicare[10], does not now cover long nursing-home stays or prescription drugs--though changes are debated--so much of that burden has fallen to Medicaid.) States also are demanding more flexibility.

The Bush administration is making bolder experimentation possible through a waiver program that lets states design new Medicaid packages--including, for the first time, offering different benefit packages for different populations--as long as the revisions don't cost the federal Treasury any extra money.

California, Arizona and Michigan are using their waivers to expand Medicaid so that both children and parents in low-income households have coverage.

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[6] *The Clanon Ledger*. March 7, 2002

[7] *Los Angeles Times*. March 5, 2002.

[8] Senate Special Committee on Aging, *Cash Crunch: The Financial Challenge of Long Term Care for Baby Boomers*, March 9, 1998. 2

[9] Senate Special Committee on Aging, *Cash Crunch: The Financial Challenge of Long Term Care for Baby Boomers*, March 9, 1998. 2

[10] Medicare was originally intended to care for America's sick, while Medicaid was created to meet the health care needs of the poor. Medicare covers the first 20 days of care in a skilled nursing facility and only under certain conditions. For days 21 through 100, the beneficiary must share the cost of care by paying a nationally set rate of $92 per day in 1997. Medicare does not cover stays in an intermediate care facility. Following day 100, beneficiaries are no longer eligible for Medicare and must then seek coverage under Medicaid. In order to receive benefits from Medicaid, residents are forced to "spend down" and liquidate their entire savings and other assets. American Health Care Association, *What You Need To Know About Private Long Term Care Insurance*.

State Context

Of special significance is the trend of Arizona people over 65 increasing from 13% in 2000 to 17% in 2010. And, by the year 2030, over 21% of our population will be over 65. Arizona's population over 85 is increasing more rapidly than any other group. This age cohort should increase anywhere from 94% to 200% by the year 2010.[11] At least 55% of those people will likely live in the Greater Phoenix area. To meet the care and housing needs of these citizens, Arizona will need its struggling long-term care system.

Long-term care (LTC) in Arizona is a network of health and supportive services that helps chronically impaired persons and their caregivers manage their situations over time, place and provider in the least restrictive setting they call home. Components in the LTC continuum include nursing homes, skilled nursing facilities (SNFs)[12], adult day care, housing with supportive services, assisted living (AL), intermediate care facilities for the mentally retarded and developmentally disabled (ICFs-MR) and home and community-based services (HCBS)[13].

On any average day, approximately close to 14,000 Arizona citizens reside in 140 licensed nursing homes and three (3) SNFs that operate as a distinct part of a general acute care hospital.[14]; *(not yet available)* reside in supportive housing; *(not yet available)* rely on adult day care; *(not yet available)* rely on supportive housing; *(not yet available)* rely on ICFs-MR; and approximately 22,000 rely on assisted living and HCBS. Approximately *(not yet available)* percent of them are age 75 and older. The average assisted living resident is 84 years old. For many, this is a temporary placement only – approximately *(not yet available)* percent of residents leave within six months. However, those residents with serious or chronic health conditions may reside in a skilled nursing facility for several years. The average cost of stay within a nursing facility is $41,000/year, and the average length of stay is 2.3 years.[15]

In 2001, Arizona citizens spent over $*(not yet available)* on skilled nursing facility care, (not yet available) percent - $*(not yet available)* - of which was paid for through the state's ALTCS program.

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[11] Sources: Arizona Department of Economic Security. Research Administration, July 2001, and*Long-Term Care Services in Arizona*, St. Luke's Charitable Trust, 1998.

[12] State law defines a SNF as Nursing care institution" means an institution or other place, however named, whether for profit or not, including facilities operated by the state or a subdivision of the state, which is advertised, offered, maintained or operated for the express or implied purpose of providing care to persons who need nursing services on a continuing basis but who do not require hospital care or care under the daily direction of a physician. A.R.S. Title 36 chapter 4 article 2 paragraph 5.02.

[13] State law defines *Home health* as the provision of nursing services or home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on a physician's orders and in accordance with federal law. A.R.S. Title 36-2939, subsection B, paragraph 2 and subsection C.

[14] Approximately 8,921 of these people reside in Metro Phoenix. Arizona SNF beds total 16,206. Metro Phoenix SNF beds number 10,583. Source: Davis Appraisal, 3rd Quarter 2001.

[15] Statement by Senator Michael B. Enzi, Senate Aging Committee Hearing on Long Term Care, March 9, 1998. Health Care Finance Administration.

The cost of LTC, which is already financially devastating to most of Arizona's older adults, will only become more expensive as our population ages and people live longer with the assistance of expensive drugs, therapies and medical technologies.

While demographics and costs will explode, the pool of paid and unpaid caregivers will shrink dramatically. This is due to small size, families living further apart and two-wage earner families. Arizona's paid caregiver workforce is unlikely to keep up with the exploding need because capped, inelastic and under-funded government payment systems do not allow providers to be competitive in a tight labor market. The AHCCCS/Medicaid system pays - on average - about $100 per patient-day[16] for 70% of the 14,000 residents in Arizona's nursing homes. These funds are expected to cover room, board, three meals a day, some therapies, overhead, social activities, linens, mortgage and caregiver salaries, among other things.[17]

The inability to offer competitive wages and benefits has created the most serious professional and paraprofessional LTC labor shortage. The labor shortage causes remaining workers to shoulder unrealistic workloads. In addition, many caregivers are required by government regulation to focus on paperwork instead of resident care. This compounds the difficult environment in which both providers and caregivers are finding it more unappealing and intolerable to work.

Staffing shortages experienced nationwide are a reality for Arizona's LTC providers and their residents as well. According to a recent trade association surveys, the *average* vacancy rates for nursing care in Arizona's nursing facilities range from 10.4% to 17% within the not-for-profit facilities,[18] and range from15.6% to 20.2% within the for-profit facilities.[19]

Another workforce risk factor compromising the quality of LTC in Arizona *is turnover rate*. A recent trade association survey reports *average* annualized turnover rates for Arizona nursing homes positions range from 71% to 95%.[20]

Representatives of stakeholder groups in our workgroup agree that:

- staffing shortages and turnover rates affect the cost, quality, and availability of care;

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[16] Average: $96.70. High: $122.26. Low: $85.79. Year 2000 Rates. Source: *2001 The Guide to the Nursing Home Industry* by HCIASachs/Arthur Anderson

[17] William L. Minnex & Charles H. Roadman. *A Comprehensive Plan to Create a Healthy, Affordable and Ethical Long-Term Care Program for America* Submitted to The Honorable Tommy Thompson, Secretary, U.S. Department of Health and Human Services.

[18] Average vacancy rates for CNAs at 10.4%, for LPNs 15.1% and for RNs 17%. Source: Joint Survey to 37 Nursing Facilities by the Arizona Association of Homes and Housing for the Aging and Southwest Institute on Aging. September 2001

[19] Average vacancy rates for CNAs at 15.6%, for LPNs 18.7% and for RNs 20.2%. Based on*Results of the 2001 AHCA Nursing Position Vacancy and Turnover Survey*published by the American Health Care Association. Survey results from 67 facilities in Arizona. February 7, 2002.

[20] Average annualized turnover rates in 2001 for CNAs at 95.2%, for LPNs 71.4% and for RNs 86.5%. Based on*Results of the 2001 AHCA Nursing Position Vacancy and Turnover Survey*published by the American Health Care Association. Survey results from 65 facilities in Arizona. February 7, 2002.

- the LTC workforce crisis is a multi-dimensional problem requiring a multi-dimensional solution;
- the most important dimension to solving this complex problem is "funding and reimbursement" achieved more readily through collaboration;
- this collaboration should include long-term care providers, program contractors, private foundations, plus academic and government agencies sharing information, increasing awareness and spearheading change; and
- primary issues related to funding and reimbursement at this time are registries, health insurance, reimbursement rates and new funding.

Registries

Temporary Staffing Agencies

1. **Issues:**

- Effects of registries (temporary worker staffing agencies) include rising costs[21] and a smaller pool of critically needed full-time caregivers.

- Faced with a shortage of health-care workers, Arizona's nursing homes have turned to registries for certified nurses aides (CNA's). These agencies often have a ready supply of nurse-aides partly because they offer better pay and flexible hours.

2. **Challenges:**

- Registries pay higher wages to temporary staff, thus attracting caregivers. Facilities desperate for caregivers (up to 20% vacancy rates for some) pay registries higher fees to bring in critically needed caregivers to offer essential care to residents. One effect is rising costs. Registry costs remains a significant percentage of the total payroll for nursing homes and the significant increase of temporary workers in recent years has raised concerns about the impact on providers finances as well as on the continuity and quality of care. The cost of putting a temporary worker on a shift is estimated to be two to three times the cost of using a staff employee.[22] Temporary workers now account for *(information not yet received)* percent of the total payroll costs in Arizona nursing homes.[23]

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[21] According to the Arizona Association of Homes and Housing for the Aging and the Arizona Health Care Association, some nursing home services cost more than Medicaid/AHCCCS pays and temporary workers are one of the fastest-growing costs faced by the care providers.

[22] Sources: Arizona Health Care Association and the Arizona Association of Homes and Housing for the Aging

[23] Sources: Arizona Health Care Association and the Arizona Association of Homes and Housing for the Aging

- Temporary work can be appealing, despite the unpredictable number of hours if offers. The lack of benefits such as health insurance is not an issue because many nursing homes and HCBS providers cannot afford to offer their CNAs affordable health-care coverage.

- Two entities compete for the same workers, yet one is restricted and the other is not. The effect is a "false labor market".

- Constant turn-around of temporary caregivers makes "quality" care and experience more challenging for the caregivers and for the resident.

- Registry contracts contain a "non-compete clause" preventing post-service free movement or full-time employment with the care facility.

Very little is known about the employment patterns and motivations of temporary workers. Most in the field contend that workers choose temporary work because of higher pay and more flexibility. Pools may also allow people to continue to work in the field as their situation changes and allow permanent workers to supplement their income. Workers, particularly nursing assistants, often alternate between temporary and permanent work.

3. Possible Solutions:

- Further research by Arizona's universities and other members of the research community (e.g. private foundations) - in collaboration with LTC providers, program contractors, registries, and nursing professionals in LTC - to include these questions:

1. What are the wages for nurses working in temporary pools?
2. How much rate reimbursement would be available if registries did not exist?
3. Are there other issues besides wages behind the growth registries?
4. What solutions are offered in other states (e.g. MN,) and what are the outcomes in those states? *(Research underway).*
5. Would capping the wages of temporary caregivers drive more people out of the profession?
6. How many temporary caregivers now working in nursing homes are also employed at other homes and rely on registries to supplement their income with additional work?
7. Is a temporary employee more expensive to a LTC provider when one considers the costs of recruitment and training, particularly when turnover is high?
8. Would capping temporary worker rates have a positive or negative effect on worker availability if temporary employment agencies were in fact keeping individuals in the field who would otherwise leave?

9. What is the comprehensive portrait of LTC nursing personnel in Arizona, including basic demographic information, educational levels, racial and ethnic diversity, and their distribution across geographic areas and LTC settings?
10. What is the wage elasticity for CNAs, LPNs and RNs in LTC?
11. What is the relationship between LTC worker satisfaction and retention and the quality of care and quality of life for recipients of care?
12. What are reasons CNAs leave their line of work and what would it take to keep them on the job (and for those who leave, what it would take to get them to return)?
13. What are strategies that foster greater accountability and responsibility of RNs for the care of residents?
14. Would better training, career paths, higher wages, or improved benefits are cost-effective for LTC employers?

- Consider the cost issues related to registries at a collaborative work-group comprised of representatives from AHCCCS, rural NFs, urban NFs and program contractors. Recommendations to would go to AHCCCS as it develops the method for NF rate setting. *(Research underway).*

- Research the legality of the non-compete clause for health care workers through the State Attorney General's office. *(Research underway).*

- *Depending on research* with the State Attorney General's office, explore banning the "non-compete clause" for health care workers through an amendment to a similar bill going through the Arizona legislature for media personnel.

- *Depending on research results*, follow the lead of Minnesota in passing legislation in the 2003 session that would limit what agencies can charge for temporary workers. In Minnesota last year, legislators passed a law that effectively caps the wages of temporary workers at 150 percent of the prevailing wage. The law also stipulates that at least 30 percent of the work hours filled by agency employees must be during weekends, holidays or night shifts.[24]

- Given the possible side-effect of legislation to cap wages at registries could be to prompt a mass exodus of qualified care-providers from nursing homes, explore, educate and collaborate to find new funding to improve compensation for the regular staff and expand the number of people coming into the profession.

- Consider an Arizona Department of Health Services requirement - as a condition for licensure - LTC providers in Arizona to collect and make public certain management information such as usage of temporary labor pools, turnover rates for nursing personnel, and stability of nursing personnel;

- Development of policies and practices for managing temporary workers by the LTC provider associations, these including contracts to assure consistent prices

[24] The law survived a federal court challenge in November 2001.

and performance standards, personnel policies concerning orientation, supervision, and resolution of problems with pool employees, and reducing the use of temporary workers by creating internal pools, developing flexible scheduling and establishing incentives for employee attendance.

Health Insurance

Health insurance for caregivers

1. **Issues:**

- Health insurance provides significant benefits for caregivers and their families.
- Nurse aides working in all types of health care settings are the least likely group of health care workers to have insurance. [25]

2. **Challenges:**

- Providers are often unable to afford the costs associated with health insurance and other employment benefits for caregiver workers.

3. **Possible Solutions:**

- Through AHCCCS, provide health insurance for parents of children enrolled in KidsCare beginning October 1, 2002. Many of Arizona's caregivers are among these parents.

  Note: Although the waiver to expand Title XXI funding to parents of KidsCare children was approved by the *Centers for Medicare and Medicaid Services (CMS),*[26] the Arizona legislature must authorize the program and approve the state appropriation. Although this issue was discussed at the legislature, there is no active legislation at this time.

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[25] *No care for the caregivers: Declining health insurance coverage for health care personnel and their children, 1988-1998*by G.S. Brady et al is published in the March 2002 issue of the *American Journal of Public Health* (Vol. 92, No 3). This study of health insurance coverage of health care personnel between 1988 and 1998 shows that they lost coverage more rapidly than other workers. In 1998, 1.36 million health care workers were uninsured, up 83.4 % from ten years earlier. In 1998, 23.8% of aides were uninsured, representing 37% of uninsured health care workers. When looked at by place of work, 20% of all nursing home workers were uninsured. However, workers in private nursing homes were much more likely to be uninsured (20.9%) than workers in public nursing homes (7.5%).

26 The Centers for Medicare and Medicaid Services (CMS, formerly HCFA) is a federal agency within the United States Department of Health and Human Services. CMS runs the Medicare and Medicaid programs and maintains oversight of the survey and certification of nursing homes and continuing care providers (including home health agencies, intermediate care facilities for the mentally retarded, and hospitals).

- Explore, through the commissioned Statewide Healthcare Insurance Task Force, possibilities associated with a "group pool" for health insurance.

Reimbursement Rate Setting

by AHCCCS for nursing facilities caring for ALTCS residents

1. **Issues:**

- Appropriate reimbursement rates for NFs and HCBS are related to the ADHS and AHCCCS collection of relevant nursing facility (NF) data to include direct care costs (nursing salaries/wages/benefits), capital costs and indirect care.

- Arizona is ranked 33rd for Average Medicaid Reimbursement Rates. Thirty-two (32) states have higher average Medicaid reimbursement rates than Arizona. Currently, 18 states have lower average Medicaid reimbursement rates than Arizona for nursing homes. [27]

2. **Challenges:**

- Insufficient data for AHCCCS rate setting for nursing facilities providing services and care for ALTCS residents.

- Disagreements among stakeholders over rate setting methodologies.

- Self-interest occasionally tempts some for-profit LTC providers to say one thing to investors and another to regulators. Sometimes, it is tempting to say nothing at all.

- Past data gathering tool not compatible with Y2K or current commonly used computer software. Statutes requiring information collection by ADHS were thus not enforced.

- Data-lag. Some costs may rise very quickly.

- Current rates do not yet reflect rerun of NF rate calculations by AHCCCS using updated Maryland Time and Motion study data affecting direct care and indirect care components resulting in an additional 3% increase for AHCCCS NF rates.

3. **Possible Solutions:**

[27] Source: 2001 The Guide to the Nursing Home Industry by HCIASachs/Arthur Anderson.

- Meetings between AHCCCS, ADHS, nursing facilities, HCBS providers, and program contractors to define reporting requirements for future AHCCCS rate setting efforts. Initial question-and-answer meetings by and at AHCCCS on January 31 and March 13, 2002. At least one more meeting to receive data by NFs and HCBS representatives will be held at AHCCCS in April.

- Create/initiate a rate-setting process by AHCCCS for HCBS that collaborates with HCBS stakeholders to include accurate and timely data.

- Collaborative workgroup(s) comprised of NF and HCBS stakeholder representatives should meet with AHCCCS to develop data collection tools, calculation methodologies and participation incentives (e.g. coordinated surveys, coordinated announcements)

- The "cost report" should be a single uniform cost report for both AHCCCS and ADHS. ADHS and AHCCCS representatives should meet to address modifications to inter-government / agency agreements to streamline reporting and clarify existing statute mandating data collection and cost reporting. *This meeting took place on March 21.*

- Remind the *Senate Ad Hoc Committee on Caregiver Wages and Workforce Development* of AHCCCS re-calculation using updated Time and Motion study results and its recommendation to increase AHCCCS NF rates by an additional 3%.[28]

- Collaborative study – collaboration to include stakeholders and a disinterested third party (e.g. Arizona university or another research institution, private foundation) – to include these questions:

  1. What is the current actual capacity for NFs and HCBS?
  2. What is the projected date when capacity will reach 90%?
  3. What is the projected date when capacity will reach 100%?
  4. How many NFs are closing?[29]
  5. Why are NFs closing?
  6. Where are these NF closings taking place?

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[28] Annualized fiscal impact of this additional 3% NF rate increase is approximately $11.5 million total funds, which equates to $7.6 million Federal, $2.3 million State, and $1.6 million County funds. (Source: AHCCCS)

[29] According to the Arizona Department of Health Services, 1,329 nursing home beds were lost in Arizona through 19 nursing home and SNF closures, downsizing and changes of ownership between February 2000 and February 2002. During the same period, 258 beds ere added to the system through four new and three upsized facilities. The net loss of nursing care beds for Arizona is 1,071.

7. What are the economic and health implications of NF closings?

New Funding Sources

Identify new funding sources to support caregiver wages and workforce development.

1. **Issue:**

- New funding sources are required to provide additional support for increased caregiver wages and workforce development.

2. **Challenges:**

- Arizona budget crisis.

3. **Possible Solutions:**

Increased Medicaid/AHCCCS payments for nursing homes using new funding sources such as:

- Recovery of unused *Residential Personal Needs Funds* previously assigned to deceased residents. Some estimate the amount available may be $1.5 million. *AHCCCS is researching this proposal and will meet with NF representatives on April 2.*

- Bad debt recovery. *AHCCCS is researching this proposal.*

- Share of cost benefits. *AHCCCS is researching this proposal.*

- Solicit private sector grants to subsidize salary increases for nurses and nurses aides.

- Solicit new federal TANF funds to subsidize salary increases for nurses and nurses aides.

- Creation of a seven-member task force to help identify funding problems and design solutions.

Conclusion

The challenge to locate funding and provide appropriate reimbursements rates to support LTC workers providing care to our state's most vulnerable citizens is made more complicated by the looming workforce crisis (shortages and turn-over rates) and Medicaid crisis. We also have an opportunity to more carefully examine possible causes of the current problem and to affect system changes to provide both short-term relief and long-term solutions. Despite its urgency, the crisis may also present an opportunity for major changes in long-term care. It may provide incentives for taking steps that have been difficult for policy makers and the long-term sector to take. Assuring adequate staffing across long-term care settings in Arizona will require both short-term actions to alleviate the immediate crisis and long-term strategies that address its roots.

Since public programs such as ALTCS will likely remain the major payor of LTC in Arizona, public policy will continue its fundamental role in shaping the LTC sector. We believe significant improvement in caregiver wages and workforce development requires collaborative mechanisms that promote a comprehensive approach, build and maintain momentum, and provide a direct conduit to public policy changes.

We believe effective solutions are within reach - as long as long-term care, academic and government officials work together to gather and share information, increase awareness and spearhead change.

Interagency Council for Long Term Care
AGENCY (Name) MATRIX

Division-Program	Program Description	Statute/ REGULATION establishing Program/ OBLIGATION	Current Status-years established	Funding Stream	Population Served	Consequences of NOTdoing Program	Court Cases

Attachment D

Attachment A

Statewide Health Care Insurance Task Force: Draft Guiding Principles

The Arizona Statewide Health Care Insurance Task Force has tentatively defined six (6) principles to guide its deliberations. These guiding principles are listed below along with a set of questions (criteria) to be answered when developing issue papers and health care models. The attached drawing (Attachment 1) summarizes these principles and restates four fundamental beliefs of the Task Force.

We should seek to make available Basic Benefits.

- Are the basic benefits (i.e., service coverage and limitations) clearly defined?
- Are the sub-populations eligible for coverage clearly defined including the coverage (or non-coverage) of non-US citizens?
- Are prevention services that will save money included as part of the basic benefit package? Can they be quantified?
- Will the benefit package provide the opportunity for improvement in health status and the delivery of quality care?
- Is the basic benefit package portable?
- What is the value (i.e., return on investment) of the basic benefit package?
- Does the package contain the appropriate incentives to support the guiding principles?

Health Care should be Available and Accessible.

- Are the right services (plans and providers) available in the right places at the right times?
- Are there incentives in place to encourage providers to provide services where needed?
- Will consumers (e.g., employers, employees, non-employed individuals) use the services, i.e., minimal barriers and appropriate incentives?
- Do commercial carriers have the incentive to participate?

Health Care should be Affordable and Properly Financed.

- Have the cost been clearly identified, both short and long term?
- Have the associated financial risks been clearly identified?
- Can the State afford it? Can members afford it? Can carriers afford to offer it?
- Can the costs be appropriately managed?

Attachment E

- Is it financially self-sustaining and solvent over the long term?

Health Care should be provided through a Seamless System.

- Do pieces of the system fit together well minimizing fragmentation and duplication? Does interdependence and coordination exist between system pieces?
- Have the interrelationships between various programs been taken into consideration such as those sponsored by Title XIX/XXI, Mexican government, Indian Health Services.
- Is one stop shopping made possible in as many situations as practical?
- Are services/care coordinated including the ability to easily move from primary care to specialty?
- Is there the flexibility and adaptability to move pieces around?
- Does the system encourage the highest and best use of services?
- Does a continuum of services exist as the population ages?
- Is the model administratively simple, i.e., low on paperwork and low on hassles?

Health Care should be done in Collaboration and in Cooperation with the various stakeholders both public and private sector and it should foster Competition.

- Is there provider acceptance to the approach?
- Does it create an atmosphere that fosters competition, collaboration, and cooperation especially beyond primary care?
- Has the government's role in facilitating competition been made clear?
- Does it provide a way for dealing properly with providers?
- Does it encourage a better-informed consumer?

Public Private Partnerships should be sought.

- Do the State's educational institutes, e.g., College of Medicine, Community Colleges, and other allied health-training program have a clearly defined role in supporting the system?
- Have the appropriate linkages to employers been established?
- Does the model have adequate links to economic / workforce development?
- Are commercial carriers involved in the model?

PLEASE NOTE: In most BUT NOT ALL instances, the page and line numbering of bills on this web site correspond to the page and line numbering of the official printed version of the bills.

Senate Engrossed

State of Arizona
Senate
Forty-fifth
Legislature
Second Regular Session
2002

SENATE BILL 1056

AN ACT

ESTABLISHING THE STATEWIDE HEALTH CARE SYSTEM TASK FORCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Statewide health care system task force

A. The statewide health care system task force is established consisting of the following members:

1. Four members of the house of representatives who are appointed by the speaker of the house of representatives, not more than two of whom are members of the same political party. The speaker of the house of representatives shall designate one of the members as cochairperson of the task force.

2. Four members of the senate who are appointed by the president of the senate, not more than two of whom are members of the same political party. The president of the senate shall designate one of the members as cochairperson of the task force.

3. One member who is a health care provider, who is licensed in this state and who is appointed by the governor.

4. One member who represents a consumer advocacy group and who is appointed by the governor.

5. One member who represents the business community and who is appointed by the governor.

6. One member who represents the university of Arizona health science center and who is appointed by the governor.

B. The task force shall:

1. Be guided by the principle that health care should be:

(a) Available and accessible.

(b) Affordable and properly financed.

(c) Provided through a seamless system.

(d) Done in collaboration and in cooperation with the various stakeholders from the public and private sectors.

2. Continue the efforts of the statewide health care insurance plan task force and develop and implement the statewide health care insurance plan as set forth in its December, 2001 report.

3. Make recommendations to narrow the gap between existing public and private health coverage programs by further examining the feasibility of implementing:

(a) Insurance reform to promote more accessible and affordable coverage options, especially those targeted at the individual and small group markets, such as the healthcare group programs established pursuant to section 36-2912, Arizona Revised Statutes.

(b) A consumer and employer education initiative on the value of health care coverage and the existing options for the uninsured within the private marketplace.

(c) Private-public coverage programs such as a high risk pool, a full cost buy-in program or a premium assistance employer buy-in program.

(d) A program to encourage employers with one hundred or fewer employees to cooperatively purchase employee health care benefits from new or existing insurance programs, including the Arizona health care cost containment system.

4. Make recommendations regarding restructuring the current state employee and retiree health care coverage program to improve access and affordability by continuing to evaluate various options, including a self-insurance system and an expansion of pool size.

5. Make recommendations to enhance existing public supported programs through:

(a) Support of effective outreach programs targeted to enroll eligible uninsured persons.

(b) Pending federal approval, coverage of title XXI parents with family income of up to two hundred per cent of the federal poverty guidelines.

(c) Identification of title XIX coverage groups that could be expanded through a state plan amendment and development of a plan for implementation of coverage groups selected for expansion.

6. Actively engage in a partnership for the statewide health program with the federal centers for medicare and medicaid services.

7. Identify ways to improve the rural health care infrastructure by:

(a) Continuing to support safety net providers.

(b) Fostering volunteerism and engaging the services of retirees from the health care professions.

(c) Encouraging competition between health care service providers.

(d) Increasing accessibility to medical services through:

(i) Promoting clinical rotations by medical students and medical residents in rural areas.

(ii) Faculty rotations in medical practices that allow physicians to participate in miniresidencies and training programs.

(iii) Tracking residency programs and where medical school graduates locate to practice medicine.

(e) Developing a plan to more effectively coordinate current rural health care resources and programs through a rural health network that includes the following:

(i) Loan repayment programs.

(ii) Scholarship, grant, career education and primary care programs.

(iii) An emergency medical services network.

(iv) Emergency interdisciplinary training.

(v) A telemedicine network.

(vi) Continuing education programs.

(vii) Outreach and promotion of public and private health care services.

(viii) Capital project grants.

(ix) Health service districts.

(x) A critical access hospital program.

(xi) Community health centers.

(xii) Mobile clinics.

C. Task force members are not eligible for compensation or for reimbursement of expenses.

D. On or before November 15 of each year, the task force shall submit a written proposal for implementing the statewide health care system plan and any findings and recommendations regarding the plan to the governor, the speaker of the house of representatives and the president of the senate and shall provide a copy of this proposal to the secretary of state and the director of the Arizona state library, archives and public records.

Sec. 2. Delayed repeal

This act is repealed from and after December 31, 2004.

What is JobPath?

JobPath is a results-focused,employer-driven workforce development strategy.

- Focusing on long-term,quality-skill training leading to jobs paying living wages in Tucson.

Attachment A

The Mission of JobPath

To assist qualified adults in attaining living wages through long-term, quality skills training.

- To assist adult to become self sufficient which results in a healthy community.

JobPath Origin

April, 1996-1,000 PCIC leaders/Community walk.

February,1997-Economic Summit-PCIC leaders,Business,Government.

Project Quest model

Public Funding-City and County

August, 1998-JobPath started

JobPath is for people who....

Can make a long-term commitment to education

Can make a long-term commitment to employment in Tucson

Are willing to make sacrifices

- Want economic success

Want to secure their future

Difference between JobPath and Other workforce strategies

Our Program	• Conventional Programs....
Economic development	• Social service
Employer driven	• Numbers driven
Participant involvement	• Client
Long-term training	• Short-term training
Community involvement	• Government regulated

JobPath

FY 2000-01

Health Care Completions	87
CNA	8
Dental Assistant	3
Patient Care Technician	1
Medical Transcriptionist	6
PN Program	34
Professional Medical Coding	3
Radiology Technologist	8
RN Program	14
Tier II	
Personal Care Givers	10

FY 2001-02

Health Care Training	107
Dental Assistant	4
Dental Hygienist	18
PN Program	4
Pharmacy Technician	5
Professional Medical Coding	2
Radiology Technologist	14
Respiratory Therapist	2
RN Program	42
Tier II	
Personal Care Givers	16

JobPath
Quality Employment through Skills Training
924 North Alvernon Way, Suite 151 · Tucson, Arizona 85711
Phone 520.324.0402 · Fax 520.324.0195 · Email jobpath@jobpathtucson.com

Tier II

OVERVIEW

JobPath is designed to serve the unskilled, unemployed or underemployed adults who have not had opportunities for further training or support to successfully complete training. The Tier II Program is structured to provide training and career options to individuals who confront additional barriers such as the lack of GED/H.S. diploma and/or English language skills, which prevent them from increasing their earning power and improving their career potential.

PURPOSE:

- Address severe shortage of direct-care workers in health care industry.
- Create gateway to employment for persons who lack education, skills and experience to be successful in the labor market.
- Use successful model, "JobPath", to connect employers, job training, and potential workers in focused, effective package.

METHOD:

- Prepare employees with work readiness classes, teaching work ethic, time management, teamwork.
- Utilize comprehensive case management, mentoring, and counselor support to ensure successful completion.
- Fast-track GED classes.

OUTCOMES:

- Participants will be placed in living wage jobs with opportunities for advancement.
- Employers provided with steady stream of health-care workers who are prepared to be productive from the first day on the job.
- Consumers receive quality health care at all levels.

Lutheran Social Ministry of the Southwest

Lutheran Senior Services

December 5, 2001

Herminia Cubillos, Executive Director
JobPath
924 N. Alvernon, Suite 131
Tucson, AZ 85711

Dear Hermi,

I wanted to take this opportunity to express in full detail the ways in which the relationship between JobPath and Lutheran Social Ministry of the Southwest Senior Services Division has enriched individuals, our program and the community.

First and foremost, JobPath's commitment to breaking through barriers to employment, recruitment, training and ongoing employment is intentional and commendable. It is without a doubt that the JobPath process changes individual lives. I have personally witnessed individuals begin the employment process with trepidation and before long take hold of their current positions with pride and advance to higher paying jobs with more responsibility eagerly.

Through our partnership, Lutheran Senior Services was able to secure a sound foundational workforce to serve Tucson's elderly population by filling entry-level health care positions. When we began our in-home services division, providing housekeeping, respite and personal care services, we had no idea of the difficulties we would face recruiting, training, and retaining a viable workforce. Through JobPath's support, we did just that, and in the course of 1 year developed a fabulous team of employees now serving approximately 300 seniors in need of immediate services in our community each month.

As you can see, the community at large has benefited from our partnership. Individuals found and retained meaningful jobs, Lutheran Senior Services has become one of the largest home health care providers in Tucson of housekeeping, respite, and personal care services, and many seniors are receiving much needed help. I would like to express my gratitude and wish you every success for future endeavors.

Sincerely,

Jody Wood

Jody Wood, Director
Lutheran Senior Services

East Valley
Service Center
7440 E. Main Street
Suite 5
Mesa, AZ 85207

(480) 325-1901

FAX
(480) 218-0513

Tucson
Service Center
5049 E. Broadway Blvd.
Suite 102
Tucson, AZ 85711

(520) 514-7642

FAX
(520) 514-7646

Lynn Baker
Executive Director

JOBPATH

Quality Employment through Skills Training

What is JOBPATH?

JobPath is a program to assist Pima County/Tucson residents who are unemployed or under employed to upgrade skills in order to earn a living wage with employers who offer benefits. JobPath is working to recruit motivated adults for training programs that meet the needs of the community. JobPath is currently recruiting in the following areas:

- *Automotive Technology*
- *Aviation*
  - *Interior Installer*
  - *Structural Repair*
- *Health Care*
  - *Associate Degree in Nursing*
  - *Radiology Technician*
  - *Respiratory Therapy*
  - *Dental Hygienist*
  - *Dental Assistant*
  - *Pharmacy Technician*
- *Machinist*
- *Computer Technology*

JOBPATH Eligibility Requirements

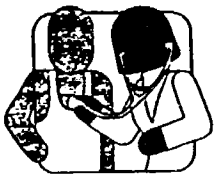
*** At least 18 years of age**
*** Legally able to work in the USA and capable to studying in English**
*** High School or GED**
***A Tucson/Pima County resident for at least a year**
*** Willing to work hard at a full-time living wage job**

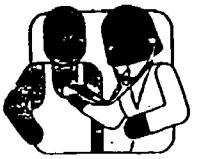
What can JOBPATH do for you?

- Assistance in identifying careers and training programs that will lead to a job with a living wage and benefits.
- Assistance with funding for training and supportive services. This *may* include tuition, books, fees, tools upon hire, childcare subsidy, and transportation expenses.
- Personalized career counseling.
- Assistance in developing a training plan to help you achieve your career goals.
- Support of others in your chosen career through regular peer support sessions.
- Assistance in connecting with employers.
- Mentoring while in training.

For Further Information
Please Call JobPath @ 324-0402

JobPath
Tier II





Are you interested in a career in the healthcare field?

Esta usted interesado (a) en hacer una carrera en el campo de la Salud?

Eligibility Requirements:

- At least 18 years of age.
- Legally able to work in the U.S.
- Currently preparing or planning to get GED
- Able to communicate in English

JobPath offers the following to qualified Individuals:

- Information regarding training and employment opportunities in the healthcare field to prepare for jobs that pay a living-wage.
- Support services including:
  - Career Counseling
  - Peer Support

Requisitos:

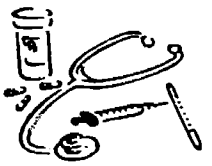
- 18 años de edad
- Permiso para trabajar en los Estados Unidos.
- Estar cursando estudios en GED o planear tomar clases para el GED.
- Habilidad para comuicarse en inglés.

JobPath ofrece las siguientes oportunidades:

- Informacion al respecto a oportunidades de entrenamiento e empleo dentro el campo de la salud prepararse para trabajo que pagan un sueldo justo.

Y tambien....

- Consultar de carrerra.
- Tener apoyo mientras completa su entrenamiento.



Para Mas Informacion
JobPath Office
520-324-0402

JOB PATH

Quality Employment through Skills Training

Graduation 2001

May 3, 2001

The health and well being of the community is determined by the quality of life enjoyed by all its citizens. It is a fact and a reality that parents working two jobs for family survival cannot avail themselves of the opportunity to participate in the social, political and/or cultural life around them. JobPath's mission is to demonstrate that both social and economic benefits can be achieved through investments in long-term training for those who otherwise would not have the opportunity.

WELCOME AND OPENING REMARKS

Herminia Cubillos, Director
JobPath

Carol A. Gorsuch, Sr. Vice Chancellor
For Educational Planning and Development
Pima Community College

JOBPATH PARTICIPANT SPEAKERS

KEYNOTE SPEAKER

Raúl M. Grijalva
Chairman, Pima County Board of Supervisors

SPECIAL RECOGNITION AWARDS

Jim Haag (1934-2000) JobPath Co-Founder
Pima County Interfaith Council Co-Chair

Carol Somers, Representative, District 13

Richard Patze, Acting Dean of Allied Health Care
Pima Community College

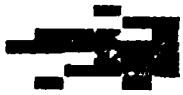
PRESENTATION OF CERTIFICATES OF COMPLETION

Andrea Robson, Co-Chair of Oversight Committee
William A. Estes Jr., Co-Chair of Oversight Committee

REFLECTION

Music by: Los Palmas de Roskruge
Rudy Valencia

Reception Following



LIST OF GRADUATES

Alli d Health Care

- **Administrative Support**

Rodriguez, Armida E.
Sarris, Alexis

- **Associate Degree in Nursing**

Anaya, Alberosa
Box, Amanda M.
Campos, Martha L.
Carlson, Shelley L.
Crawford, Susan R.
Darris, Casey
Deatherage, Kathleen M.
Green, Nancy V.
Kidder, Kristen L.
Kruse, Tracy A.
Martinez, Mario X.
Ramirez, Amy
Ryan, Krista M.
Tremmel, Felicia S.

- **Home Health**

Batriz, Norma
Dickerson, Lori
Herrera, Maria Luisa
Jimenez, Marisela
Nido, Carmen L.
Olsen, Mónica L.
Ramirez, Leticia
Rivera, Leticia
Serrano, Adelina
Valencia, Maria

- **Dental Assisting**

Coalter, Courtney
Duffey, Breanne
Ransom, Christine E.

- **Radiology Technician**

Chandler, Nicole M.
Degnan, Carter W.
Popp, Patricia A.
Robinson, Derek P.
Shaw, Mistine N.
Tatro, Kellie C.

- **Medical Transcriptionist**

Gerver, Kristine E.

- **Medical Records Coding**

Haight, Linda J.
Marshall, Nancy A.
Peve, Constance M.
Ramirez, Diane S
Savory, Aaron N.

- **Practical Nurse**

Canzoneri, Neysa
Castillo, Vanessa
Felker, Kimberly
Lopez, Andres L.
Mellberg, Nancy
Mills-Sutton, Sallie R.
Neville, Marilyn
Parker, Shanasy J.
Ramsay, Lorie L.
Rodriguez, Patricia
Ryan, Cecelia
Sosa, Lillian J.
Tedla, Rose V

Aviation

- **Aviation Interior**

Acedo, Richard G.
Aldrich, Jeffrey
Beltran, Dora A.
Brown, L.Russell
Camacho, Diego A.
Camacho, Everardo
Conn, William K.
Corn, James R.
Eppinger, George M.
Farrell, Dennis F.
Galvan, J. Edward
Goodspeed, Seth L.
Gutierrez, Martin A.
Hofstra, Kenneth E.
Orr, Shawn P.
Ozuna, Fernando A.
Ramirez, Adrian D.
Stewart, Randy D.
Vidal, Josh T.

- **Aviation Structural**

Baldwin, Craig A.
Byington, Jason A.
Creek, Bruce
Garay, Manuel
Gonzales, Juan C.
Harris, Donald D.
Hickey Adam T.
Lopez, Carlos R.
Medina, Monica L.
Mennenga, Shawn B.
Olguin, Norma E.
Piccini, Michael J.
Rodriguez, Jesus S.
Schouten, Melissa M.
Tanner, Chris A.
Volpe, Michael J.

Computer

- **A+ Computer**

Duran, Vanessa R.
Elias, Randal H.
Green, Donice
Olson, Steve
Wiegel, Craig

Construction

Spicker, Micheel S.

Machinist

Cox, Peter W.

Teachers open the door, but you must enter it by yourself.

(Chinese Proverb)

Editor: Jill Jorden Spitz | Telephone 520-573-4177 | Fax 573-4144 | E-mail business@azstarnet.con

Business

D SECTION

Saturday
May 5, 2001

ARIZONA DAILY STAR • SERVING TUCSON SI

JOBPATH GRADUATION

"You know what? I'm a darn good investment."

Nancy Mellberg, *JobPath graduate, below right*

A first step on the path to a better job

Photos by Max Becherer / Staff

Adelina Serrano, *right, gets a hug from her teacher, Jan Lawall, after Thursday's graduation ceremony.*

Training helps people out of low-pay, dead-end work

By Tiffany Kjos
ARIZONA DAILY STAR

JobPath, a training program designed to take people out of low-paying jobs, has sent 97 more people on their way to lucrative careers.

Dozens of people packed the Pima Community College district board room Thursday to cheer on relatives and friends receiving certificates or diplomas in 13 fields, including nursing and aviation.

JobPath, funded by the city, the county and private sources, has graduated 181 students in its three years of existence. The program pays for students' tuition, books, transportation, child care and tools, and provides a support network of peers and case workers.

Raul Grijalva, chairman of the Pima County Board of Supervisors, gave the keynote speech at the ceremony, but the real stars were the graduates.

Nancy Mellberg was among six students selected to stand before the crowd and talk about JobPath. Struggling against tears, Mellberg, explained how she and her five children fled a long, bad relationship, leaving her with no job and little hope.

"With help from my mother, my children and JobPath, I have overcome many obstacles," she almost whispered.

She found her voice a moment later when she declared, "You know what? I'm a darn good investment."

Participants repay JobPath in cash or community service, with one hour of community service subtracting $10 from the debt. While they are in JobPath, most students work full time and go to school full time.

Patricia Popp said being in JobPath was like having a safety net.

"At first I thought it was too good to be true, that a program like this only wanted community service in return. So I started looking for the catch," she said.

She didn't find one, but she did end up with a radiology technologist degree.

JobPath is the brainchild of the Pima County Interfaith Council, which started the non-profit program in hopes of strengthening the community by helping people get training for real careers.

Most of the schooling takes place through Pima Community College. Other training was provided through Lutheran Social Ministry of the Southwest and Keane Inc.

The average JobPath participant:

- Is 32 years old.

SEE JOBPATH / D2

Interested in program?

- For more information about JobPath, call 324-0402.

JOBPATH

A way to get out of low-paying, dead-end jobs

Continued from Page D1

- Has children.
- Works two or three jobs.
- Earns between $13,000 and $14,000 a year.

Randy Stewart's wife, three children, parents, grandmother, sister and nephew all watched him get his certificate in aviation interiors. Stewart, who works as a security guard and on-call corrections officer, has already had three interviews with aviation firms.

Stewart got into JobPath after his street- and parking-lot-cleaning business went under and he couldn't find a job that paid well.

With JobPath, "my whole life changed," he said. "Now I can provide for my family and hopefully put away money for my kids' school."

Contact Star Business reporter Tiffany Kjos at 434-4083 or tkjos@azstarnet.com.

Caregiving crisis leaves cries ignored

Bard Lindeman
Seniors

At the root of the persistent, nagging problems that plague nursing homes across the country is the devil labeled: *staff*.

When your frail mother cries out during the night in pain or fear, does anyone come to hold her hand and deal with her dementia? When a skin ulcer becomes raw, does anyone notice the worsening problem? When a resident is dehydrated, is anyone there to pour a glass of water?

The answers become "yes" only when there is enough staff — and when the stalwart, often minority women known as certified nursing aides (CNAs) are professionally trained and reasonably paid.

How to make all this happen? That's the question that remains for our best minds.

Our scene today is Easton, Kan., a rural community of just 200. With 63 workers, the largest employer in town is Martha ("My friends call me 'Marty'") Hegarty, owner of the Country Care skilled nursing facility.

"We care for 56 patients 24 hours a day and 365 days a year," begins Hegarty, appearing before the immigration subcommittee of the Senate Judiciary Committee.

"You've heard about the shortage of registered nurses," she continues. "Well, I'm here to make certain you don't forget about paraprofessionals, those who are on the front lines of caregiving."

In language a schoolchild could follow, Hegarty logically lays out the national dilemma, one she declares has reached crisis proportions. She tells her small Washington audience that, in mid-America, "The number of elderly is exploding, while the people who would provide the care are leaving in droves."

Ninety-three percent of all nursing aides are women, and it's difficult to find new workers since any able-bodied woman today can find work in sales, fast-food restaurants or highway motels. Moreover, there is now riverboat gambling 30 miles away from Easton on the Missouri River. Plainly, times are hard for any operator of a nursing home.

"When Medicaid pays me $3.20 per hour to care for each patient," Hegarty testifies, "I simply cannot compete. Young people can work in the casinos for $15 to $25 per hour."

Other nursing homes, she added, "are offering free computers to come work for them. Several of my LPN (licensed practical nurses) received postcards offering $5,000 signing bonuses for leaving me to work in Leavenworth."

"I'm here," she said, biting off her words, "to ask that you help stop this destructive cycle," which simply means rising costs with no increases in staff or quality of care provided.

Hegarty did not come to her witness table unprepared. She laid down head-turning numbers.

For example:

- According to the federal government (Health Care Financing Administration), nursing homes currently provide substandard care because they are short-staffed by 250,000 CNAs — and 60,000 RNs.
- Experts predict the nation will need an additional 600,000 CNAs over the next five years.
- Further, the Congressional Research Service says the population "requiring long-term care will explode by some 75 percent over the next 40 years."

"Who will fill these jobs?" Hegarty asks. In 1996, faced with a continuing labor shortage, she petitioned the Immigration & Naturalization Service (INS) for two RNs from the Philippines. In March of this year — five years after she filed the requisite papers — Hegarty's imported nurses reported for duty.

This independent operator told the subcommittee: "The INS needs to reform the process. More than that, there must be a special system for the critical care needs our nation faces. Everyone can see this train wreck in the making but it is only you senators who can take the necessary steps to avert it."

The harsh truth is that tonight, and every night, call buttons all over the industry, numbering 17,000 nursing and rehabilitation institutions are going unanswered. Cries in the night are ignored. Too few hired hands are available to serve 1.6 million sick, frail and handicapped men and women. Is anyone in government truly listening? And coping?

PRIME NOTES

- Want a warm, fuzzy intergenerational yarn? Andrew Leatherman, 14, is teaching residents of Mary Hill Manor, a nursing home in Niagara, Wis., how to go online, send e-mail and stay current with the news.
- Actor Kirk Douglas, 84, told Esquire, "So what if my stroke left me with a speech impediment? Moses had one, and he did all right."

Write to Bard Lindeman at 5428 Oxbow Rd., Stone Mountain, Ga. 30087-1228, or e-mail to Lindy@abraxis.com. You may also fax him at (404) 815-5787.

Business

D Tuesday
July 24, 2001

ARIZONA DAILY STAR

Arizona's nursing shortage is second-worst nationally

By Jane Erikson
ARIZONA DAILY STAR

Arizona's population growth has rapidly outpaced that of its registered nurse work force, according to a federal study.

The state's ratio of employed nurses per 100,000 residents dropped 13 percent from 1996 to 2000, the second-largest decrease among the 50 states and Washington, D.C., according to the U.S. General Accounting Office.

Alaska's nurse-to-population ratio dropped 19.5 percent between 1996 and 2000. During that time, the average for the country dropped just 2 percent, the GAO found.

The report is the latest of several over the past year that predict a national crisis in nursing, with available nurses falling as much as 20 percent below the nation's need by the year 2020.

The nursing shortage has hit hospitals the hardest, forcing them to close patient beds. The shortage is a key reason for emergency room overcrowding — hospitals simply don't have enough nurses to move patients requiring hospitalization out of the ER and into beds.

Anne McNamara, a registered nurse who heads the Arizona Hospital and Healthcare Association's efforts to resolve the state's nursing shortage, said she was not surprised by Arizona's second-worst status.

"Clearly, the developmer our state's nursing work force not kept up with the state's ploding population growth," Namara said.

Hospital officials throug the state recognize the nur shortage as one of their most cal problems, she said.

"It's keeping them up at ni that they don't have enough n es to staff their beds," she sai

The GAO study does not

SEE SHORTAGE

SHORTAGE

Arizona program to raise money for nursing scholarships

Continued from Page D1

its own explanations for the current nursing shortage, which experts describe as the worst ever.

Reasons previously identified include the growing number of better-paying career options for young men and women and the fact that nurses working today are typically women in their mid-30s to late 40s who need time to raise their children.

McNamara's Colleagues in Caring program, which she described as just getting off the ground, will raise money for scholarships for people who want to enter nursing school and to finance local projects designed to increase young people's interest in nursing.

"Our third goal is looking at what we call 'commitment, passion and rededication' — how do we create a workplace where people don't want to leave," McNamara said.

University Medical Center in Tucson has 33 vacant positions, out of a total nursing staff of 950, said Marty Enriquez, the hospital's vice president for patient care services.

"We can't fill all our slots, and we're getting fewer experienced nurses applying for those slots," Enriquez said — partly because nursing is so physically and emotionally demanding.

"As our nurses continue to age, the strain is a lot harder when you're in your late 40s than when you're in your early 20s," Enriquez said.

UMC has had about 35 vacancies for at least a year — a 4 percent vacancy rate, she said.

"There are hospitals in Phoenix struggling with 30 and 40 percent vacancy rates," she said.

Nurse Erin Brown, who has worked at UMC for 11 years, talked Monday about how the shortage affects her work with patients recovering from orthopedic and neurosurgery.

When she started at UMC, she said, she usually cared for four patients at a time — three if they were so seriously ill that they needed more care. Now, she routinely cares for six patients at once, she said.

"When I have four patients, I give awesome care," she said. "At the end of the day I go home knowing I've sat with them, I've touched them, I've interacted with them, and that's very rewarding.

"But when you get six, your pace is so much faster that something gives. And what usually gives is that real personal satisfaction in the job."

Contact Star Business reporter Jane Erikson at 573-4118 or at jerikson@azstarnet.com.

Tucson & Arizona

Tucson Citizen

CITY EDITOR, WI

www.tucsoncitizen.com

Lottery/2 Obituaries/5

Tuesday, July 24, 2001

Nursing shortage grows in Arizona

The caregiver-to-patient ratio drops 13% from 1996 to 2000, making this state the fifth-worst nationally, a federal report shows.

By ANNE T. DENOGEAN
Citizen Staff Writer

Arizona is among the states hit hardest by the national nursing shortage, according to a new federal report.

The number of employed nurses per 100,000 Arizonans dropped 13 percent from 1996 to 2000, the General Accounting Office report showed. Only Alaska, with a 19.5 percent drop, had a greater decline.

The decrease left Arizona with one of the lowest ratios of working nurses-to-residents in the nation. Only California, Nevada, Texas and Utah are worse off.

"We are having a shortage, as are many states," said Marla Weston, executive director of the Arizona Nurses Association. "But I don't think anyone really recognized how dramatic the change was in Arizona as compared to other states. I think most nurses and most nursing leaders in this state were surprised."

The GAO report cited two reasons for the national shortage: the aging of the nurse workforce as fewer young people enter the profession, and job dissatisfaction for those already in the workforce.

The sources of dissatisfaction include "inadequate staffing, heavy workloads, the increased use of overtime, lack of sufficient support staff, and the adequacy of wages," the report said.

NURSES TO RESIDENTS

Ratio of nurses to residents:
- Arizona - 628 per 100,000
- U.S. - 782 per 100,000

Source: *General Accounting Office*

Weston and Anne McNamara, who monitors the nurse workforce for the Arizona Hospital and Healthcare Association, said those are the same issues faced by Arizona 33,135 registered nurses.

But they said those conditions here are no worse than anywhere else, making it hard to explain the intensity of the state's shortage.

"We haven't heard of nurses not coming here," Weston said.

McNamara said a recent national survey indicated Arizona is on target with nurses' salaries, but she thinks the pay here is lower than in other parts of the nation.

"Salaries in the western United States tend to be lower than in the East," Weston said. "So salaries are certainly not attracting people to come here. (The difference) is not dramatic enough that I would consider that to be the deciding issue."

STATE, continued/Page 3C

State 5th-worst in nurse-to-patient ratio, report finds

Continued from 1C

Both suggested rapid population growth is a more likely reason for the decreasing ratio of nurses to residents in Arizona.

Many people are moving here, and the number of nurses simply is not keeping up with the number of residents, McNamara said. The state's nursing schools graduate about 1,000 new nurses each year, a number that hasn't increased much over the past five to eight years, she said.

"We probably need 1,500 new graduates," she said.

Concerned parties are trying to address the issues surrounding the state's nursing shortage.

Gov. Jane Hull plans to convene a blue-ribbon panel this summer to address the issue.

The Arizona Hospital and Healthcare Association is addressing nurse education, recruitment and retention through its new Campaign for Caring. It aims to raise $8 million over the next three years for outreach, scholarships and workplace improvement grants.

And the Arizona Nurses Association will hold a convention in September to discuss strategies for attracting more people to the nursing field and efforts to improve working conditions.

"Nurses really like taking care of patients (but) are frustrated that conditions prevent them from delivering the kind of care they want to give," Weston said.

Business
ARIZONA DAILY STAR • SERVING TUC
Wedn sday
May 9, 2001

Shortage of nurses target of task force

Hull reveals plan at TMC ceremony

By Jane Erikson
ARIZONA DAILY STAR

Gov. Jane Hull announced Tuesday that she is putting together a task force to find solutions to the state's shortage of registered nurses.

Arizona has more than 45,000 active registered nurses and needs about 3,000 more, according to a recent survey by the Arizona Hospital and Healthcare Association.

The state's shortage mirrors a nationwide trend. A study published in the Journal of the American Medical Association last July estimated that by the year 2020, the nation will have 20 percent fewer nurses than it needs.

A major reason for the shortage is the growing number of career opportunities for women, compared with a generation ago, the study noted.

The American Nurses Association says 2.2 million nurses are working in hospitals and other health-care settings. But a recent survey by the federal Bureau of Health Professions found 494,000 registered nurses were not using their licenses, compared with 443,000 in 1996 and 387,000 in 1992.

The shortage has led to burnout, particularly among hospital nurses: one in three under age 30 plans to leave his or her job within the coming year, according to a study published Monday in the health-policy journal Health Affairs.

At Tucson Medical Center, where Hull made her announcement, nearly 300 of the hospital's 674 beds were empty yesterday, largely because of the nursing shortage, said TMC Senior Vice President Jack Jewett.

At University Medical Center, 30 nursing positions are unfilled, said Marty Enriquez, a

NURSES 1D6

NURSES

Better pay benefits cited as major needs

Continued from Page D1

registered nurse and the hospital's vice president for patient care services. UMC employs about 950 nurses, Enriquez said.

Nurses interviewed Tuesday at TMC and at UMC cited better pay and benefits as critical to attracting people to nursing and keeping them in the profession.

An Arizona Hospital and Healthcare Association salary survey last year put the median annual pay for a registered nurse in the state at $41,433.

"There's too few nurses and too much work to do," said Ruthie Wells, an emergency room nurse at TMC. The solution, Wells said: "Better pay, better benefits, more incentives for young people."

Wells and Vicki McIntyre, a registered nurse who works as a nurse mentor at TMC, applauded Hull's decision to study the problem.

"It's way overdue," McIntyre said of the task force. "It's a multifaceted problem, and it needs to be looked at."

Enriquez said Hull's task force needs to propose solutions to state legislators.

Enriquez said nursing needs the same kind of help that education will get under Proposition 301, a state sales tax increase approved by voters last November, expected to generate more than $400 million a year for teachers, schools, colleges and universities.

Hull praised Tucson Electric Power Co. for promising to donate $150,000 over the next three years for nursing scholarships at Pima Community College, but otherwise she did not specify possible solutions to the nursing shortage.

Enriquez noted that other states have created similar task forces and are considering legislation to limit nurses' work hours and nurse-patient ratios, among other provisions.

"It's wonderful that we're finally going to be doing something," Enriquez said. "The more people that become aware of it, if nurses feel like they're being heard, I think all those things could contribute to nurses staying in nursing and new people wanting to be in nursing."

Hull promised to appoint nurses to her task force and said she will announce who will be on the committee next week.

"We cannot move forward without you," she told the nurses gathered for a ceremony honoring TMC nurses, as part of National Nurses Week. It ends Saturday, the anniversary of the birth of Florence Nightingale in 1820.

▶ Contact Star Business reporter Jane Erikson at 573-4118 or at jerikson@azstarnet.com.

Work force's new face

Companies say it makes sense to hire Latinos with their population and buying power growing.

By STEPHANIE ARMOUR
Gannett News Service

Corina Alvarez is the face of the new American work force. She's young, she's Hispanic and she's very much in demand.

Consider what happened when the 31-year-old Cuban-American went looking for a job. As soon as she posted her résumé on an online Hispanic job board, calls and contacts from companies came tumbling in.

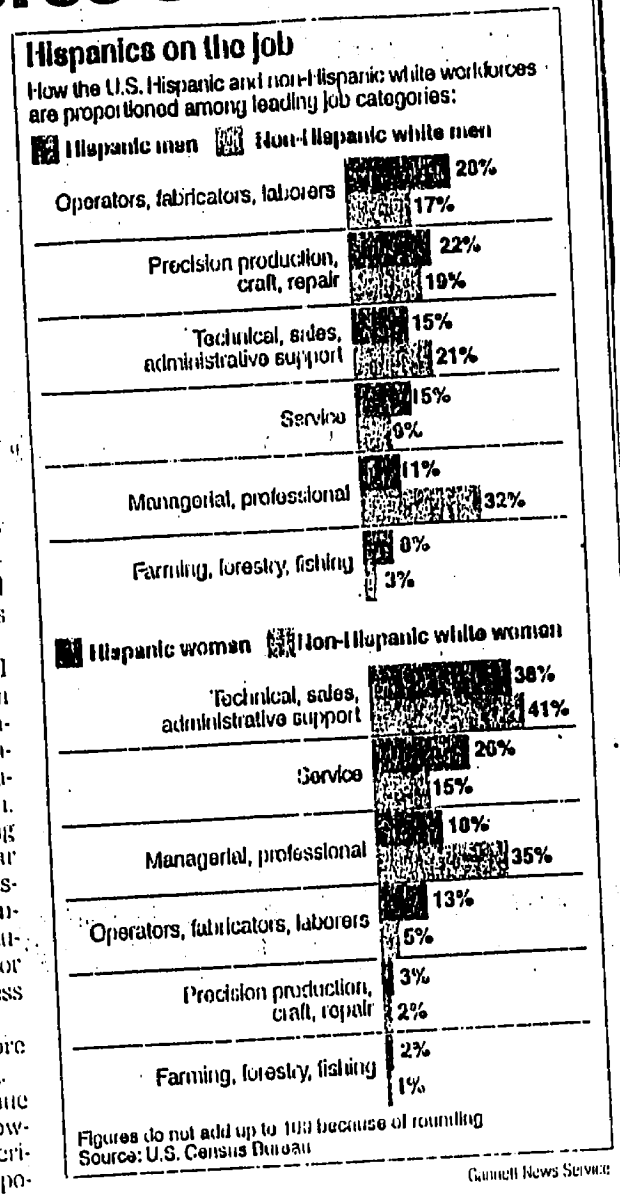
"It was so exciting; I had zillions of calls from recruiters and companies," said the public relations manager at a Miami-based Internet firm. "Companies are realizing that the more familiar they become with Hispanic culture and language, the more opportunities there will be for them. It's smart business sense."

It's a message more employers are heeding.

As Hispanics continue to make up an ever-growing share of the American work force, Corporate America is responding with a simple message: "*Bienvenidos*," or welcome. Businesses including PepsiCo, Chevron, Coors Brewing, Kmart and PricewaterhouseCoopers are stepping up recruitment and retention efforts. They're hiring interpreters, translating employee handbooks into Spanish and launching mentoring programs.

An unprecedented demographic shift is behind the emphasis. The number of Hispanics in the country surged by

EMPLOYERS, continued/Page 3B



Gannett News Service

Employers seeking out Hispanics

Continued from 1B

nearly 60 percent since 1990 – to 35.3 million – putting the population at a virtual tie with African-Americans as the nation's largest minority group, according to recent census data. The number of non-Hispanic whites increased only 5.3 percent.

As Hispanic workers make up an increasing number of clients, customers and potential hires, employers are reaching out to this demographic group as a matter of business survival.

The North American Free Trade Agreement has fostered growing economic ties with Mexico. The exchange of goods is worth about $250 billion annually and has accelerated the need for American based companies to add Spanish-speaking hires.

"A third of the Latinos are under 18, so this is going to be the future of the work force in the United States," said Sonia Perez, a deputy vice president at the National Council of La Raza. "This is a population we need to invest in, pay attention to."

Shift brings challenges

But the shift is also bringing new challenges. Increasing numbers of workers are claiming they've been discriminated against by being forced to speak only English on the job, federal officials say, with many of those allegations coming from Hispanic employees. And Hispanics remain underrepresented in high paying positions.

Business

Elder care takes its toll

Caregivers find the health system provides for acute but not chronic care.

By EILEEN ALT POWELL
The Associated Press

NEW YORK – When Marilyn Raschka's parents hit their late 80s, it became increasingly apparent they were having trouble coping in their Hartford, Wis., home.

Her father suffered bouts of depression and at one point needed to be hospitalized. Her mother lost interest in cooking, stopped doing the laundry and ignored other chores.

"At first I thought I could handle it long-distance," said Raschka, who lived overseas and worked as a teacher and free-lance writer. "I came home for a couple of months, but then I left again. I had a job, a life. I liked it."

In mid-1995, however, Raschka moved back to Hartford.

"As the weeks went by, it became obvious I could go no farther than two blocks away," she said. "I was wearing a rut in the sidewalk – back and forth with meals, back and forth with medicine, back and forth with laundry."

Her mother died at 93 in 1999, and Raschka now lives with and cares for her 94-year-old father, who has been in a wheelchair since suffering a stroke last year.

"There are times you feel very isolated, and there are times you feel stressed," said Raschka, who is 56. "But in the end, you get through it all because you know you are responsible."

Millions of Americans find themselves in the role of full- or part-time caregiver. It's especially true for baby boomers, whose parents are reaching the age when many face chronic health problems.

A study by the National Alliance for Caregiving and the AARP found nearly one-quarter of the nation's households have at least one adult who is caring for someone 50 or older. Most often the caregiver is a woman.

"It's a myth that people don't take care of their relatives, that families typically put their relatives in nursing homes," said Gail Hunt, executive director of the National Alliance for Caregiving, a coalition of public and private groups based in Bethesda, Md. "In fact, about 80 percent of the care given to older people is given by family and friends. And it can take a toll."

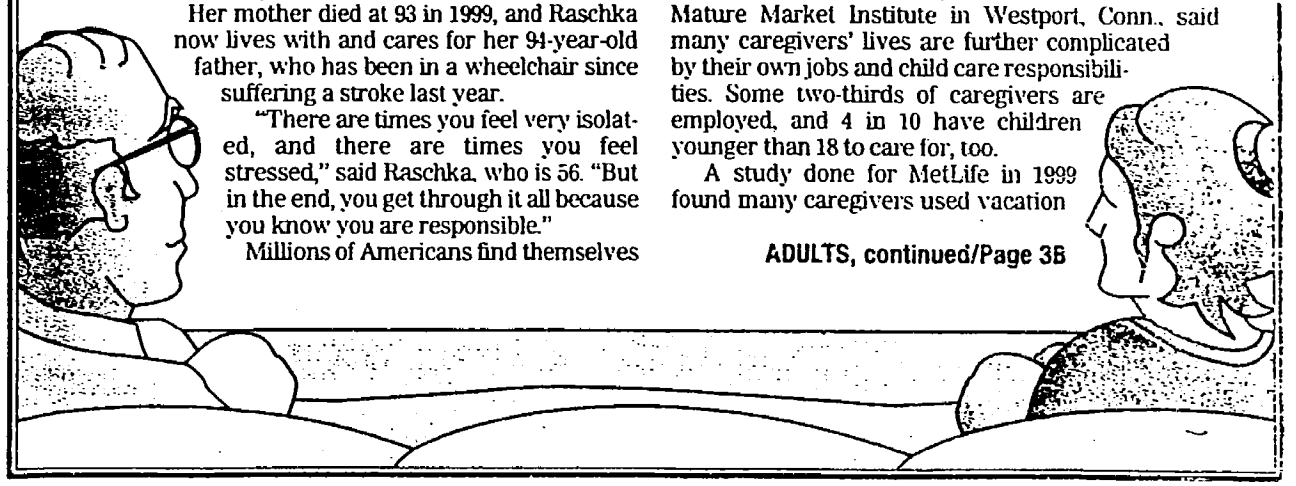
There is a shortage of professional home-care workers, and they're often expensive to hire, Hunt said. And many caregivers don't seek help, even when they're overwhelmed, she added.

"We hear caregivers say all the time, 'We haven't had a vacation in six or seven years because we had no one to take care of Grandmother,'" Hunt said.

Sandra Timmermann, director of the MetLife Mature Market Institute in Westport, Conn., said many caregivers' lives are further complicated by their own jobs and child care responsibilities. Some two-thirds of caregivers are employed, and 4 in 10 have children younger than 18 to care for, too.

A study done for MetLife in 1999 found many caregivers used vacation

ADULTS, continued/Page 3B



Adults often must juggle jobs with caregiving

Continued from 1B

or sick days to care for ailing parents while others cut back work hours or switched to part-time jobs. Still others took leaves, quit or retired early. The study estimated that the average loss in wages, Social Security benefits and pension rights totaled nearly $660,000 over a caregiver's lifetime.

"Eldercare now is where childcare was a few decades ago," Timmermann said. "There's still a stigma to saying, 'I have to leave early to take my mother to the doctor.' You wouldn't feel that way if you said, 'My son has the flu, and I have to go home.'"

That attitude, she believes, is changing as more baby boomers reach senior positions and formulate policy in their companies.

Health-care specialist Carol Levine knows firsthand the problems of juggling work and caregiving. After her husband, Howard, was paralyzed in an auto accident in 1990, she had to provide round-the-clock care.

"I realized that the health-care system did a great job at acute care, at saving lives, but was not very supportive on the chronic-care side," Levine said.

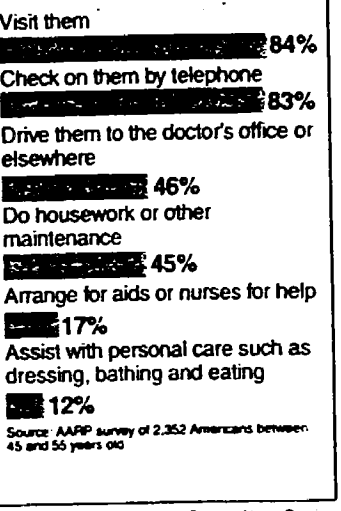
The AIDS policy specialist turned her attention to the needs of caregivers and for five years has been a director at the United Hospital Fund in New York City. Her project involves working with hospitals, community groups and caregivers to develop models to make it easier for families to cope with the needs of the elderly and disabled.

Home-care workers stay with Levine's husband during the day, but she handles his care at night. In recent weeks, she's also been traveling to upstate New York to help her mother, who is 89 and recovering from cancer surgery.

One of the best resources to help caregivers is the Eldercare Locator, a directory service underwritten by the U.S. Administration on Aging. Caregivers and the elderly can dial (800) 677-1116 to find local support services. The administration also runs a website at www.aoa.gov with information on caregiving and services and links to other sites.

Family-friendly

Members of the sandwich generation, 45 to 55 years old, routinely help their parents and other older adults. A national survey found they frequently or sometimes:



Source: AARP survey of 2,352 Americans between 45 and 55 years old

Gannett News Service

Online chat rooms, such as those run by ElderCare Online at www.ec-online.net, are a popular way for caregivers to share their feelings and exchange tips.

Direct Caregiver Association

The unnecessary crisis in Long Term Care:

A CRITICAL SHORTAGE OF CAREGIVERS

CHRONIC TURNOVER OF EMPLOYEES

Direct Caregiver Association

Why?

- Poor Training
  - No comprehensive model curriculum
  - Insufficient training: work stress, injuries
- Chronic Turnover
  - Job dissatisfaction
  - Poor wages and benefits
- No career advancement
- No community recognition for Direct Caregivers

Direct Caregiver Association

One community's solution:

THE CAREGIVER RESOURCE CENTER

Assuring that elders and disabled individuals have access to reliable, high quality Direct Caregivers

Attachment B

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

A model community-based program
to be replicated across the country

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

Our Partners in Collaboration:

- **Direct Caregivers**
- **Consumers**
  - People who are receiving or will need long-term care
- **Long-Term Care Providers**
  - Home Care Services
  - Nursing Homes
  - Assisted Living Centers
- **Supporting Community Organizations**
  - Hospitals
  - Businesses
  - Not-For-Profits

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

Goals:

- Recruit caring people into entry-level health care jobs

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

Goals:

- Screen, train, job-counsel, and support Direct Caregivers
- Promote Direct Caregiver job satisfaction and job security
- Provide continuing education and advanced training
- Provide accreditation for Direct Caregivers who:
  - Work in the Long-Term Care industry
  - Work privately

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

Goals:

- Increase consumer confidence and satisfaction

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

Goals:

- Increase the number of qualified, reliable Direct Caregivers
- Minimize employee turnover

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

Benefits for our members –

DIRECT CAREGIVERS:

- Career Counseling
- Comprehensive Training
- Prepare for Accreditation
- Job Placement
- Monthly In-Service Education
- On-going Counseling
- Peer mentoring and support
- Workshops – Seminars - Retreats

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

Benefits for our members –

CONSUMERS:

- Access to high quality long-term care
- Accreditation for privately-hired Direct Caregivers

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

Benefits for our members –

LONG TERM CARE PROVIDERS:

- Access the Caregiver Resource Center's Job Placement Program
- Monthly In-Service Education to Direct Caregiver employees
- Reduce costs for Recruitment, Training, Turnover
- Demonstrate increased respect for Direct Caregiver employees
- Validate with Accreditation of Direct Caregiver employees
- Seminars and Workshops for Nursing and Management Staff

Direct Caregiver Association

THE CAREGIVER RESOURCE CENTER

Sources of Funding:

- Annual Membership Contribution
- Job Placement Fees
- Workshop and Skill Training Fees
- State and Local Government Job Training Dollars
- State Funding For Model Training Program
- Private Donations and Bequests
- Corporate and Foundation Donations

Direct Caregiver Association

Recommendations:

1. State standardized employee designation: "Direct Caregiver."
2. State mandate for accreditation for Direct Caregivers
3. State mandated screening procedures
4. State standardized curriculum, training goals, and job requirements, job descriptions and responsibilities
5. State Government Funds to develop Caregiver Resource Centers in Tucson, Phoenix, and Prescott

SOME IDEAS TO CONSIDER FOR SKILLED NURSING FACILITIES

REDESIGNING OF STAFFING CONFIGURATION

- Allow for Med Techs to pass medications
  Allow for Patient Care Technicians to draw blood and do other specific patient care
  Allow for Single Task Workers, e.g., individuals to feed residents at meal times

PROVIDE EDUCATION INCENTIVES

- Reimbursement to facility for providing CNA training
  Payment to student while taking CNA training
  Educational grants for students in Nursing programs
  Establish nursing programs in other areas
  Increase high school CNA programs

ELIMINATE REGULATORY BARRIERS

Delays in Nurse Aide Certification due to slow turnaround in background checks
Enable faster easier process for immigration of healthcare workers
Eliminate loss of CNA Training Program as a remedy to poor surveys.

- Redefine US Wage and Labor laws to allow volunteers to work

ELIMINATE PROGRAM CONTRACTORS

Redirect funds to providers
Eliminate duplicated efforts

- Streamline work efforts

TURNOVER ISSUES

Pay scales and staffing levels based on ALTCS payments
Enable Nurses to do their jobs. Difficult to Obtain Medications, Extensive Assessment Requirements, Growing Acuity of Patients not Recognized by Level of Care Tools, Expectations for Nurses to be Physicians, Expanding Paperwork
Adjust Reimbursement to Nursing Facilities to allow for profitable operation.

OTHER

AHCCCS and Program Contractors Need to become Advocates for patient care—Not just the cheapest place to put them. ALTCS clients should be given free choice.
Put Cap on Registry Fees
Place cap on legal fees and settlements for liability settlements
Require reimbursement to facility for frivolous liability law suits

Attachment C

PRESENTATION TO THE SENATE AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Bev Hermon
BH Consulting
November 19, 2001

Indications of the Inadequacy of a $7.50 Service Rate:

- **Eligible families with a developmentally disabled and chronically ill child who apply and meet the standards for services are given an annual allocation of service hours for in-home services. Respite is the most often requested service. A survey taken by the State Autism Society revealed that of those that responded, 20% of the families who meet state requirements for Arizona Long Term Care never have been able to find a provider. The Advocacy our office provides for chronically ill children confirms the fact individuals who are difficult to serve, are not receiving services. DDD reverted $3 million in state match this year for overestimating the service costs. Most of the Community Provider organizations I represent who provide this service lose money.**

- **Group homes have turnover rates up to 100% and more. Providers have tried all the enticements and small scale fringe benefits that other industries use, but their collective experience is that it is the "take home pay" that causes potential employees to pass up caregiver jobs. The $7.50 rate, and the inability to provide increases in pay costs providers those employees who are dedicated and find satisfaction in serving individuals with developmental disabilities. They leave to find more lucrative employment. The same job for the State of Arizona is an example.**

- **Group Home and Program vacancies are at a dangerous level. Many providers have vacancy rates of 20-30%. The group home setting is a permanent home for many of the DD aging population. The constant turnover in staff has a negative effect on people who are very dependent.**

- **Community Providers offering $7.50/hour are not competitive in the market place with retail, fast food, credit card services, convenience markets and other entry level jobs that pay $8-12/hour.**

- **Perhaps the best indicator of the inadequacy of the rates is the fact that the state has raised the rate paid for the exact same work to $8.09 and hour for entry level and $9.21 for an experienced person. The pay scale goes to $13 an hour.**

Attachment A.

Other factors influencing providers ability to compete for employees:

- **In addition to the rate inadequacy, providers on multi-year fixed rate contracts have to cope with double-digit increases in health insurance, liability, vehicle insurance and inflationary costs in food, housing and other client costs, as well as unfunded mandates such as the $44 the state charges the provider for each new employee to be fingerprinted.**

- **Provider organizations are very dependent upon yearly United Way funding to help in defraying those costs. All indications are that the United Way will not have the same dollar amounts to assist local organizations.**

- **In the last 8-10 years, the only increases providers have received are dedicated only to increase the Direct Care rate. The result is that organizations are less able to provide benefits such as professional growth.**

In conclusion, the $7.50 rate needs to be raised to a competitive level in the market place to stabilize the provider work force.

Facility Premium Increases
1999,2000,2001

facility name	1999 premium	2000 premium	2001 premium
sun view care cent	$30,154.00	$124,020.00	$123,900.00
havasu nursing cer	$21,402.00	$19,215.00	$31,807.00
heritage life care	$81,636.00	$87,288.00	$130,232.00
north glendale life c	$119,578.00	$226,808.00	$245,685.00
springdale village	$43,541.00	$161,928.00	$700,000.00
plaza healthcare	$137,089.00	$137,159.00	$234,000.00
village green healtr	$45,288.00	$74,004.00	$199,734.00
la mesa healthcare	$54,036.00	$80,100.00	$201,312.00
santa rita care cent	$11,000.00	$11,841.00	$61,600.00
desert haven nursir	$81,612.00	$83,298.00	$97,188.00
phoenix mtn nursin	$22,483.00	$18,919.00	$24,745.00
yuma nursing cente	$17,475.00	$19,827.00	$33,102.00
desert valley care c	$49,854.00	$47,077.00	$88,932.00
gardens rehab and	$13,047.00	$42,000.00	$64,184.00
forum at tucson	$59,565.00	$96,043.00	$190,300.00
scottsdale village s	$69,316.00	$108,014.00	$144,412.00
mountain view man	$15,390.00	$19,941.00	$32,008.00
pecos nursing cent	$13,600.00	$12,287.72	$96,000.00
valley healthcare	$195,190.00	$436,437.00	$218,992.00
sonoran rehab	$137,564.00	$230,625.00	$143,968.00
desert life rehab	$324,071.00	$506,905.00	$375,126.00
villa campana	$148,329.00	$141,022.00	$107,468.00
kachina point	$162,255.00	$141,022.00	$192,632.00
sunwest nursing &	$36,202.00	$63,182.00	$111,097.00
	$1,889,677.00	$2,888,962.72	$3,848,424.00
		$999,285.72	$959,461.28
1999 - 2000 Change %		52.88%	
2000 - 2001 Change %			33.21%
1999 - 2001 Change %		103.66%	

Attachment B

Healthcare Systems Services
Arizona Facilities
Average Of Nursing,Overhead, and Capital Cost

	Labor PPD	Other PPD	Total PPD
Capital Cost Building		$11.64	$11.64
Capital.Cost MME		$0.00	$0.00
Employee Benefits		$11.56	$11.56
Admin General	$6.12	$11.16	$17.29
Plant	$1.55	$5.36	$6.91
Laundry	$1.27	$0.50	$1.77
Housekeeping	$3.18	$0.74	$3.93
Dietary	$5.86	$5.67	$11.53
Nursing Administration	$3.99	$0.44	$4.43
Central Supply	$0.43	$0.50	$0.93
Pharmacy	$0.00	$0.01	$0.01
Medical Records	$0.79	$0.14	$0.94
Social Services	$1.84	$0.16	$2.00
Recreation	$1.62	$0.16	$1.78
Nursing	$42.70	$6.69	$49.39
	$69.36	**$54.73**	**$124.10**

Attachment A

Arizona Department of Health Services

Arizona D partment of Health Services
Division of Assurance and Lic nsure Services

The Division of Assurance and Licensure Services (Division) is responsible for ensuring that Health and Child Care Facilities comply with state regulations. In addition the Offices of Long Term Care and Medical Facilities, under a cooperative agreement with the Centers for Medicaid and Medicare Services (CMS, formerly HCFA) of the US Department of Health and Human Services, is responsible for ensuring that facilities accepting Medicare and Medicaid patients meet federal regulations and certification standards.

The Division's primary responsibilities are surveys, complaint investigations, enforcement activities, technical assistance and providing access to public records.

Licensure Surveys – Surveys may be conducted by one to five surveyors over a half day to week period of time, depending on the facility. During this time surveyor(s) evaluate all aspects of resident care, procedures and practices, physical environment, administration and staff qualifications.

Complaint Investigations – Each complaint received by the Division is prioritized and assigned for investigation. A complaint may have multiple allegations, which are each investigated for possible state and federal deficiencies. Complaints are prioritized as follows:

Priority 1:	Allegation involves immediate threat to health and safety; Must be initiated within 2 working days.
Priority 2:	Allegation involves potential threat to health and safety; Must be initiated within 10 working days.
Priority 3:	Allegation does not involve threat to health and safety; Must be initiated within 45 working days.

Inspections in response to complaints are generally shorter in duration than licensure surveys and focus primarily on those areas of resident care alleged to be at fault. If during the course of a complaint investigation additional problems are uncovered, a full on-site inspection may be initiated based on both state and federal regulations.

Inspections, whether standard or in response to complaints, are conducted without notice to the facility. Survey schedules are changed annually. Generally, facilities with poor surveys and numerous verified complaints are surveyed more frequently than facilities with deficiency free surveys.

Surveys are typically conducted on weekdays although survey teams do conduct inspections at night, on weekends and during holidays.

Attachment A

At the conclusion of each inspection, the findings of the surveyors are shared with the facility administrative staff in an exit interview and are included in a survey report, that is then forwarded to the facility. If the Division has determined that the nursing home failed to comply with all applicable state and federal licensure standards, the facility will be cited for deficiencies.

Enforcement Remedies – In many cases, facilities are given the opportunity to correct less serious deficiencies without incurring fines or other penalties. If warranted, however, the Division may impose a fine, restrict admissions, appoint a temporary manager, issue a provisional license, suspend or revoke a nursing home's license, or use other remedies for violations of statutes as provided by state or federal law, or as authorized by enforcement regulations and agreements.

Technical Assistance – Division Staff provide technical assistance regarding compliance with rules and regulations. Classes are offered for providers who want to open new facilities to teach them the requirements and thereby protect the health and safety of clients or residents. Technical assistance is also offered in classes and on-site to any provider receiving surveys or investigations.

Public Records – The information on state and federal inspections and complaint investigation is available from the Division. When reviewing an inspection report it is important to remember that facilities have the right to appeal survey findings and penalties imposed. On appeal, the decision of the Division may be upheld or reversed, or a settlement may be reached in which fines are reduced.

It is also important to note that inspection reports show only a one-time "snapshot" of facility compliance with established standards. To more fully assess the quality of care provided by a facility, it is important that current and past survey reports be reviewed.

Complete survey reports and facility plans of correction, edited to protect patient confidentiality, are available at each facility as well as at the Division.

Arizona Department of Health Services
Division of Assurance and Licensure Services

Type of Facility	Number of Residents	Staffing Requirements
Assisted Living Licensure Assisted Living Centers (11 or more residents) Assisted Living Homes (10 or fewer residents) Adult Foster Care (4 or fewer residents) Adult Day Health Care Centers Unclassified Respite Care Developmentally Disabled Group Home (Physical Inspection for DES) Foster Home Inspections (Physical Inspection for DES)	1300 780	Caregiver 18 years old. Assistant Caregiver 16 years old. Manager 21 years old. TB, first aid, CPR training
Behavioral Health Licensure Psychiatric acute hospital Behavioral health residential agency Specialized transitional agency Shelter for victims of domestic violence Rural substance abuse transitional agency Outpatient clinic Adult therapeutic foster home	860	Caregiver 21 years old. TB, first aid, CPR training
Long Term Care Nursing Care Institutions Intermediate Care Facilities for the Mentally Retarded (ICFMR)	145 11	Caregiver 16 years old TB, certified nursing assistant
Medical Facilities Hospitals Home Health Agencies Hospices Outpatient Treatment Centers Ambulatory Surgical Centers End-Stage Renal Dialysis Centers (including those on Federal or Tribal Land) Recovery Care Centers	1200	No age requirement for most, others 18 years old. TB, CPR training, orientation, in-service training.
Child Care Licensure Child Care Facilities Child Care Group Homes	2500	Teachers/ Caregiver 18 years old. Director 21 years old.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY (DES)
DIVISION OF EMPLOYMENT & REHABILITATION SERVICES
CHILD CARE ADMINISTRATION (CCA) PROGRAM OVERVIEW FOR SFY 2002

Mission: The mission of the Child Care Administration (CCA) is to support the well being and economic independence of Arizona families by providing child care assistance and developing child care services.

Administrative Structure: CCA has been appropriated $134.8 million for state fiscal year 2002 to assist 41,907 children (23,543 families) on an average monthly basis with child care subsidies[1]. 205 DES FTE's determine eligibility, authorize services, certify family child care homes, register providers, reimburse providers and manage programs. Services are available at 52 offices statewide.

Categories of eligibility: The four major categories of eligibility include:

- I. Cash Assistance Related Child Care
  JOBS Child Care - Families receiving Cash Assistance and participating in the Jobs program, Tribal Native Employment Works (NEW) programs, and the Two Parent Employment (TPEP) program. Families at-risk of TANF dependency are also eligible for child care assistance as determined by their Jobs casemanager.

  Employed Child Care - Families that are receiving Cash Assistance and need child care to accept or maintain employment.

- II. Transitional Child Care (TCC)
  Employed families that received Cash Assistance for at least one month and apply for child care assistance within 6 months of their Cash Assistance closure date. Gross monthly income level must be at or below 165% Federal Poverty Level (FPL). Up to 24 months of TCC may be provided. If after the 24 month period, the family's income is still at or below 165% FPL, they may continue to receive services under the Low Income Working Program.

- III. Low-Income Working Child Care*
  Families whose gross monthly incomes are at or below 165% FPL, and who need child care assistance for employment.

- IV. Special Circumstances Child Care*
  Families who reside in homeless or domestic violence shelters and/or who need child care due to a disability and who have gross monthly income levels that are at or below 165% FPL. Also, teen parents (19 years or younger) whose income is at or below 165% FPL (and need child care assistance for high school, GED or E.S.O.L. classes, or remedial educational activities in pursuit of a high school diploma) are eligible. In addition, children receiving Child Protective Services (CPS) are eligible without regard to income, as determined on a case by case basis by their CPS Case Manager.

  For most of the categories of eligibility, assistance for supplemental child care for education/training activities is available to individuals working at least 20 hours per week. Educational progress must be satisfactorily, and educational activity must be related to an employment goal.

  *For categories III & IV, if a waiting list is implemented for newly applying families, priority will be given to families with income at or below 100% of FPL. (Does not apply for CPS).

Child Care Providers
CCA maintains financial agreements with approximately 6,784 providers statewide (a net increase of 4% over last state fiscal year). Three major categories of providers are reimbursed for services to eligible children:

• DHS Licensed Centers, Certified Group Homes	1,537
• DES Certified Family Child Care Homes	1,510
• Non-Certified Relative Providers	3,737

Availability & Quality of Care Services
CCA utilizes 4% of certain funds plus specifically earmarked federal funds to expand the supply of child care, improve parental access, and improve the quality of care. Major activities include:

- Establishing and expanding quality programs serving infants and toddlers, school age children, teen parents, and families living in homeless and domestic violence shelters, etc.
- Maintaining a statewide Child Care Resource and Referral (CCR&R) program serving an estimated 25,000 families (37,000 children) in need of care with referrals. An additional 10,000 general inquiries are also received annually by CCR&R from consumers and providers. The development of consumer education outreach efforts through CCR&R including the development of a web site and a statewide campaign to disseminate information about quality child care is also a component of this service.
- Providing training for child care providers and the funding of curriculum and facility enhancements to improve quality of child care.
- Recruiting, orienting and training famiiy child care providers to improve access to and quality of child care.
- Establishing a professional development registry to track trainings, trainers, and education and experience of care providers as part of a broade: career development system for child care and early education providers. The goal is to improve the status of those working in the field and th quality of care and education for children and their families.

[1] A portion of the eligibility determination and program casemanagement is contracted with a private vendor, Maximus, in Eas Maricopa County. Maximus is responsible for the TANF-related and Transitional Child Care programs in these geographic areas.

Attachment B

Arizona Department of Economic Security
Division of Developmental Disabilities

Response to Caregiver Wages and Workforce Development Questions
November 7, 2001

1. Last session, money was appropriated for provider rate adjustments (General Appropriations Act, Laws 2001, Chapter 236). The Governor vetoed the first year increases for all areas except DDD and long-term care providers. Senator Yrun would like to know how the money is monitored once it is passed on to the providers. Her real concern is if the money is going to salary increases for the workers and if DES monitors and/or controls this.

   Once the money is placed into the provider rate, the Division has no ability to ensure that the rate increase is passed on to workers other than reports by the providers. We had an early 1990's lawsuit around the Division trying to hold a provider to specific expenditures within their contract. Ultimately, the Attorney General's office indicated that the Division could not hold a provider to a specific expenditure if the contract was on a negotiated rate. Consideration would have to be given to modifying the procurement process to ensure pay increases provided in contract rates are passed to the direct care workers as intended. The 2001 appropriation language for provider rate adjustments ("bottom up") would have optimized the chances that this funding would have gone to the area of greatest need.

2. Are in-home caregivers (personal attendants) regulated? Certified? Or licensed? Are background checks performed?

   Home and community based providers, including personal attendants, are certified through the Division and registered with Arizona Health Care Cost Containment System. Certification requirements include a Class II fingerprint clearance, First Aide and CPR certification, and behavior management training. A provider's home must pass a fire, health, and safety inspection if providing care in their home. If a parent or family member becomes a home based provider for an individual with whom they share a home, only First Aide/CPR certification is required.

3. Olmstead Decision – requires all states to prepare an action plan (to provide services in the least restrictive environment). Who is putting the AZ plan together and what is the status (is it completed, if not what is the target date?)?

   The Olmstead Decision essentially requires states to move (or plan to move) individuals from institutions into less restrictive community settings. Since this state has few individuals living in an institution, the Arizona plan concentrates on increasing the network of community-based settings and providers for individuals with developmental disabilities. The Arizona Olmstead plan was completed under the leadership of the Arizona Health Care Cost Containment System. The next step is the implementation of the plan.

Attachment C

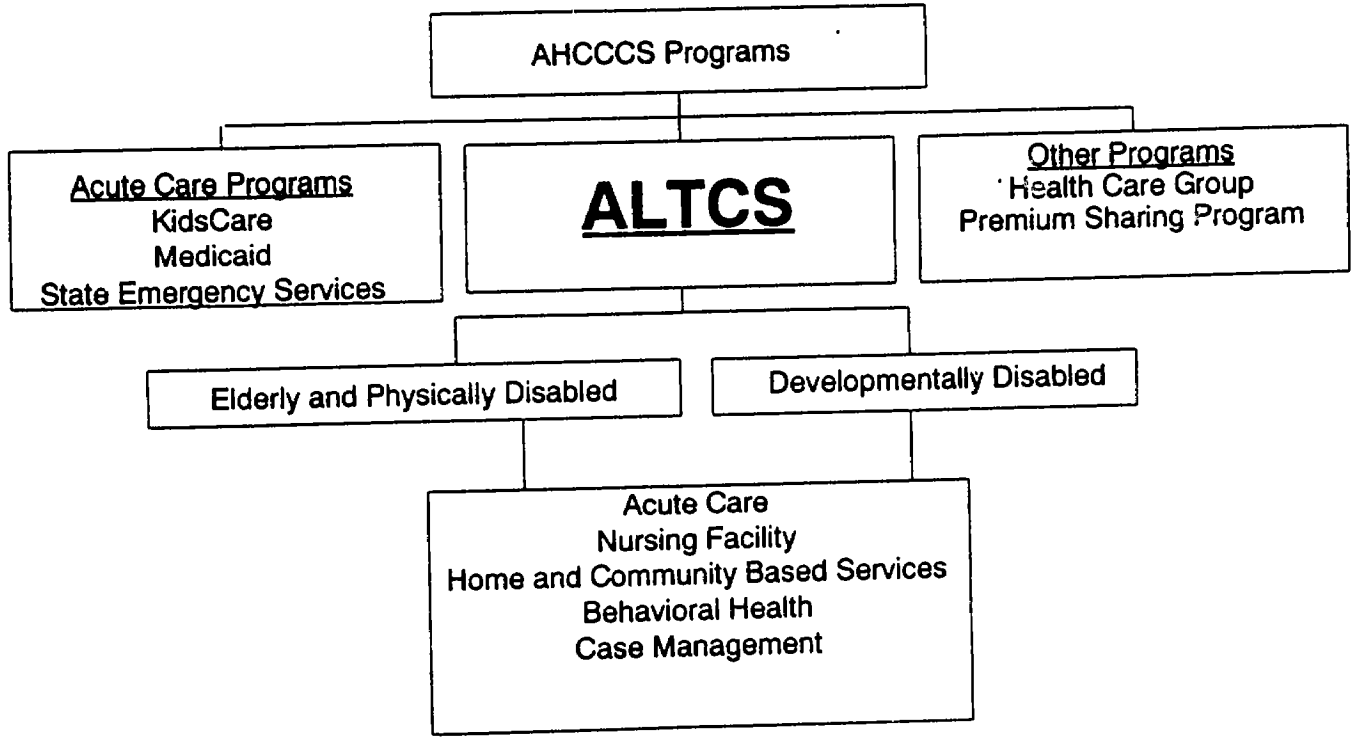
Attachment D

The Arizona Health Care Cost Containment System

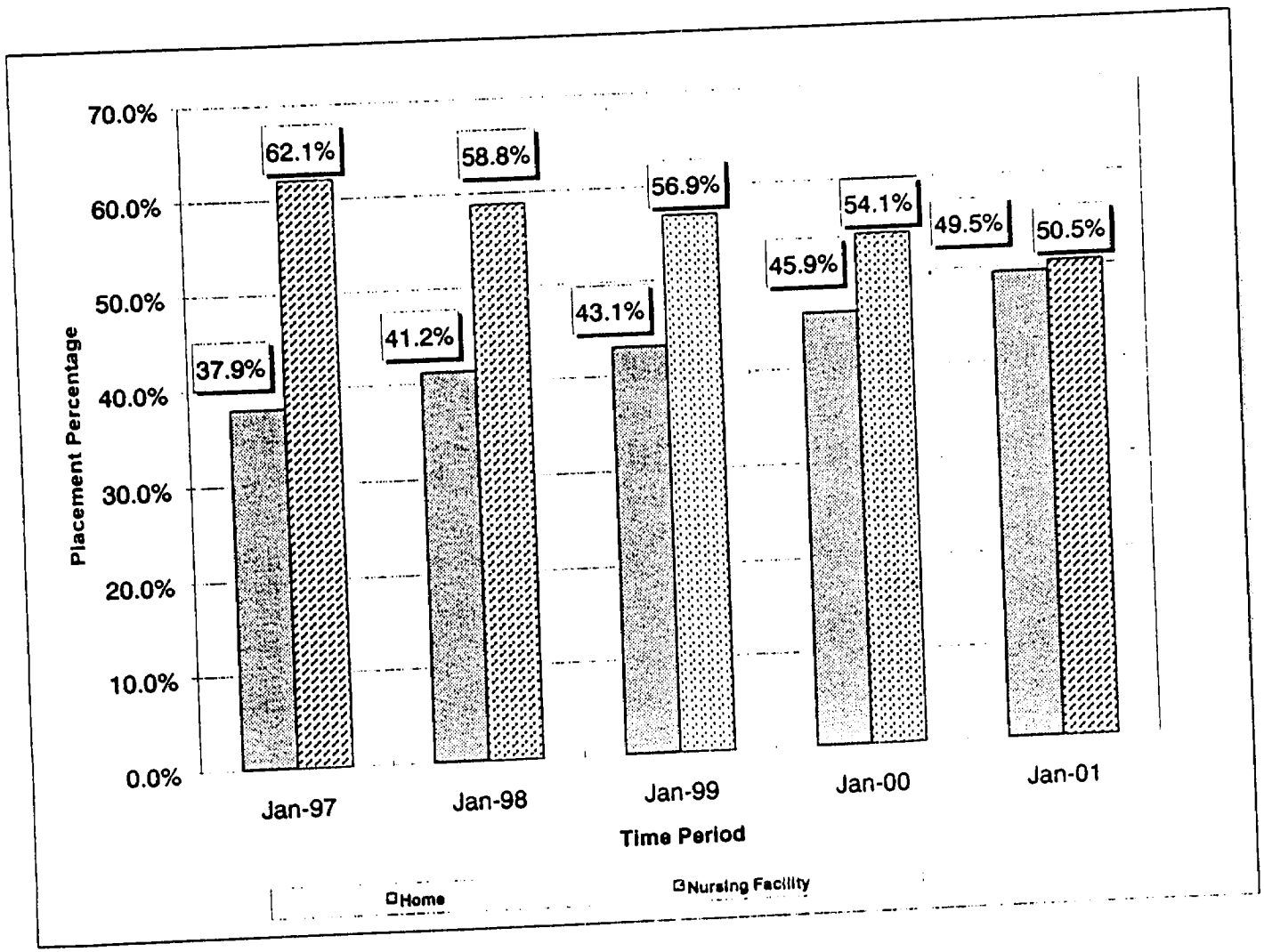
Funding Mechanism for Arizona Long Term Care System (ALTCS)

November 7, 2001

AHCCCS PROGRAMS



ALTCS Placement Data



AHCCCS

How Is It Determined Where a Member Lives?

- Consumer Directed Care or Person Centered Planning
- Least Restrictive Environment
- Supreme Court's Olmstead Decision
- Health and Human Services Objective
  - ...to help more individuals become aware of services and supports available to them in the community, and transition out of nursing homes if that is their choice."

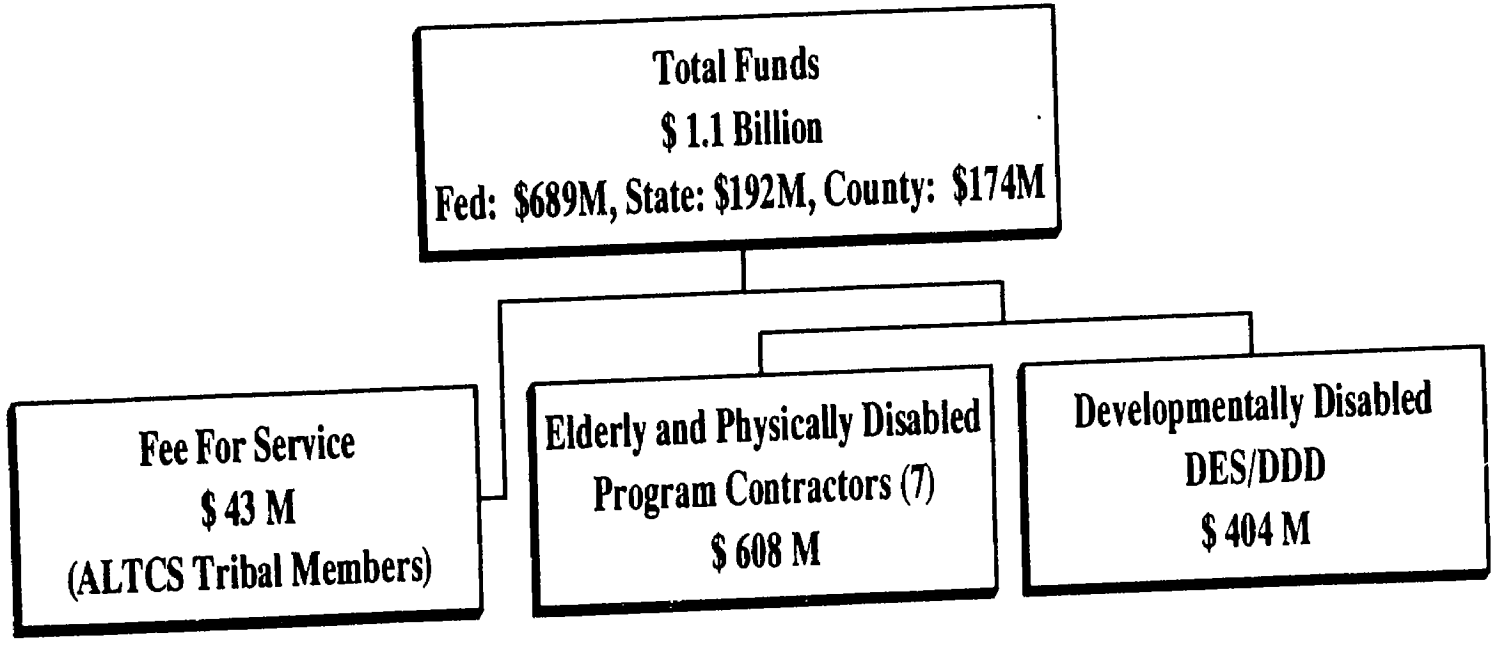
AHCCCS

Placement Process

- Assigned a case manager
- Complete an assessment with the member/family
- Discuss choices of services and settings
- Decision is made by member/family of what services and settings are needed and wanted

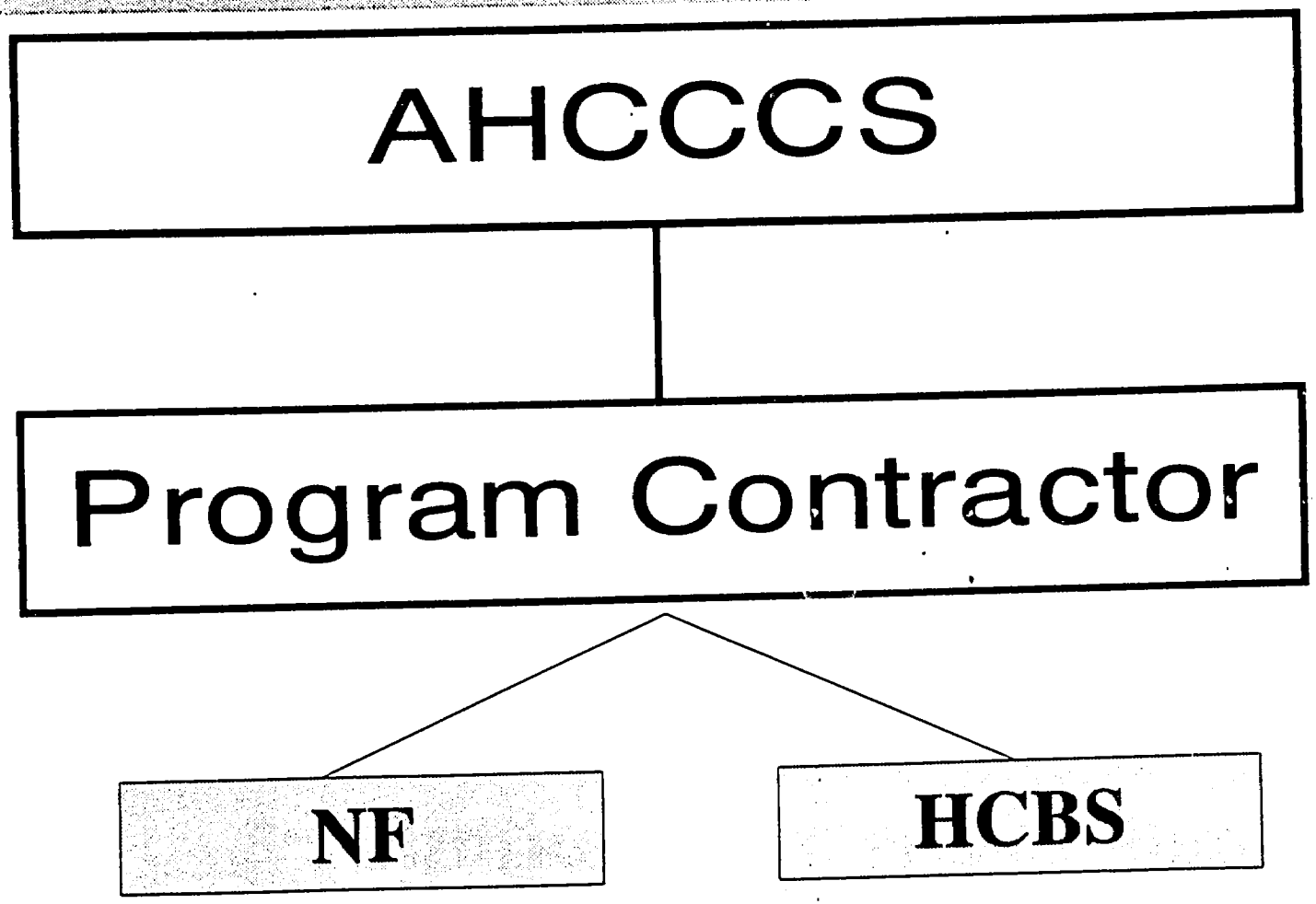
What Are The ALTCS Funding Streams?

SFY '02 Budget



AHCCCS

How are the monies distributed?



AHCCCS

Capitation Rate Development

Why? Need to establish monthly capitation rate for members enrolled with program contractors

How often? Annually

Independent actuaries develop capitation rates that are actuarially sound

How? Based on six major areas:

- Historical utilization of services
- Program Contractor financial experience
- National and local inflationary trends (including FFS rate increases)
- Program changes
- Percentage of members in different placement settings (HCBS and NF)
- Geographic location (e.g., urban vs. rural)

AHCCCS

Rate Development (NF & HCBS)

Why?	Establish rates to pay provider for NF and HCBS services provided to FFS members Use as a benchmark for building capitaiton rate increases
How Often?	Annually - Inflation by component and/or service - Rebase (recalculation of rates based on updated cost data)
How for NFs?	Based on three major areas - Direct care (e.g., wages and benefits for nurses and aides) *Adjusted for three levels-of-care - Indirect care (e.g., administrative overhead, meals, laundry) *Adjusted for occupancy - Capital (e.g.,building and equipment) *Adjusted for occupancy
How for HCBS?	Per service unit (e.g., hourly) rates based on costs, wages, ERE/benefits, travel, and administrative overhead

AHCCCS

Percentage of Increase for the Last 3 Years?

Years	Nursing Facility	HCBS
1999-2000	4.0%	7.9%
2000-2001	4.4%	12.8%
2001-2002	6.0%	15.3%

Capitation Rate Components

	Members	%	Gross Rate	Net Rate
Institutional - Nursing Facility	550	55%	$3,300	$1,815
Home and Community Based (HCB)	450	45%	$1,100	$ 495
Case Management				$ 75
Acute Medical Care				$ 400
Administration				$ 191
Risk/Contingency				$ 44
Share of Cost				($ 350)
Total Net Rate				$2,615

What Optional Medicaid Services Are Not Covered by AHCCCS?

- Adult Vision Care
- Adult Dental Care

AHCCCS

How was appropriation for providers distributed?

- Legislature authorized an additional 3.7% above general medical inflation to increase wages for direct care workers and employee related expenses for NF and HCBS.
- Appropriations for direct care providers above general medical inflation:
  - NF 2.4%
  - HCBS 11.7%
- Program contractor capitation rates were increased by these percentages for NF and HCBS direct care providers.

How is AHCCCS going to monitor provider increases?

- ALTCS contracts require Program Contractors to pass through increases to NF and HCBS direct care providers.
- Program Contractors shall monitor how the NF and HCBS providers pass through increases to direct care workers.
- Program contractors will submit a final report to AHCCCS by May 1, 2002 on the direct care workers.
- AHCCCS will summarize the data into a single report for the JLBC by July 1, 2002.

What is the current availability of LTC services across the state?

- Program Contractors submit an annual network development plan and Management Plan which provides:
  - Current status of network
  - Immediate short-term intervention when gaps occur
  - Interventions to fill network gaps, and barriers to those interventions
  - Outcome measures/evaluation of interventions
  - On-going activities for network development
  - Account for specialty populations
  - Account for membership growth and changes in demographics
- AHCCCS reviews and approves all plans
- Member/Provider Councils can provide feedback to the program contractors

How will AHCCCS provide for services with a growing AZ population?

- Data and Information
  - Program Contractor's Annual Network Development and Management Plan
  - Encounter data from Program Contractors
  - Arizona's Community Based Services and Settings Report
  - Feedback from Member/Provider Councils
- Planning and Monitoring Efforts
  - Participation with Various Committees and Councils
  - LTC Taskforce Legislative Committee
  - Tri-Agency Meetings (DES, DHS and AHCCCS)
  - Participation on Governor's Councils on Developmental Disability and Aging

STATES' RESPONSES ON CAREGIVER WORKFORCE DEVELOPMENT 2000 - 2001

The National Conference of State Legislatures (Issue Brief on Community-Based Long-Term Care, 2001) reports three primary areas of state initiatives: 1) expanding respite care for family caregivers; 2) managed care projects; and 3) empowering consumers through cash payment of benefits or paid case management by self or relatives. Additionally, the following recruitment & retention strategies were recently initiated:

STATES	TASK FORCE / STUDY COMMITTEE	INCREASE WORKER WAGES[1]	CAREER LADDER INITIATIVES[2]	INCREASE ACCESS TO HEALTH INS.	INCREASE PROVIDER REIMB.	INCREASE TRAINING REQUIR.	OTHER[3]
Arizona	X				X		
Arkansas		X					
Colorado	X						
Deleware			X				
Georgia	X			X	X		
Iowa	X						
Kansas	X						
Maine		X	X		X	X	X
Massachusetts		X	X				X
Michigan	X		X				X
Minnesota		X	X		X		X
Missouri	X	X					X
Montana		X	X				
Nevada	X		X				X
New Jersey		X		X			
North Carolina	X		X	X	X		
North Dakota		X					
Oregon	X						
Pennsylvania	X	X		X			
Rhode Island	X	X		X	X		
Vermont	X	X		X			
Virginia	X		X				
Washington		X				X	X
Wisconsin	X	X	X			X	X
	15	13	10	6	6	3	8

[1] Required pass-through, shift differentials, transportation reimbursement, on-duty meals.
[2] Curricula for CNAs to qualify as LPNs; advanced training for CNAs; career advancement certification for CNAs; new job classification of Senior CNA; training to administer medication; new job classification of Medication Aide; new job classification of Nurse Aide II with additional training requirements; collaboration with community colleges to develop career ladders for LTC workers; guidelines for training & testing unlicensed workers.
[3] Funding to increase staffing ratios; funding for training scholarships; funding for staff development & training initiatives; funding for worker appreciation initiatives; establish web-based training in collaboration with community colleges; expand scope of duties for aides; reduce paperwork.

A

Attachment

Direct CareGiver Association

P.O. Box 65597 · Tucson, AZ 85728-5597 · (520) 360-8124

Nationally, we are experiencing an alarming lack of Certified Nurses Aides (CNAs) and Certified Caregivers. These key health care worker classifications are found in assisted living centers, private homes, nursing homes, retirement communities, and home care agencies. For the most part, these professionals address the personal care needs of our loved ones and elderly neighbors. They do this on a daily basis, often with great compassion and dedication, yet as a group, they are some of the worst compensated and poorly benefited of American workers.

National projections indicate that the need for qualified individuals in this critical field will more than double in the next 20 years. Yet there currently exists a mere handful of programs that seek to address the need to create the skilled, highly professional workforce that will be required in the relatively-near future as the "Baby Boomer" generation retires.

To be able to attract the best, most talented health care workers to this growing field, we must take steps now to create exceptional educational and mentoring opportunities for these caregivers, as well as establish a recognized career track for advancement in the long-term care field. At present the Direct Caregiver Association is in the forefront of addressing these issues on a local basis in Southern Arizona. It is our intention that we provide the model that will eventually be replicated nationwide in other communities.

The Direct Caregiver Association is a self-sustaining, not-for-profit organization that seeks to bring innovation, solid planning and creativity to the task of professionalizing and certifying individuals interested in becoming Caregivers to serve our country's rapidly growing senior population.

The Direct Caregiver Association's goals include:

- **Public Education and Awareness** – Educate the general public and consumers of healthcare about the crisis facing the long term care industry and the existing obstacles that stand in the way of recruiting and retaining qualified, trained caregivers.

- **Direct Caregiver Training** – Develop a comprehensive healthcare training program that will become a national model for use in recruiting, screening, training, placing, and retaining qualified individuals to work as Certified Nursing Assistants and Certified Universal Caregivers.

- **Caregiver Resource Center** – To develop a model Caregiver Resource Center that would provide career counseling, training, continuing education, professional development and ongoing support to the Direct Caregiver.

- **Accreditation of Direct Caregivers** -- Create a community-wide accreditation model that would raise the standard of care provided by workers who are employed in the industry or work privately.

Direct CareGiver Association

P.O. Box 65597 · Tucson, AZ 85728-5597 · (520) 360-8124

PROVIDER MEMBERS

- Atria Campana Del Rio
- Carestone Assisted Living
- Cascades Retirement Properties, Inc.
- Catalina In-Home Services
- Dependable Nurses
- Desert Steppes Adult Care
- Elderhaven
- Handmaker Jewish Services
- Odyssey HealthCare, Inc.
- Regent/Canyon Crest Assisted Living
- Santa Catalina Retirement Community
- The Forum at Tucson

SUPPORTING ORGANIZATIONS

- Alzheimer's Association
- American Parkinson Disease Association
- Finley Distributing Co.
- Kindred Hospital
- Primavera Services
- Southern Arizona Alzheimer's Association
- Tucson Medical Center

PROFESSIONAL COUNCIL

- Kate McMillan, Esquire
- Kay Richter, Esquire

Direct CareGiver Association

P.O. Box 65597 · Tucson, AZ 85728-5597 · (520) 360-8124

BENEFITS TO PROVIDER MEMBERS

- Monthly continuing education for your employees who are Certified Nurses Aides and Certified Caregivers.
- Direct Caregiver employee access to support services to assist with family and personal issues.
- Access to pre-screened, qualified caregivers through the Direct CareGiver Association Job Placement Program.
- Meetings for Providers
- Workshops and seminars for your management and nursing staff.
- Quarterly Newsletter
- Membership directory listing.

SENATE AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

Notes from 8/29/01 Flip Chart

Information Requested

Funding sources
Number of workers, including faith based volunteers and unpaid family members
Trends in caregivers' salaries
Comparison to other service industries (restaurants, hotels, etc.) & professions (teachers)
Turnover rates, vacancy rates & average tenure
Demographics of caregivers, including settings
Cost structures & contracting methods
Real cost to provide services:

- Benefit packages
- Supervision
- Overtime costs
- Cost of recruitment
- Training
- Administrative costs
- Ancillary workers – aides, food services, etc.

Trends in settings; HCBS & residential; systemic movement, not linear
Training requirements
Available training programs
Temporary workers, nurse registers & other pools of people
Career ladder
Projected need for caregivers

- optimistic, pessimistic, median
- short term vs. over 10 years
- systemic

Issues Identified

What is a "successful" outcome?
Nursing shortages
Shortage of home care agencies as well as caregivers
Quality of care issues
Ways to encourage independence and treat with dignity
Specialized rural issues; travel, fewer staff, access to services
Developmentally disabled; special needs; infants, children, disabled, aging
DD caregivers cannot be over 40 due to lifting requirements
Waiting lists
Consumers who cannot access ALTCS or private providers
Complexity of the system
Multiple funding sources & corresponding performance requirements

Attachment C

Technology
Effects of regulation/ need for oversight
State workers' pay & benefits vs. private providers' pay & benefits
Caregivers' needs
Respite care
Consistency in training curriculum
Training mechanisms
Level of care tied to caregiver qualifications
Value of accreditation

Possible Sources

Interagency Council on Long Term Care
Statewide Health Insurance Plan Task Force
National Family Caregivers Association
State Board of Nursing (survery)
Arizona Health Care Cost Containment System (AHCCCS)

SENATE AD HOC ON CAREGIVER WAGES AND WORKFORCE DEVELOPEMENT
ARIZONA LONG TERM CARE SYSTEM FUNDING
September 18, 2001

I. WHAT IS ALTCS?

AHCCCS Administration
- ✓ Acute Care Programs (Acute, KidsCare, Prop. 204)
- ✓ Other Programs (Health Care Group, Premium Sharing, Pharmacy)
- ✓ **Arizona Long Term Care System (ALTCS)** (Elderly and Physically Disabled, Developmentally Disabled)

II. WHO DOES ALTCS SERVE?

✓ Elderly and Physically Disabled
20,029, recent growth rate has been approx. 8% +
50.5% Home Based Services, 49.5% Nursing Facilities

✓ Developmentally Disabled
12,453
99% + Home Based Services

III. COVERED SERVICES AND SETTINGS

Services:
- Acute Medical Care
- Behavioral Health Services
- Nursing & Home Health Aide Services
- Adult Day Health
- Personal Care / Attendant
- Durable Medical Equipment / Medical Supplies
- Nursing Facility Services

Settings:
- Own Home
- Alternative Residential Setting
- Nursing Facility

IV. THE FUNDING

- Elderly and Physically Disabled
  - SFY 2002: $633 million
  - SFY 2003: $695 million
  - ✓ Federal Share: 65%
  - ✓ State/County Share: 35%
    - SFY 2002: State – 23%, County – 77%
    - SFY 2003: State – 25%, County – 75%

- Developmentally Disabled
  - SFY 2002: $404 million
  - SFY 2003: $467 million
  - ✓ Federal Share: 65%
  - ✓ State Share: 35%

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Attachment 3

Arizona Long Term Care System Model

September 1, 2001

Potential ALTCS Member

2,300 Applications/Month

Financial/Medical Eligibility

1. Citizen/Qualified Alien
2. AZ Resident
3. $2,000/$3,000 Resources
4. $1,593 Income Maximum[1]
5. Transfer of Resources
6. SSN
7. Medical Eligibility/PAS (Need LOC in NF)

ALTCS Program Contractor

	Enrollment
DES-DDD	12,453
Maricopa County	8,295
Pima County	3,117
Lifemark	2,977
Tribes	1,312
Yavapai County	970
Cochise County	810
Pinal County	692
FFS Regular	1,856
Total	32,482

Enrollment as of 9-1-2001

32,482 Enrolled as of 9/1/2001 } 12,453 DD, 20,029 EPD

PCP/ CASE MANAGER

Covered Services

Acute Care Services
Nursing Facility
ICF/MR
Hospice } 50.5% of EPD, 1% of DD
Behavioral Health
HCBS } 49.5% of EPD and 99% of DD

- Homemaker
- Personal Care
- Respite Care
- Attendant Care
- Home Health Nurse
- Home Health Aide
- Transportation
- Adult Day Health
- Home Delivered Meals
- DD Day Care
- Habilitation

KEY

EPD - Elderly & Physically Disabled (Age 65+, Blind or Disabled)
DD - Developmentally Disabled
ICF/MR - Intermediate Care Facility for Mental Retarded
LOC - Level of Care
NF - Nursing Facility
PAS - Pre Admission Screening

[1] Income Limit is 300% of SSI maximum and increases annually in January

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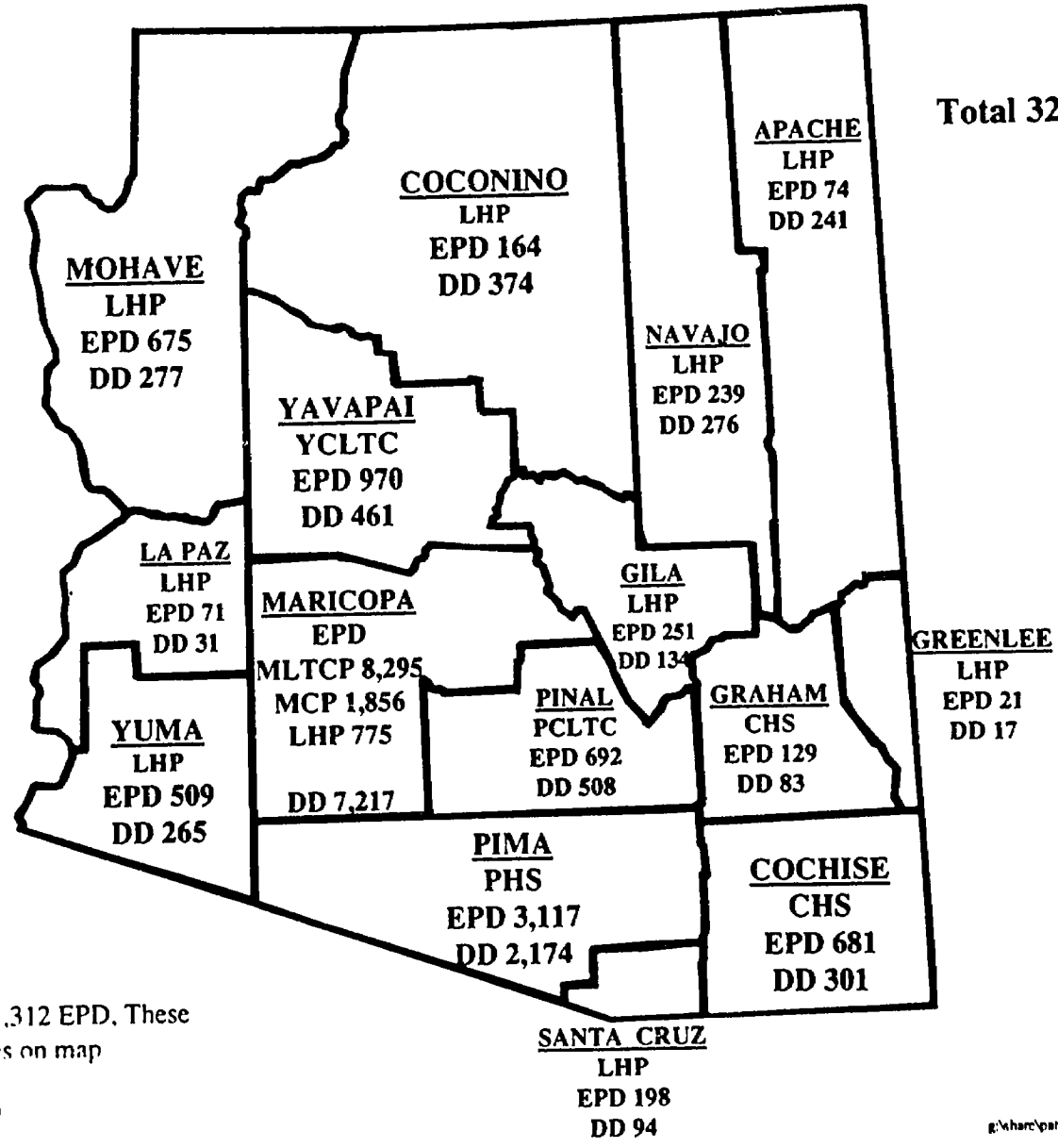
ALTCS Enrollment by County

September 1, 2001



LHP = Lifemark Health Plan
MCP = Mercy Care Plan
MLTCP = Maricopa Long Term Care Plan
PHS = Pima Health Systems
PGLTC = Pinal Gila Long Term Care
CHS = Cochise Health Systems
YCLTC = Yavapai County Long Term Care

American Indian Contractors = 1,312 EPD. These members are not shown in figures on map

Source: Enrollment/Eligibility Status Report

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ALTCS Population Ages

June 1, 2001

Age	Total*	% of Population
0-3	1,230	3.9%
4-6	1,615	5.1%
7-12	2,575	8.1%
13-18	1,903	6.0%
19-20	510	1.6%
21-64	9,535	30.1%
65+	14,354	45.2%
Total	**31,722**	**100 %**

* Population numbers not broken out by EPD and DD

ALTCS MEDICAL ELIGIBILITY

EPD

An A/R who needs the entry level of care will require care greater than what is considered supervisory care and may present a combination of the following needs or impairments:

1) requires nursing care by or under the supervision of a nurse on a daily basis;
2) requires regular medical monitoring;
3) impaired cognitive functioning and psychosocial deficits;
4) impairments in ADLs and incontinence:

- bathing
- dressing
- grooming
- mobility
- toileting
- eating
- transfer

DD

An A/R who needs the entry level of care will require care greater than what is considered supervisory or custodial care and may present a combination of the following needs or impairments:

1) requires 24 hours supervision;
2) requires an intensive, multidisciplinary, continuous training program;
3) requires a trained caregiver;
4) requires regular medical monitoring;
5) requires intervention for significant behavior problems;
6) has significant impairments in development or independent living skills; and
7) has impaired communication.

ALTCS Living Arrangements

Acceptable living arrangements for an ALTCS applicant are:

- Medical Institutions
  - Nursing Facility
  - Intermediate Care Facility for the Mentally Retarded
  - Residential treatment facility if under age 21
  - Psychiatric hospitals if under age 21 or age 65 or older (placement limited to 30 days for persons age 21 through 64)
  - Hospice
- Home and Community Based Services
  - Home
  - Alternate Residential Settings
    - Adult Foster Care Home
    - Adult and Child Development Home
    - Group Home
    - Behavioral Health Center (Levels I, II and III)
    - Center for the Traumatically Brain Injured
    - Assisted Living Center Unit (a facility that provides units to 11 or more residents)
    - Assisted Living Home (provides rooms for 10 or fewer residents)
    - Alzheimer's Treatment Facility (pilot project in Maricopa and Yavapai Counties)
    - Therapeutic Foster Care Home
    - Rural Substance Abuse Center

SENATE AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

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Multiple funding sources & corresponding performance requirements

Attachment 4

Technology
Effects of regulation/ need for oversight
State workers' pay & benefits vs. private providers' pay & benefits
Caregivers' needs
Respite care
Consistency in training curriculum
Training mechanisms
Level of care tied to caregiver qualifications
Value of accreditation

Possible Sources

Interagency Council on Long Term Care
Statewide Health Insurance Plan Task Force
National Family Caregivers Association
State Board of Nursing (survery)
Arizona Health Care Cost Containment System (AHCCCS)

The 21st Century Workforce Shortage and Implications for Health and Human Services Agencies

Facts and Figures From "The APHSA State Government Summit on the Workforce Crisis"

Michael Cheek, Project Director, APHSA Center for Workers with Disabilities

DRAFT

For several years, researchers have been predicting a significant increase in demand for long-term supports and services driven by the number of Americans who will be age 65 or older by the year 2030. Experts have indicated that in that year, one in every five U.S. citizens will be an elder.

Concurrently, the number of individuals with chronic illnesses and/or life-long disabilities also has increased in part because of unprecedented advances in medical technology yielding longer survival rates. The combined effect in coming years will be an unprecedented increase in the portion of the U.S. population either with a disability and/or of advanced age who also will need long term care supports.

Leading researchers in the field have indicated that demand for community-based residential staff for persons with mental retardation and developmental disabilities will increase by 54.1 percent. While demand for home health and personal care attendants will increase by 46 percent and the demand for human service workers and assistants will increase by 73.4 percent.[1]

In addition to rising demand, long-term care settings, facility-based or community-based face increasing competition for workers from both outside of and within the human services field. For example, fast food services, retail stores and other portions of the service and hospitality industry for workers are direct competition. The average starting wage for nursing home staff is $8.46, for home health,$8.58, while retail workers often start at $8.12 – slightly less money for monumentally less demanding work.

Because of lower wages and other job-related issues, such as professional image, researchers at the University of Minnesota Institute on Community Integration have found that the turn-over rate of employees in public facilities serving persons with mental retardation and developmental disabilities, nationwide, is approximately 62 percent. Vacancy rates average 12 – 23 percent.

Turn-over rates for nursing home certified nursing assistants (CNAs) was found to be even higher – 63 to 100 percent with a cost per higher between $2,500 to $4,000. Research conducted on employment in other areas of long-term care, including community-based services for persons of

[1] Hewitt, Amy, Ph.D. University of Minnesota, Institute on Community Inclusion. November, 2000.

Attachment 5

advanced age and persons with mental illness, found similar results.[2]

The Big Picture. Further complicating matters is that the workforce shortage also is poignantly felt in virtually every part of the human services industry – including acute (out-patient and in-patient) health care services and child welfare services.[3] Health care workforce shortages areas include registered nurses, direct care workers (described above), pharmacists, dentists, information specialists, medical coders, and the entire mental health workforce.

Of this segment of the U.S. workforce, the nursing has received the most attention and offers an in depth look at today's direct care workforce. Researchers agree that the following factors impacting on the registered nursing (RN) workforce are present in other service areas:

- The majority of workers are female;
- The mean age of a working RN is 42.5;
- The average age of new RNs in 1999 was 35.5 years for individuals holding an associate degree and 30.8 years for BSNs; and
- The number of individuals entering the RN profession is decreasing.

Thus, while future demand is mounting, the workforce that society is currently reliant upon and hopes to use a the foundation for meeting out-year demand is, itself, part of the baby-boom generation.[4] In fact, 47.5 percent of today's long term care workforce is estimated to be part of the baby-boom generation who likely will either have aged parents to care for in the near future and/or may need support themselves in the out-years.[5] Similar data has been compiled for other direct care service areas.

In addition, the supply of workers has been, and is likely to continue, declining. Generally speaking, birth rates among Generation X members are lower than their predecessors producing a smaller pool of potential workers. Additionally, a higher percentage of the general workforce is composed of "white collar" workers, as the U.S. continues its shift from a manufacturing to an information-based economy.

The combined effect of increased competition, lower wages, and other economic factors, has created enormous barriers to recruiting and retaining competent direct contact workers across the nation and, in turn, made it increasingly difficult for services agencies to maintain continuity of care in acute health care settings and for the rising number of persons of advanced age and persons with chronic physical, developmental, and/or psychiatric disabilities. Given current demographic trends, the situation is likely to grow much more serious in the years ahead unless public policymakers take effective steps to rectify the problem.

Whether the topic is home services workers for frail, older persons, personal attendants for working age persons with disabilities, child welfare workers, or acute health care services, public dollars are ultimately chasing the same dwindling pool of workers.

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[2] State Government Summit on the Workforce Crisis; June 1, 2001. Chicago, IL. See description in the closing section of this document.

[3] In May, 2001, APHSA and the Child Welfare League of America produced a special report, entitled "*The Child Welfare Workforce Challenge*," documenting the crisis in welfare services for children.

[4] Salsberg, Edward, S., Ph.D. Center for Health Workforce Studies, State University of New York; June 2001.

[5] Hewitt, Amy, Ph.D. University of Minnesota, Institute on Community Inclusion. November, 2000.

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[4] Salsberg, Edward, S., Ph.D. Center for Health Workforce Studies, State University of New York; June 2001.

[5] Hewitt, Amy, Ph.D. University of Minnesota, Institute on Community Inclusion. November, 2000.

Already, concerns on this point have arisen following the Health Care Financing Administration's (now the Centers for Medicare & and Medicaid Services) announcement of its intent to promulgate "minimum staffing" requirements in nursing facilities and the provision of additional federal funds to support institutional staffing. Such piece-meal initiatives potentially could pull personnel resources from community-based services towards more costly institutional settings. Unless affected state agencies build collaborative strategies for addressing the work force issue, they may find themselves in mutually destructive competition for direct service staff with one another.

Workforce Summit. On June 1, the American Public Human Services Association (APHSA) an affiliate, the National Association of State Medicaid Directors (NASMD), the APHSA Center for Workers with Disabilities, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), the National Governors' Association (NGA), the National Association of State Units on Aging (NASUA), and the National Association of State Mental Health Program Directors (NASMHPD) held a meeting of state government organizations to address the growing chasm between the demand for long-term or continuing care services and supports and the availability of qualified, well-trained direct service staff.

Other organizations in attendance included the National Conference of State Legislatures (NCSL), the Association of State and Territorial Health Officials (ASTHO), and the National Association of State and Territorial AIDS/HIV Directors (NASTAD).

Points of discussion included: (1) the scope and scale of the workforce crisis; (2) current strategies being used by states and localities to reduce workforce shortages; (3) new ways state government agencies and their representative organizations can collaborate to address the workforce issue and, concurrently, reduce redundant and conflicting initiatives.

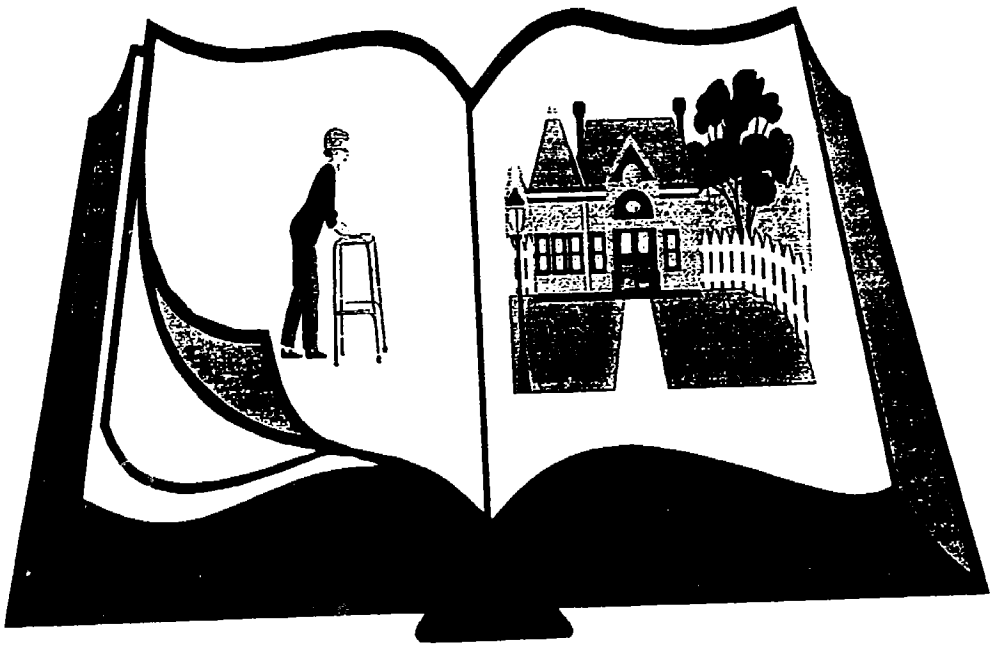
Specific action steps suggested by meeting participants for the state government work group included:

- Pursuit of changes in federal law and rules;
- Garnering Private Sector Support;
- Linkage with Systems Change Grants Technical Assistance Center;
- Educate consumers, providers, and legislators on the necessity for a broad-based public initiative;
- Garner training dollars from private sector;
- In reach to schools in order to grow interest in health and human services jobs;
- Linkage Workforce Investment Act One Stops and Workforce Investment Boards;
- National Skills Standards Board -- secure their attention and define LTC jobs;
- Creative supplementation of direct support staff in long term care with assistive technology and environmental modification;
- Support family members who are providing long term care;
- Work with advocacy organizations on develop a unified movement;
- Develop data - work with DOL to refine their fields and collection methodology;
- Look to providers for innovations;

- Continue to promote efficiencies in home and community based services settings; and
- Address competition issue between institutional care and home and community based services.

Arizona's Community Based Services and Settings Report

October, 2000



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and The Arizona Department of Economic Security
www.de.state.az.us

Attachment 6

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Report Summary

What is the Community Based Report?

The Community Based Services and Settings Report is a project to forecast and plan for the needs of the elderly and physically disabled (EPD) needing long-term care services in Arizona. This report shares data, trends, and findings from the two major long-term care home and community based programs managed by the Department of Economic Security (ADES) and Arizona Health Care Cost Containment System (AHCCCS). The ADES program is called Non-Medical Home and Community Based Services (NMHCBS). The AHCCCS program is called Arizona Long-Term Care System (ALTCS).

The concept, research, and drafting of this report was a collaborative effort of the community based project task force (see Appendix E). The members of the task force represent different regions of the state and include government and advocacy entities.

Goals and Objectives

The goal of the task force is to produce a bi-annual report that will be used by the task force and other entities to plan and forecast the needs of long-term care customers in the area of NMHCBS and the Medicaid Home and Community Based Services (HCBS) programs. The objectives of the task force in creating this report are to:

- Provide administrative and demographic data;
- Identify implications based on the data; and
- Share data and implications with other interested parties planning for growth.

Note: Bi-annual rotation will begin in Fiscal Year 2001 to coincide with the state budget cycle.

Background

"If Arizona is going to meet the challenges and maximize the opportunities that the growth in our senior population is going to present, we need to seriously evaluate and start to plan for the health, housing, transportation, economic stability and many other needs that such growth brings."[1]

As the persons with disabilities and the aging populations grow in Arizona, the demand for NMHCBS and ALTCS will increase. Some of the demographic realities facing Arizona now and in the future are:

- In 1996, there were approximately 4.5 million people living in Arizona;[2]
- This is anticipated to increase to 9.8 million people in Arizona by 2040;[3]
- The number of persons 55 or older will increase from about 900,000 in 1995 to more than 2.1 million by 2020;
- By 2014, the number of persons 85 or older will double to approximately 149,000 and comprise 14% of the population aged 65 or older;

Continued on next page

[1] 72nd Arizona Town Hall and University of Arizona (1998). "Meeting the Challenges and Opportunities of Arizona's Growing Senior Population," pp. 1-3, Tucson, Arizona.
[2] AZ Department of Economic Security, Research Administration, Population Statistics Unit (1996 and 1997), Phoenix, AZ
[3] AZ Department of Economic Security, Research Administration, Population Statistics Unit (1996 and 1997), Phoenix, AZ

Background, Continued

- Currently 110,000 non-institutionalized Arizonans age 65 or older need some type of assistance with mobility or self-care;
- In 1989, the median income for a single male 65 years of age or older was $13,210 versus single women who were at $10,320;
- Arizona Native Americans account for 17% of the Native American population in the United States aged 65 or older;[4] and
- The ALTCS budget is approximately 30% of the total AHCCCS budget for 4% of the population.

In addition to the escalating growth for long-term care research needs, there is a national push by the disability community (elderly and physically disabled) for more input into their care. This is called "consumer directed care" or "person centered planning." This is further supported by the numerous articles that articulate the fact that the "baby boomers" will want more involvement in their current and future needs.[5]

Arizona must pay attention to upcoming issues regarding baby boomers. "The most significant is the fact that the baby bust generation (generation following the baby boomers) constitutes a much smaller proportion of the population than the baby boomers. As a result, there will be fewer working-aged adults to support the needs of a large elderly population through their economic productivity and tax revenues."[6] There is an increasing prevalence of caregivers in the workforce, thus increasing the need for outside services.[7]

This is even more important in a state like Arizona where the HCBS programs show an overall sustained growth. NMHCBS had a 14% overall growth in the last four years and the ALTCS population had an overall growth of 21% with an 8% population growth in HCBS. With the growth, comes an increase in expenditures. NMHCBS expenditures have grown by 9%. ALTCS/HCBS expenditures have increase by 40%. The good news however, is that for the ALTCS program, the state is listening to the consumers and increasing the percentage of persons living in the community. This is also a cost effective way to manage the long-term care program. Meanwhile, the capitation has remained almost constant from 1996 to 1999. This is because it is cost effective to have consumers live in their own homes or in alternative residential settings.

About the Report

The report is divided into four chapters:

- Who do we Serve?
- What are the Trends in Enrollment?
- Where Does Program Funding Come From?
- How is the Money Spent?

Continued on next page

[4] 72nd Arizona Town Hall and University of Arizona (1998). Arizona Department of Economic Security Projects, Tucson, Arizona.
[5] Accountability Action – Volume 4: Issues 1 and 2 (fall, 1999 / winter, 2000). "The Need is Real, the Time is Right," published by the Foundation for Accountability, Portland, Oregon
[6] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.
[7] Aging Initiative: Project 2030 (December, 1998). "Final Report," p. 47, St. Paul, Minnesota.

About the Report, Continued

The report is primarily limited to information dealing with Arizona' s NMHCBS program and the ALTCS Program for SFY and FFY 1999. Other limitations include:

- NMHCBS utilizes the state fiscal year (SFY) calendar for annual reporting (7/1-6/30);
- ALTCS utilizes the federal fiscal year (FFY) calendar for annual reporting (10/1-9/30); and
- NMHCBS and ALTCS use similar data collection methodologies, but parameters may differ (e.g. age ranges).

The task force opted to focus on the EPD ALTCS and NMHCBS population. For more detailed information, including national comparisons, the reader may wish to review the 1998 Community Based Services and Settings Report presented by the community based project task force located on the Internet at http://www.ahcccs.state.az.us/Publications/reports.htm.

Policy Directions

Now is the time to increase our understanding of the economic trends and their intersection with demographics. Future growth and increased demands on the current structure require creative and innovative strategies from the community, for profit, non-profit and governmental agencies. Some findings that may have an impact on Arizona' s policy directions are highlighted below.

- Shifts in attitudes about the roles and responsibilities for formal providers of care;
- Aging population expected to reach 9.8 million people in Arizona over the next forty years;
- Changes in the roles carried out by the informal family support system;
- Cost and mandates of NMHCBS;
- Access, availability, and increased delivery of quality NMHCBS and ALTCS HCBS; and
- Maintaining a sufficient labor force to address the demand for services.

Conclusion

Nationally, both President Clinton and the United States Department of Health and Human Services (HHS) Secretary, Donna Shalala, have expressed their commitment to expanding access to home and community-based services for persons of all ages with disabilities. They stated, "We are eager to continue to work with states to help more individuals become aware of services and supports available to them in the community, and transition out of nursing homes if that is their choice."[8b] Arizona needs to take advantage of this momentum and act on its policy directions with input from current and future consumers.

For two years, the community based taskforce has identified and discussed the need to share data and work collaboratively to forecast and plan LTC HCBS services. The goal of sharing data and implications has been accomplished by producing this report. The next steps for the taskforce call for maintaining momentum by continuing to:

- Share data;
- Identify gaps, forecast and plan for the future needs of LTC accordingly;
- Collaborate on key policy implications (e.g., additional needs and service gaps); and
- Monitor the progress of the efforts.

Both ADES and AHCCCS are committed to maintaining a range of services and supports for EPD Arizonans that seek to provide the population with choices in the maintenance of independence and dignity, while also addressing the needs of their caregivers.

[8b] Health and Human Services (HHS) letter dated May, 2000.

Chapter 1: Who do we Serve?

Introduction

Currently, there are at least 265 million people living in the United States.[9] In 1996, there were approximately 4.5 million people living in Arizona.[10] This is anticipated to increase to 9.6 million people in Arizona by 2040.[11]

"In Arizona, the Department of Economic Security projects that the number of citizens 55 or older will increase from about 900,000 in 1995 to more than 2.1 million by 2020. By 2014, the number of persons 85 or older will double to approximately 149,000 and comprise 14% of the age 65 or older population. Currently, 110,000 non-institutionalized Arizonans age 65 or older need some type of assistance with mobility or self-care. [12] The information that follows describes the characteristics of individuals we serve in both Arizona HCBS program populations.

Fast Facts

NMHCBS and ALTCS populations demonstrate similarities in both gender and ethnicity. Both programs serve mainly women, 66 and 67% respectively. The primary consumer in the NMHCBS program is a white female between the ages of 75 and 89. In the ALTCS program, the primary customer is a white female between the ages of 80 and 89. They also serve similar ethnic populations.

The two programs have key differences in the age populations they serve. ALTCS serves a larger percentage of younger individuals as well as a larger percentage of very old individuals as compared to NMHCBS. The following statistics provide verification.

Program	Age Group	Percentage
ALTCS (EPD Only)	0 to 64*	24%
	90 and older	18%
NMHCBS	0 to 60**	10%
	90 and older	10%

* ALTCS Physically disabled (non-DD) children aged 0 to 21 have grown steadily since 1993. Examples of children within the program are: Ventilator dependent; Muscular disorders; Spina Bifida; and Behavioral health disorders organic in nature.

** By design, the NMHCBS program serves under 60 with a documented disability.

A typical in-home consumer will be a white female in her 80s who has sufficient activity of daily living (ADL) deficits such as bathing and instrumental activity of daily living (IADL) deficits such as shopping, laundry, and housekeeping to warrant assistance. Deficits are due to the aging and disease processes. Anecdotally, the NMHCBS program may keep consumers from entering into the ALTCS program by quickly providing services that help them maximize their independence at an earlier stage in the need for assistance.

Usually those consumers in the ALTCS program have more functional and medical needs. There are however, consumers in the NMHCBS program who are very frail but do not qualify for ALTCS because of income.

Note: Future reports will track and compare demographic changes in the populations

Continued on next page

[9] AARP. (1998). Across the States 1998; Profiles of Long-Term Care Systems, pg. 5. Washington, D.C

[10] AZ Department of Economic Security, Research Administration, Population Statistics Unit (1996 and 1997), Phoenix, AZ

[11] AZ Department of Economic Security, Research Administration, Population Statistics Unit (1996 and 1997), Phoenix, AZ

[12] 72nd Arizona Town Hall and University of Arizona (1998). Tucson, Arizona.

Implications

With the trended growth of the Arizona population as stated in the introduction, both programs can expect a steadily increasing aging and disabled population.

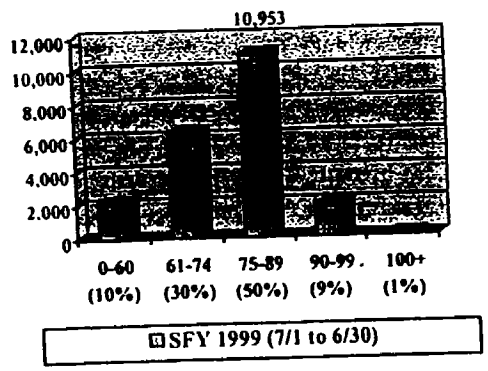
This may be compounded by the fact that there is an increasing prevalence of caregivers in the workforce, thereby decreasing the caregiver pool that has traditionally stayed at home. "The most typical employed caregiver, according to the U. S. Department of Labor, is a woman in her mid-forties who is employed and provides, on average 18 hours of care per week for her mother who either lives with her or nearby."[13] "According to a survey by the National Family Caregivers Association in Kensington, Maryland, 61% of those who have been caregivers for an extended period of time report feeling depressed, and 67% report being frustrated."[14] Two issues may then occur:

- The working caregivers need respite and request it from the HCBS programs (see growth in the respite program in the enrollment chapter); and/or
- The consumer may need more care than can be provided by the caregiver and requests it from the HCBS programs.

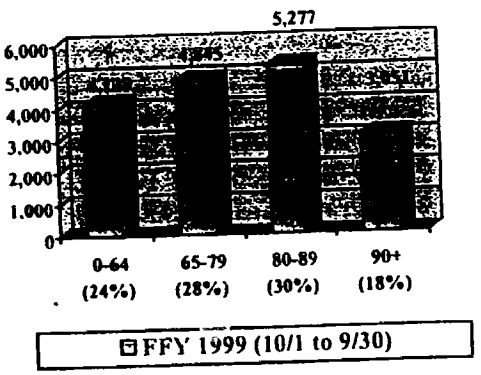
Age

The following charts show the differences and similarities between age cohorts, for both gender and ethnicity in NMHCBS and ALTCS.

NMHCBS



ALTCS (Nursing Facilities and HCBS)



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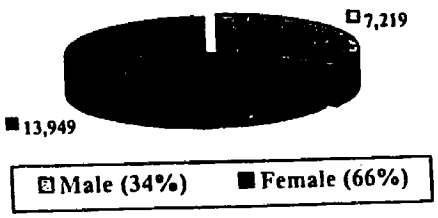
[13] Aging Initiative Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.
[14] Gauzer, Bernard (July, 2000). "How Can We Help," p. 4 and 5, Parade, Arizona Daily Star, New York, Now York.

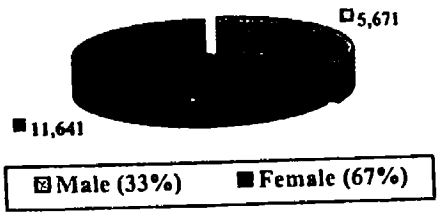
Gender

Both programs serve primarily women (65% NMHCBS and 67% ALTCS). ALTCS served 43% of its population in the community in FFY 1999.

NMHCBS (EPD population: 21,168)

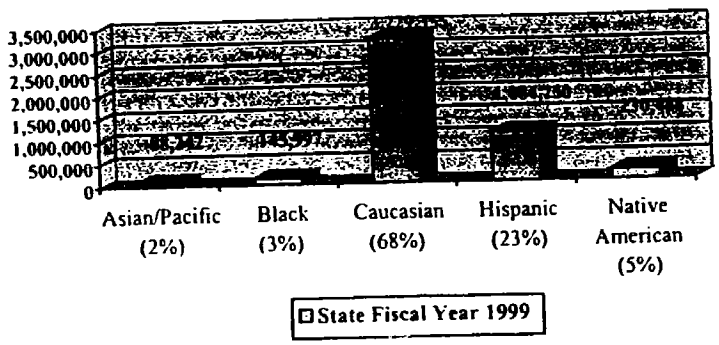


ALTCS (EPD population: 17,312)
(HCBS and Nursing Facility)



Arizona's General Population

A graph of the general population for Arizona has been included to compare the ethnicity of the general population to those in both programs. July 1, 1999 Arizona population estimate.

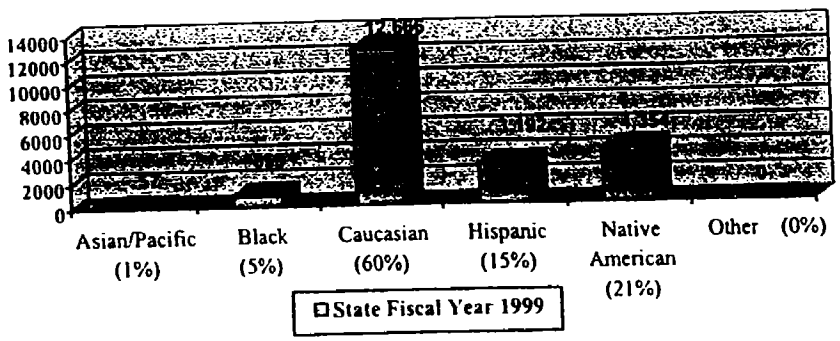


Source: Population Estimates Program, Population Division, U.S. Census Bureau.

Ethnicity

Both programs serve similar ethnic populations.

NMHCBS



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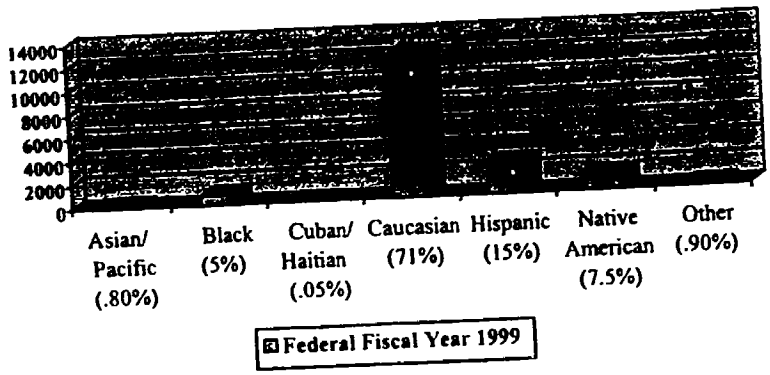
ALTCS (Nursing Facilities and HCBS)



Chapter 2: What are the Trends in Enrollment?

Introduction

"If Arizona is going to meet the challenges and maximize the opportunities that the growth in our senior population is going to present, we need to seriously evaluate and start to plan for the health, housing, transportation, economic stability, and many other needs that such growth brings."[15] Demographics coupled with the following information, when trended over time, may assist policy makers and stakeholders with future strategies in servicing this growing population.

Fast Facts

NMHCBS and ALTCS have seen an increase in demand for services as a result of growth in both programs. NMHCBS enrollment has grown 14% since 1996 (18,227 to 21,168). Service needs in NMHCBS changed from 1996 to 1999 (see Attachment C and page 5 for more details):

- Home health aid decreased by 26% as personal care increased by the same percentage;
- Home nursing has decreased in the same timeframe by 10%; and
- Respite has increased during this timeframe by 73% (Pent-up demand due to minimal funding prior to FFY 1997).

ALTCS HCBS population has grown from 35% to 43% of the overall EPD ALTCS population since 1996. Overall program growth for the last four years was 21% (12,788 to 16,187). The Joint Legislative Budget Committee (JLBC) has forecasted a 7% overall program growth:

- Nursing home enrollment has decreased by 4% of the total population since 1997 (1997=54% to 1999=50%); and
- With the advent of increased choice in settings, the number and percent of ALTCS members choosing alternative residential settings has increased significantly.

Implications

- The funding for the NMHCBS program has not grown proportionately to the expansion of this program' s consumer growth.
- The NMHCBS program operates on a fixed cost basis as it is not an entitlement. Due to this fact, the program has been unable to fully meet demands of those requesting and qualifying for services. There is a statewide waiting list of approximately 1,000 consumers as of June 30, 1999.
- The NMHCBS program shifted many consumers to personal care service (more cost effective) from home health aid service based on newly developed criteria. Although this enabled the program to serve more consumers, it is believed that the program needs an infusion of funds as it has maximized cost efficiencies.
- Continued growth in both programs means continued and increasing demands on the professional and paraprofessional work force which is already strained.
- Innovative strategies are needed to continue to sustain consumers in their own homes.
- Nationally, there is a concerted effort by the disability community for input in their care. This is called "consumer directed care" or "person centered planning". Numerous articles are also articulating the notion that the "baby boomers " will also want more involvement in how their current and future needs are met.[16]
- Alternative residential settings must continue to expand. Consumers who can not maintain themselves in their home, but are not ready for a nursing facility, need alternative choices.
- Consumers will continue to need assistance with coordination of care/services via some type of case management or care coordination (case management is described in Appendix B).

Continued on next page

[15] 72nd Arizona Town Hall and University of Arizona (1998). Tucson, Arizona.

[16] Accountability Action – Volume 4: Issues 1 and 2 (fall 1999 / winter 2000). "The Need is Real, The Time is Right," published by the Foundation for Accountability, Portland Oregon.

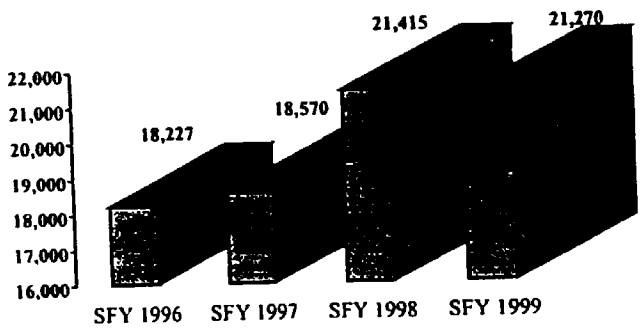
NMHCBS

The NMHCBS program has grown by approximately 14% (18,227 to 21,168) in the last four years. However, the program did see a 1% decline in enrollment from 1998 to 1999. This slight decrease is attributable to:

- Consumers transitioning to ALTCS;
- Increased adherence by case managers to the functional eligibility criteria;
- Decreased applications in the SSI population since the $70.00 payments for the housekeeping are no longer available;
- Fixed cost, meaning no additional funds were available to accommodate demand; and
- Potential consumers on the waiting list were not served.

Services

NMHCBS offers seven in-home services; adult day health care (ADHC), home delivered meals (HDM), home health aid (HHA), home nursing (NUR), housekeeping (HSK), personal care (PC), and respite care (RC). The graphs below illustrate the total number of unduplicated (counted only once) clients. Consumers may however, receive several services at one time (e.g., personal care, meals, and housekeeping).



Note: This includes individuals receiving Adult Day Health, Home Delivered Meals, Home Health Aid, Housekeeping, Personal Care, Respite Care, Home Nursing, and Case Management. Reflects an unduplicated count

Enrollment Growth

The table below illustrates the percentage of growth in enrollment from state fiscal year 1996 to state fiscal year 1999.

NMHCBS Service	% of Growth SFY 1996 to 1999	Explanation for Double-Digit Changes
Home Health Aid	-26% (Decrease)	Establishment of medical needs criteria for service; if it is purely functional, the consumer is given a personal care service
Home Nursing	-10% (Decrease)	Establishment of medical need criteria for service
Adult Day Health	1%	N/A
Housekeeping	6%	N/A
Home Delivered Meals*	22%	Native Americans are reporting consumer counts*
Personal Care	26%	Consumers began using personal care service if the assistance needs were functional in nature only and had no medical component
Respite Care**	73%	Increase in funding and better accounting of consumer use

*Duplicate counts – numbers may decrease for SFY 2000 with an unduplicated count.
**1996 – Pilot Project Region One. 1997 – Substantive additional state funding.

Continued on next page

NMHCBS Services SFY99

The table below illustrates the number of persons utilizing NMHCBS by service and by county.

N M H C B S (OWN HOME)

COUNTIES	HHA	PC	HOME NURSING	HSK	RESPITE	HDM	ADHC	Unduplicated Count
Apache	0	1	77	64	88	2701	0	2846
Cochise	19	119	102	390	33	525	0	877
Coconino	45	0	69	175	23	350	0	531
Gila	50	0	33	131	30	221	0	401
Graham	0	46	35	136	16	143	0	261
Greenlee	0	26	58	96	0	67	0	157
LaPaz	0	25	0	93	3	114	0	178
Maricopa	633	691	147	2665	113	3228	180	6585
Mohave	77	43	64	286	56	1069	0	1377
Navajo	58	28	91	188	23	486	0	691
Pima	2	698	141	1401	84	1358	163	3667
Pinal	131	72	254	218	14	428	0	1093
Santa Cruz	95	6	134	108	8	94	0	263
Yavapai	305	0	325	203	18	1175	27	1513
Yuma	38	47	13	235	26	467	31	930
Totals	1,453	1,802	1,543	6,389	535	12,426	401	21,270

Key: HHA =Home Health Aid, PC = Personal Care, HSK = Housekeeping, HDM = Home Delivered Meals, ADHC = Adult Day Health Care.

ALTCS / HCBS

Although nursing facility enrollment has increased since 1997 (9,166 to 9,460), as the percentage of the total population, it has decrease by 4%(54% to 50%). Conversely, the HCBS percent of the total population has increase by 4%.

ALTCS does not have enrollment figures by specific in-home services. However, AHCCCS has placement information that assists the program with trending consumer choices. The ALTCS HCBS program offers consumers the choice of living in their own home or in a community setting. The community settings are:

- Adult foster care (AFC);
- Assisted living home or center/unit; or
- Behavioral health (BH) setting.

The HCBS population is divided into "own home" and "alternative."

- The own home population has grown since 1997 (5,480 - 6,599). As a percentage of the total HCBS population it has decreased by 4% (88% - 84%).
- The alternative residential population has grown from 942 members in 1997 to 1,226 members in 1999. As a percentage of the HCBS population, it has grown 4% (12% - 16%).

Continued on next page

Alternatives

As a percentage of alternative residential settings, the following applies:

- AFCs, having the greatest number of consumers, has decreased from 73% in 1997 to 50% in 1999;
- Assisted living centers have increased from 11% in 1997 to 24% in 1999;
- Assisted living homes have increased from 16% in 1997 to 23% in 1999; and
- Behavioral health homes have increased from 4% in 1997 to 6% in 1999.

Note: See Appendix A for definitions.

ALTCS In Home Services & Settings

The chart below illustrates the number of persons receiving services in their own home or in alternative settings in the community by service/setting and county in FFY1999.

County FFY99	Home and Community-Based Services (HCBS)					
Apache	40	-	-	-	4	44
Cochise	240	1	-	-	9	250
Coconino	58	-	-	1	5	64
Gila	61	-	-	-	3	64
Graham	35	-	-	-	4	39
Greenlee	5	-	-	-	-	5
La Paz	26	1		-	-	27
Maricopa	3,485	397	176	49	60	4,167
Mohave	176	28	32	-	14	250
Navajo	112	-	-	-	20	132
Pima	948	126	67	23	92	1,256
Pinal	311	4	8	3	28	354
Santa Cruz	108	-	-	-	8	116
Yavapai	338	19		1	14	372
Yuma	128	-	11	-	16	155
Totals	6,071	.576	294	77	277	7,295

*Own Home means any combination of adult day health, home delivered meals, home health nursing and/or aid, housekeeping, personal care, and/or respite care delivered in the consumer's home.

Key: AFC= Adult Care Home; ALC= Residential Living Center; ALH= Assisted Living Home; Behavioral Health = Special TBI homes, licensed level II homes, and level I homes.

Total HCBS for all Counties: 7,295
Total Alternative Residential: 1,224 (18%)

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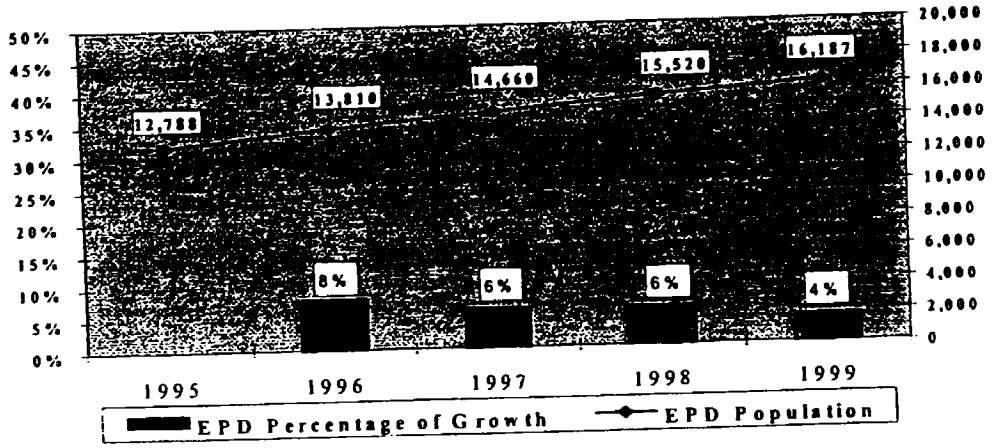
ALTCS / EPD Enrollment

The following graph includes statistics on Elderly and Physically Disabled enrollments from 1995 - 1999.

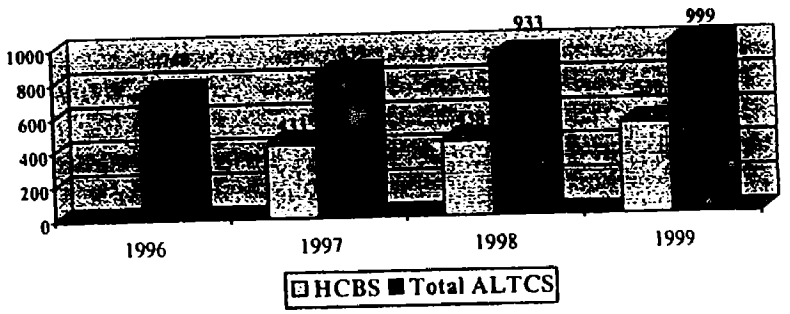


Note: Excludes "On Reservation " Native Americans.

ALTCS / HCBS Native American EPD Enrollment

The ALTCS Native American population resides either "On Reservation" or "Off Reservation." Most "off reservation" Native Americans (urban) are enrolled with the Program Contractor who provides services for that county. "On Reservation" Native Americans are either case managed by their tribe or by the *Native American Community Health Center (NACHC). There has been a steady increase in both total ALTCS population and in the number of consumers in HCBS. The increase in HCBS is attributable to the efforts of both the Inter-Tribal Council of Arizona (ITCA) and the Navajo Nation.

ITCA received a five-year grant in 1998 to target and assist tribes in their efforts to build HCBS networks. They have also been diligent in developing outreach programs with regard to the ALTCS program. The Navajo Nation has also made strides in developing an independent provider network as well as collaboratively working with their service units to increase workers for the ALTCS HCBS consumers who live on reservation. The chart below shows statistics on ALTCS Native American population growth. There has been a 25% increase in population during the last four years and 18% growth in HCBS during the last three years.



Note: 1996 HCBS statistics unavailable.
*Native American Community Health Center (NACHC) represents all other tribes not contracted with AHCCCS.

Continued on next page

ALTCS In-Home Services / Settings-Native American

The chart below illustrates the number of persons receiving services in their own home or in alternative residential settings in the community by tribe and services/settings in FFY1999.

	Home and Community-Based Services (HCBS)					
	*Own Home			Behavioral Hlth.		
Gila River	14	-	-	-	1	15
NACHC*	57	-	-	-	-	57
Navajo	323	-	-	-	-	323
Pascua Yaqui	16	-	-	-	-	16
San Carlos	5	-	-	-	-	5
Tohono O' Odham	69	-	-	-	-	69
White Mountain	44	-	-	1	-	45
Totals	528	-	-	1	1	530

*Own Home means any combination of adult day health, home delivered meals, home health nursing and/or aid, housekeeping, personal care, and/or respite care delivered in the consumer's home.

Key: AFC= Adult Care Home; ALC= Residential Living Center; ALH= Assisted Living Home; Behavioral Health = Special TBI homes, licensed level II homes, and level I homes.

Total HCBS for all Tribes: 530
Total Alternative Residential: 2

Chapter 3: Where Does Program Funding Come From?

Introduction

As the individuals with disabilities and the aging populations grow in Arizona, the demand for Non-Medical Home and Community Based Services (NMHCBS) and medically necessary long-term care (LTC) services (nursing facility and HCBS) will increase. These services are primarily funded by Medicaid (Title XIX), through the Arizona Health Care Cost Containment System (AHCCCS), and state services through the Arizona Department of Economic Security (ADES) (Title III/XX, and community funds). To further clarify the funding for both programs, more detailed information is provided in this chapter.

Fast Facts

- The majority of NMHCBS program dollars for home care (RN, HHA, PC, HSK, and ADHC) is from state appropriations (74%). This program is not an entitlement, but an appropriation. The state appropriation has remained at $8 million annually since 1994.
- The majority of ALTCS program dollars are from federal appropriations (65%). This program is an entitlement.
- Nationally, less than one half of those over 65 have set aside an adequate amount of money to take them all the way through retirement.[17]
- "Nationally, younger boomers (32 to 40 years old) have experienced significant declines in their real income levels. Close to 15% of all baby boomers lack a high school diploma."[18]

Implications

The NMHCBS program is not an entitlement. Therefore, funding or increases in funding may vary given other governmental priorities. This may have an impact on services to consumers who depend on this program for assistance. For example, the waiting list increased 40% in SFY 1999, growing from 800 to 1,122 consumers.

The ALTCS program is an entitlement based on financial, functional and medical criteria. As an entitlement program, ALTCS has a better ability, financially, to meet consumer needs.

The increase in the future population over age 65 and the fact that they may not have enough money to take care of their needs may put a significant stress on the amount of appropriated dollars that will be required to maintain consumers at a maximum level of independence.

NMHCBS

Federal, state, and local funding are combined to support the NMHCBS System. The funding sources include the following:

- Federal Funds:
  - Older Americans Act (PL 89-73) (OAA, Title III and Title VII), and
  - Social Services Block Grant (SSBG);
- State Appropriated Funds; and
- Locally generated sources including client contributions, city funds, county United Way funds, and local foundations.

Continued on next page

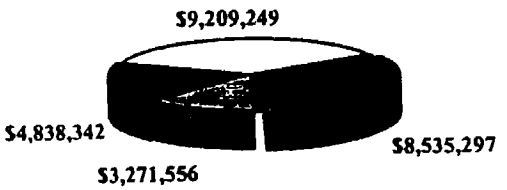
[17] 72nd Arizona Town Hall and University of Arizona (1998). Tucson, Arizona.

[18] Aging Initiative Project 2030 (January, 1999). "Workforce and Economic Vitality Issue Paper," p. 6. St. Paul, Minnesota.

NMHCBS, Continued

The total service funds for NMHCBS for SFY 1999, which were expended, is $25,854,445. The breakout is indicated below.

- Home Care funding includes RN, HHA, PC, HSK, ADHC, and CM. Total funding for this area was 74% state and 26% federal funds.
- Home Delivered Meals are primarily federally funded.
- County, community, and consumer contributions are allocated to the home care and meals programs. These additional funds enable more people to be served.



■ State Government Funds ■ OAA Funds ■ SSBG Funds ■ Local Funds

Total Funds for SFY 1999: $25,854,444

ALTCS / HCBS

The ALTCS program (EPD and DD) is funded by three sources:

- Federal funds (Title XIX) = 65%,
- County funds = 21%, and
- State funds = 14%.

ALTCS Sources of Funds for FFY 1999:

■ State Government Funds ■ County Funds ■ Federal Funds

Total Funds for FFY1999: $764,135,800

Services include medical, behavioral, nursing facility and HCBS. The total ALTCS funds for FFY 1999 were $764,135,800 (includes Title XIX DDD population). The ALTCS budget is approximately 40% of the entire AHCCCS budget. Sixty-seven percent of the ALTCS population are Elderly or Physically Disabled (EPD). Of those, 43% resided in the community.

Note: EPD only budget is approximately $560 million.

Chapter 4: How is the Money Spent?

Introduction

In 1989, the median income in Arizona for a single male 65 years of age or older was $13,210 versus single women who were at $10,320. Also of note is that Arizona Native Americans account for 17% of the Native American population 65 years of age or older in the United States.[19] These two facts imply that, for a fair share of our population, the ability to purchase needed services will be limited.

As the baby boomer generation continues to age, there is increasingly more demand for HCBS services, thereby producing an increase in spending. Chapter four will describe how the money is spent and on what type of services. It will also demonstrate that HCBS services and settings, in the ALTCS program, are cost efficient and respond to consumer choice.

Fast Facts

NMHCBS expenditures are reported by State Fiscal Year (7/1 to 6/30). Expenditures have grown 15% from 1996 to 1999. The biggest increases are in personal care and respite care, which correlates with the shift from home health aid to personal care and the increase in demand and funding for respite care. Nationally, "respite care is the most prevalent service provided by states for family caregivers."[20]

ALTCS HCBS expenditures have grown by 40% from 1996 to 1999.

- The biggest increase is in the category called "other," which incorporates Adult Day Health Care (ADHC), Environmental Modification and Alternative Residential Settings. As ADHC and Environmental Modification expenditures have remained essentially the same for three years, the conclusion is that the addition of assisted living centers and homes is the key factor in the increase.
- There has been a shift from personal care (-18%) to attendant care (+32%) thereby accounting for the increase in expenditures for attendant care. Many consumers prefer attendant care as that person can take care of numerous needs including housekeeping (HSK) while the personal care worker is limited to a person's care needs.
- The EPD population has continued to grow from 6% to 9% annually. During the same timeframe, HCBS growth has gone from 35% to 43%. The growth in capitation has remained almost constant from 1996 to 1999 because it is more cost effective to maintain consumers in their own home or alternative setting. Trends indicate the number of people living in the community will continue to increase.

Continued on next page

[19] 72nd Arizona Town Hall and University of Arizona (1998). "The Challenges and Opportunities of Arizona's Growing Senior Population," pp. 1-3. Tucson, Arizona

[20] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota

Fast Facts, Continued

The ALTCS Program as a whole somewhat mirrors the national trend for Medicaid.

- "Nationally, in 1993, poor elderly and non-elderly disabled represented 27% of the total Medicaid enrollees, but 59% of all Medicaid dollars. Impoverished adults and children, on the other hand, represented 73% of enrollees, but consumed only 27% of all Medicaid dollars."[21]
- Services for the ALTCS program include medical, behavioral, nursing facility, and HCBS. The total ALTCS funds for FFY 1999 were $764,135,800 (includes DDD population). The ALTCS budget is approximately 40% of the entire AHCCCS budget. The EPD only AHCCCS budget is approximately 30% of the entire AHCCCS budget. Sixty-seven percent of the ALTCS population are Elderly or Physically Disabled (EPD). Of those, 43% resided in the community in FFY 1999.

Implications

As the long-term care programs become a greater portion of our government' s budget, the state needs to understand the following:

- Baby boomers may request changes in the current service venue that may or may not impact expenditure.
- Both programs are researching strategies to continue to hire paraprofessionals to meet the consumer demand. This is especially important in the recruitment of attendant care providers.
- As the need for health and long-term care is growing, our resources will be increasingly stretched.

"The most significant is the fact that the baby bust generation (the generation following the baby boomers) constitutes a much smaller proportion of the population than the baby boomers. As a result there will be fewer working age adults to support the needs of a large elderly population through their economic productivity and tax revenues."[22]

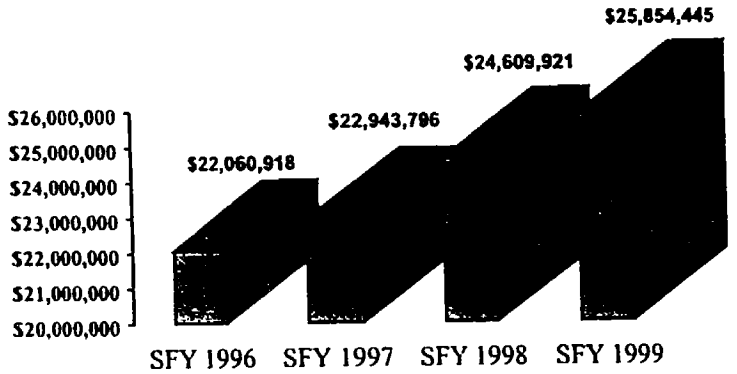
Continued on next page

[21] The Robert Wood Johnson Foundation (August, 1996). "Chronic Care in America: A 21st Century Challenge," p. 46, Princeton, New Jersey.
[22] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.

NMHCBS

NMHCBS has seen an increase in cost from approximately $22 million in SFY 1996 to $25 million in SFY 1999. Non-medical HCBS expenditures are reported on a state fiscal year (July 1 to June 30) schedule. Total expenditures for SFY 1999 are $25,854,445. This includes federal, state, county, and community contributions.

The graph below shows the totals for all of the non-medical expenditure years. Figures include case management with a range from $3.5 million to $4.4 million from SFY 1996 to SFY 1999.



Increases and decreases in enrollment reflect the increases and decreases of expenditures for the NMHCBS program. The table below states the total increase and decrease in expenditure from 1996 to 1999. The chart on the following page demonstrates increases and decreases by year.

Service	% of Growth: SFY 1996 to SFY 1999
Adult Day Health	-16% (Decrease)
Home Health Aid	-9% (Decrease)
Home Nursing	-6% (Decrease)
Home Delivered Meals	14%
Respite Care	26%
Personal Care	31%
Housekeeping	34%

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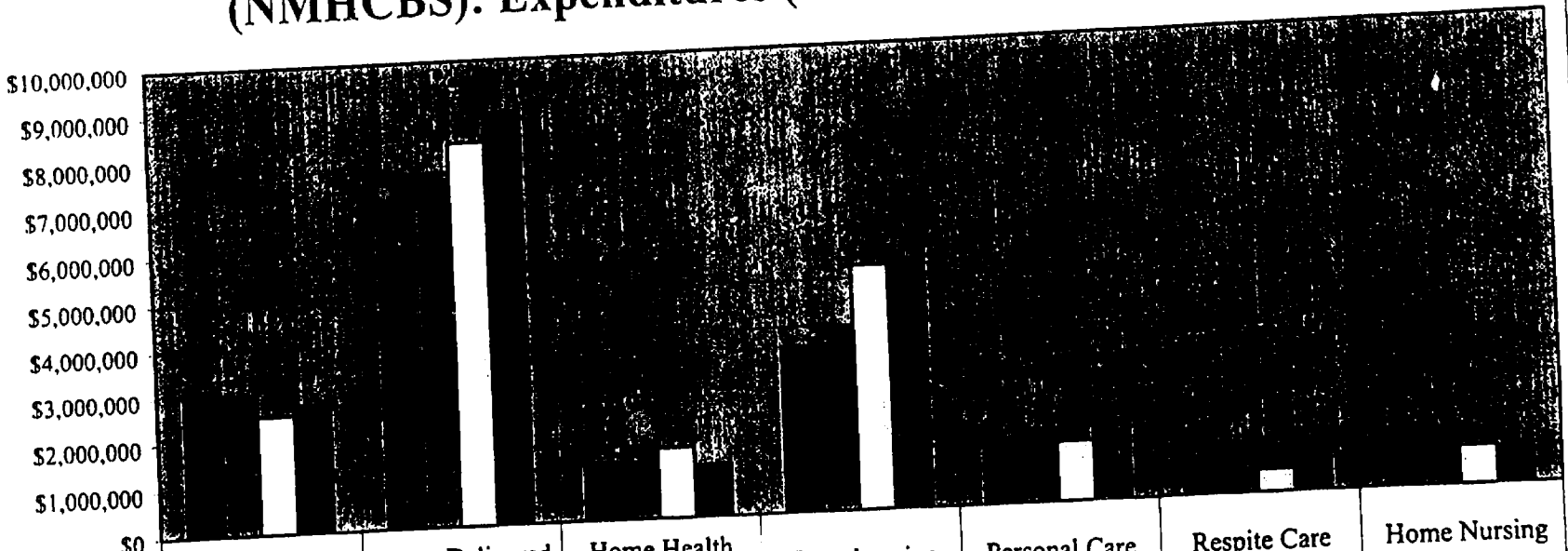
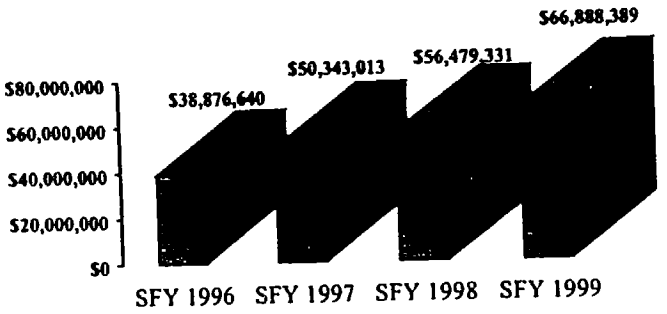
Non-Medical Home and Community Based Services (NMHCBS): Expenditures (State and Federal Funds)



	Adult Day Health	Home Delivered Meals	Home Health Aide	Housekeeping	Personal Care	Respite Care	Home Nursing
1996	$3,127,483	$7,621,071	$1,218,345	$3,565,129	$1,165,449	$456,598	$794,531
1997	$3,004,569	$7,627,404	$1,558,474	$3,936,874	$1,200,002	$477,736	$763,238
1998	$2,529,550	$8,254,681	$1,510,502	$5,277,400	$1,267,814	$479,268	$806,051
1999	$2,626,413	$8,849,598	$1,106,902	$5,376,389	$1,685,448	$620,857	$746,744

*Indicates growth percentage from 1996 through 1999

ALTCS / HCBS The ALTCS HCBS program (LTC services only) has experienced a 40% growth in expenditures in the last four years. The figures below represent expenditures for all services as reported by the Program Contractors.



ALTCS / HCBS The enrollment increases in the ALTCS HCBS program as well as the increases in the utilization of services are reflective of the increases of expenditure for the program. The table below states the total increase and decrease in expenditure from 1996 to 1999.

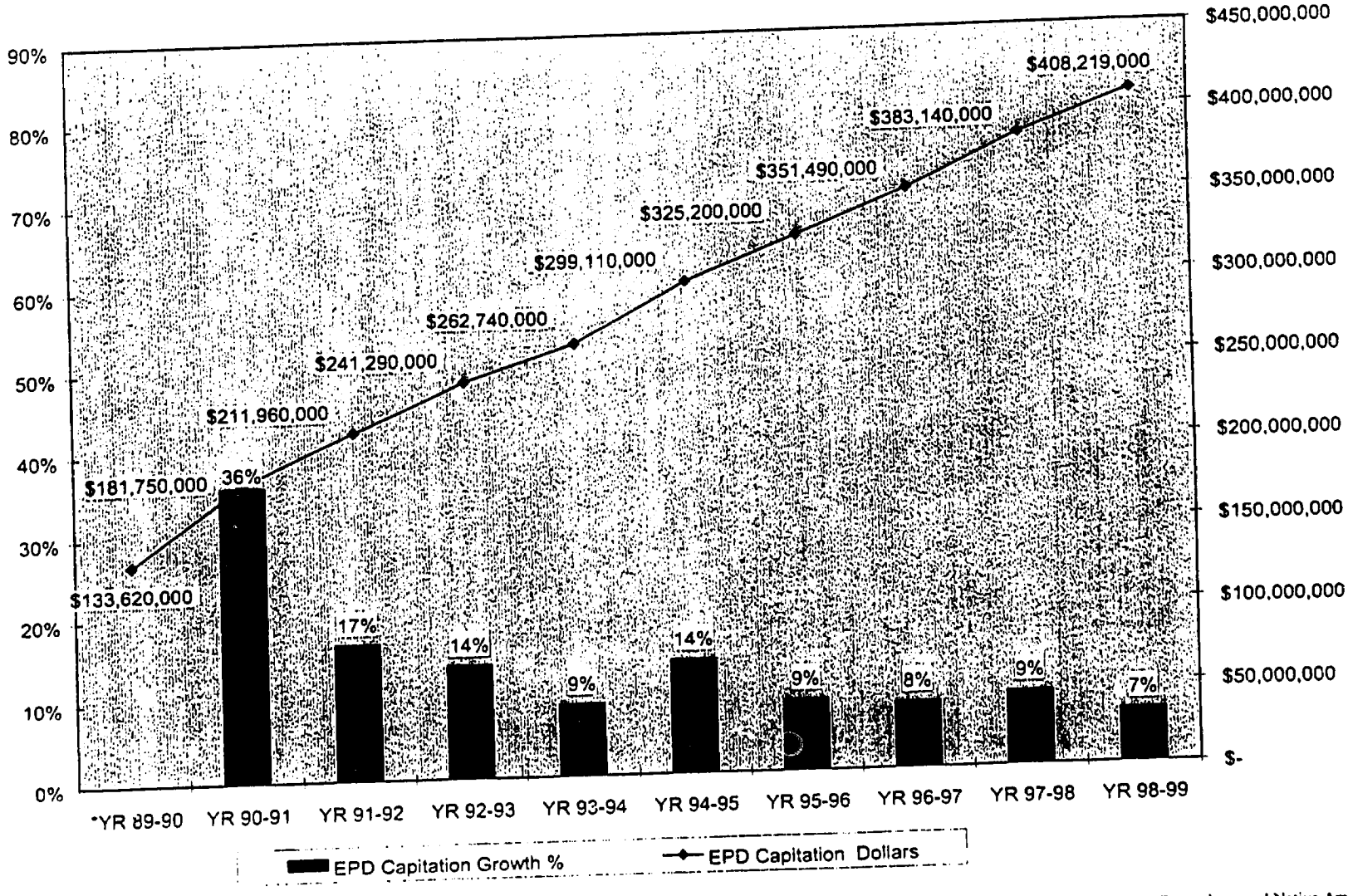
Service (Excludes Case Management)	% of Growth: FFY 1996 to SFY 1999
Home Health Services (RN & HHA)	5%
Attendant Care	32%
Home Delivered Meals	45%
Housekeeping	11%
Personal Care	-18%
Other (Adult Day Health, Environmental Modification, Alternative Residential Settings)	87% (Attributable to Alternative Residential Settings)
Respite Care	58%

The chart on the following page demonstrates increases and decreases by year.

ALTCS / HCBS The final two graphs are particular to the ALTCS program as a capitated model.

- Referencing the graph on page 18, it demonstrates that during the past four years the amount paid by Program Contractors for nursing facility and HCBS services has had an average annual growth of 7% to 9%. This mirrors the EPD population growth.
- The final graph on page 19 demonstrates that the EPD population has continued to grow from 6% to 9% annually. During the same timeframe, HCBS growth has gone from 35% to 43%. The growth in capitation has remained almost constant from 1996 to 1999 because it is more cost effective to maintain consumers in their own home or alternative setting.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ELDERLY AND PHYSICALLY DISABLED CAPITATION DOLLARS PAID ANNUALLY



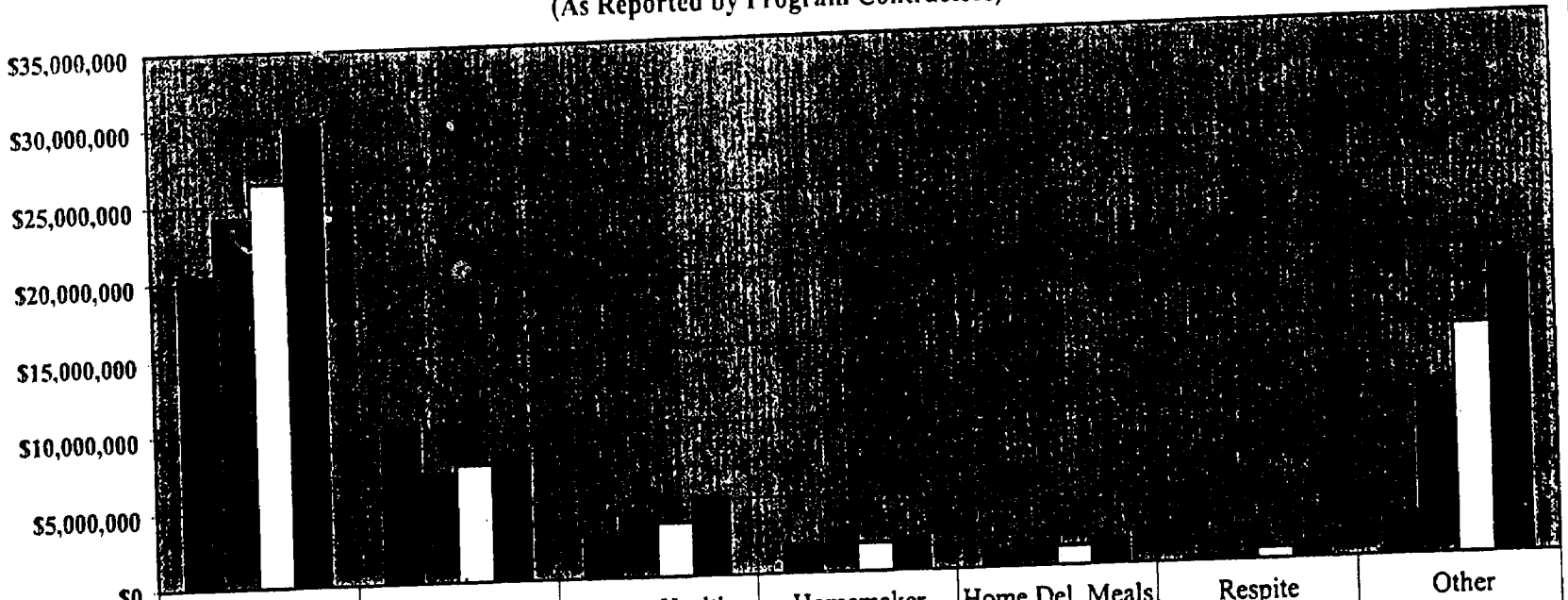
Excludes: Ventilator Dependents and Native Americans

*Program began 1/1/89

ALTCS HCBS PROGRAM

State-Wide Expenditures by Service

(As Reported by Program Contractors)



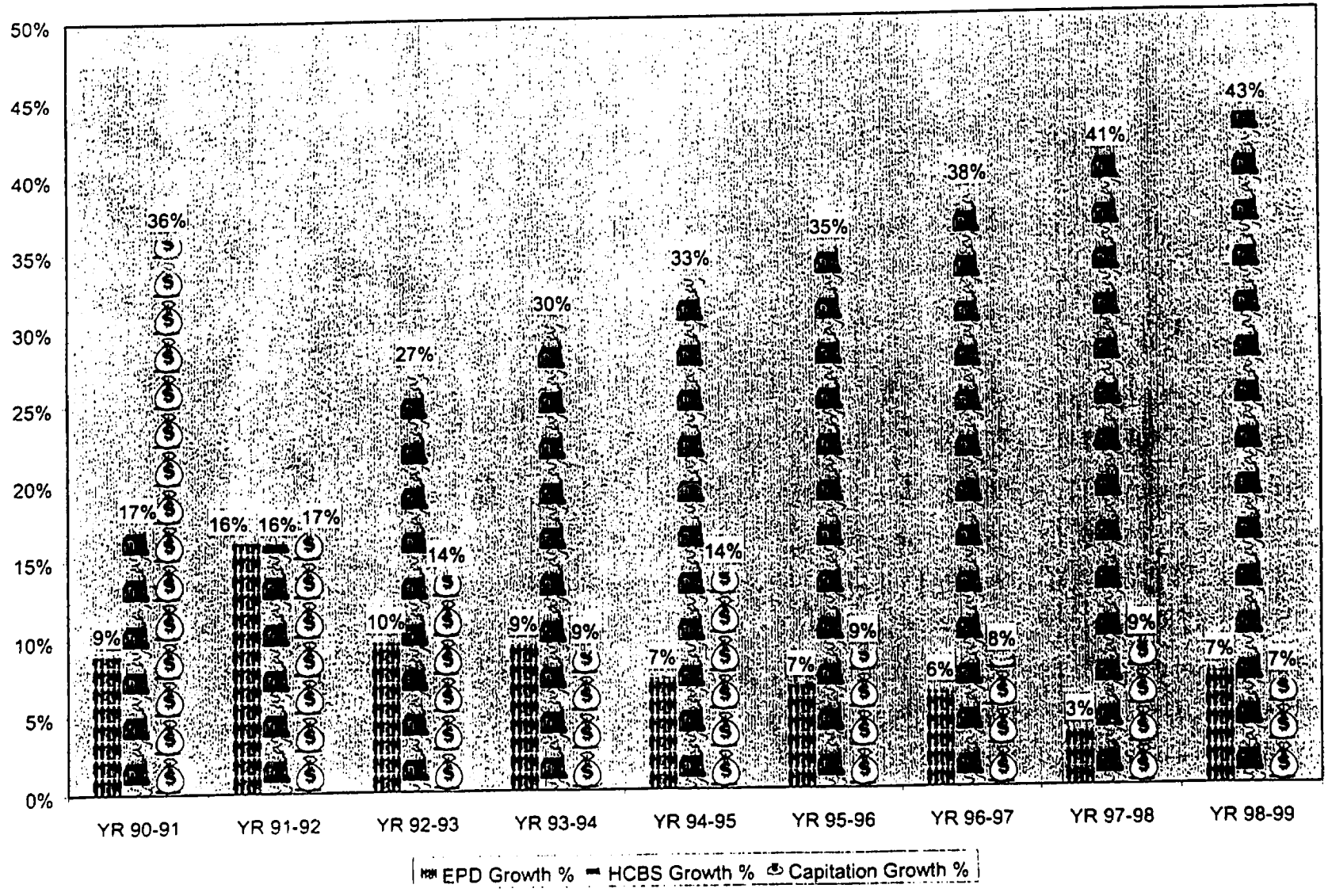
	Attendant Care	Personal Care	Home Health	Homemaker	Home Del. Meals	Respite	Other
1996	$20,377,039	$10,224,461	$2,730,558	$1,909,203	$907,148	$258,412	$2,420,818
1997	$24,168,369	$7,133,378	$4,153,775	$2,837,652	$923,377	$362,509	$10,763,953
1998	$26,389,961	$7,685,142	$3,570,080	$1,908,316	$1,282,218	$754,429	$14,889,185
1999	$30,022,152	$8,373,212	$5,152,253	$2,162,113	$1,659,547	$614,431	$18,904,681

*Indicates growth percentage from 1996 through 1999

Note: "Other" includes adult day health care, environmental modification, and alternative residential settings.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ELDERLY AND PHYSICALLY DISABLED PERCENT OF GROWTH FOR HCBS PLACEMENT, ENROLLMENT, CAPTIATION DOLLARS



Appendix A: Definitions

Services
*Starred Items mean that both programs provide this service.

***Adult Day Health:** A program that provides planned care and supervision, recreation and socialization, personal living skills training, group meals, health monitoring and various preventive, therapeutic and restorative health care services.

Arizona Long-Term Care System (ALTCS): ALTCS is a program under AHCCCS that delivers long-term, acute, behavioral health, and case management services to members, as authorized by A.R.S. § 36-29321. Long-term Care services include both nursing facilities and HCBS.

Attendant Care: A service provided by a trained attendant for members who reside in their own homes and which may include homemaker services, personal care, coordination of services, general supervision and assistance, companionship, socialization and skills development. **(ALTCS/HCBS only)**

Case Management (ALTCS/HCBS): The process through which appropriate and cost effective medical, medically-related social services, and behavioral health services are identified, planned, obtained, and monitored for individuals eligible for ALTCS services (A.A.C. R9-28-510). The process integrates the ALTCS member's and the case manager's review of the member's strengths and needs resulting in agreed upon appropriate and cost effective acute and long term care services.

Case management (NMHCBS): The assessment and development of an individualized service plan through which the eligibility of an individual is determined, appropriate services or benefits are identified, planned, reported, monitored or terminated, and follow-up is provided if and when appropriate (A.R.S. § 46-191.3).

***Chore/Pest Control:** A service that provides building specifications or items which allow members to function as independently as possible in their own homes.

***Emergency Alert System:** A service that provides monitoring devices/systems for members who are unable to access assistance in an emergency and/or live alone.

Environmental Modification: A service that provides building specification or items which allow members to function as independently as possible in their own homes. **(ALTCS only)**

***Home Delivered Meals:** A service that provides a nutritious meal containing at least one-third of the federal recommended daily allowance for the member, delivered to the member's own home.

Home Health Aid (NMHCBS Definition): This service provides intermittent health maintenance, continued treatments or monitoring of a health condition, and supportive care for daily living activities at the individual's place of residence.

Home Health Services: (ALTCS Definition): Includes Home Health Aid and Home Nursing (Intermittent or Continuous). Part-time or intermittent care for members who do not require hospital care; service is provided under direction of a physician to prevent re-hospitalization or institutionalization; may include nursing, therapies, supplies and home health aid services.

Continued on next page

Services, Continued

***Homemaker:** A service that provides assistance in the performance of routine household activities such as shopping, cooking and running errands.

Home Nursing (NMHCBS Description): This service provides intermittent skilled nursing services in the individual' s place of residences. Skilled nursing services may include health maintenance, continued treatments, or supervision of a health condition.

Non-Medical Home and Community Based Services (NMHCBS): A comprehensive, case managed system of care provided to a functionally disabled individual in the individual' s home or community that supports the role of family and caregivers as part of the service plan. The service plan may include personal care, housekeeping, chore services, adult day health care, respite, and home delivered meals, as well as health care services and other related health and social services that are a necessary, but subordinate, part of the service plan (A.R.S. § 46-191.7).

***Personal Care:** A service that provides assistance with personal physical needs such as washing hair, bathing and dressing.

Respite Care (ALTCS Description): Includes groups, in-home and continuous respite care. A service that provides short-term care and supervision to relieve primary caregivers. It is available for up to 24-hours per day and limited to 720 hours per year. Group respite is similar to Adult Day Health and is provided as a substitute when Adult Day Health services are not available.

Respite Care (NMHCBS Description): This service provides short-term care and supervision to relieve primary caregivers or clients. May be referred to be available on a 24-hour basis.

Transportation: A service that provides non-emergency transportation to medical, social or related activities.

Settings Limited to ALTCS

Adult Foster Care: An ALTCS HCBS approved alternative residential setting that provides room, board, supervision and coordination of necessary services within a family type environment for up to four adult residents.

Assisted Living Home (formerly known as "Adult Care Home"): An ALTCS approved alternative residential setting that provides resident rooms to ten or fewer residents. For ALTCS approval, the home must be certified to provide personal care.

Assisted Living Centers- Units Only (formerly known as "Supportive Residential Living Centers"): An ALTCS approved alternative residential setting that provides a private apartment, unless otherwise requested by a resident, that includes a living and sleeping space, kitchen area, private bathroom and storage area.

Behavioral Health Level II: A behavioral health service agency licensed by ADHS to provide a structured residential setting with 24-hour supervision and counseling or other therapeutic activities for individuals who do not require the intensity of treatment services or on-site medical services found in a Level I behavioral health facility.

Appendix B: HCBS Programs: Similarities and Differences

NMHCBS

The Aging and Adult Administration (AA) within the Arizona Department of Economic Security (ADES) is responsible for delivery of Non-Medical Home and Community Based Services (NMHCBS) for individuals 60 years of age or older or disabled who meet the eligibility requirements. The program receives state, federal, and local funding. There are eight Area Agencies on Aging (AAA) and one prime sponsor (non-AAA entity) that serve individuals in Arizona. AAAs utilize a case management system to determine need and authorize services. The AAAs are responsible for contracting with providers for the direct provision of services.

The program provides in-home, respite, and adult day health care services. On reservations, consumers receive home delivered meals and respite care via the AAA. All consumers live in there own home. Other in-home services provided to reservations are through federal funds that are given directly to the tribes. Services are limited by available federal and state funding.

ALTCS

The Arizona Health Care Cost Containment System (AHCCCS), Arizona Long-Term Care System (ALTCS) is funded by federal, state, and county monies. ALTCS serves the elderly, physically disabled, and developmentally disabled determined to be at an institutional level of care and financially eligible. Acute (medical), institutional, case management, home and community based services, and behavioral health services are all covered services under ALTCS. Members are enrolled with AHCCCS contracted managed care organizations (program contractors). There are eight program contractors including the Arizona Department of Economic Security / Division of Developmental Disabilities (ADES/DDD). The eight program contractors provide case management and services in designated geographic areas. ADES/DDD provides case management and contracts with individual providers to render care to members statewide. "On-Reservation" EPD tribal members receive case management. The remainder of the service package is on a fee-for-service basis. During FFY 1999, 67% of the ALTCS population served were EPD. Of that number 43% lived in the community receiving in-home services or lived in alternative residential settings.

Case Management

For both programs, case management is a central cog and key service in the coordination of hands-on services. .In the NMHCBS program, where funding is limited, the case manager plays a critical role in assessing finances and assisting the consumer, when possible, in the private purchase of a service, or perhaps, community scholarship funds for the service. As a Medicaid program, ALTCS has prescribed financial, functional, and medical criteria. Eligibility is determined by AHCCCS prior to the consumer receiving a case manager. The ALTCS program is required to provide for the needs of all members in the community up to the cost that would be spent if the consumer were in the facility.

The case manager will make every effort to foster a person-centered approach and respect maximum member/family self-determination while promoting the values of dignity, independence, self-determination, individuality, privacy, and choice. Case management begins with respect for the member' s preferences, interests, needs, culture, language, and belief system.

Continued on next page

Case Management, Continued

The involvement of the member in strengths and needs identification and in decision making is a basic tenet of case management practice. Care plan development is a shared responsibility with the member/family/significant others input seen as key to the success of the plan. The member/family/significant others are partners with the case managers in the development of the plan with the case manager in a facilitating mode.

Case managers are expected to use a holistic approach regarding the member assessment and needs, taking into account not only covered services but also other needed community resources as applicable. Case managers are expected to:

- Provide adequate information and teaching to assist the member/family in making informed decisions and choices;
- Provide a continuum of service options that support the expectations and agreement established through the care plan process;
- Integrate services available throughout the community;
- Advocate for the member, family or significant other as the need occurs;
- Allow the member, family, or significant other to identify their role in interacting with the service system;
- Provide members with flexible and creative service delivery options;
- Provide necessary information to providers about any changes in consumer's functional level to assist the provider in planning, delivering, and monitoring services; and
- Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the consumer.

Comparisons

Categories	NMHCBS	ALTCS HCBS
Eligibility	Meets functional/medical criteria: either 60+ or physically disabled	Meets financial, functional, and medical criteria
Funding Availability	Limited to federal and state allocations and community contributions– Not an entitlement	Medicaid funded program (federal, state, and county) - Entitlement based on eligibility
Case Management	No prescribed ratio of case manager to consumer. Caseload is usually a minimum of 100+ per case manager. Visits at 3 to 6 month intervals with SPP direct pay and wait list members with alternative visit intervals.	Caseloads have prescribed ratios. HCBS 1 to 48 with three month interval visits and SNF = 1:120 with 6 month intervals.
Services		
Acute Care	No	Yes
Behavioral Health Care	No	Yes
Adult Day Health Care	Yes	Yes
Attendant Care	No	Yes
Home Health Aid	Yes	Yes
Home Nursing	Yes/Limited	Yes/Extensive
Housekeeping/Pest Control	Yes	Yes
Home Delivered Meals	Yes	Yes
Personal Care	Yes	Yes
Respite Care	Yes	Yes
Environment Modification	No	Yes
Alternative Res. Settings	No	Yes
Waiting list for services	Yes (1,122), as of June 30, 1999	No

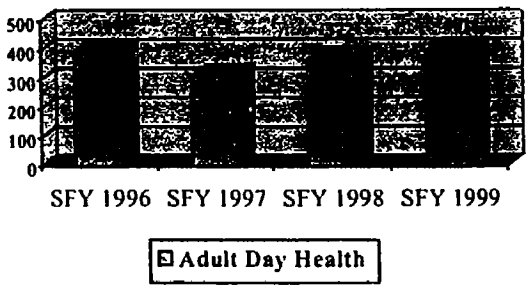
Appendix C: NMHCBS Enrollment Detail

Introduction

The following series of graphs demonstrates changes in the number of consumers who utilized the individual NMHCBS services over time.

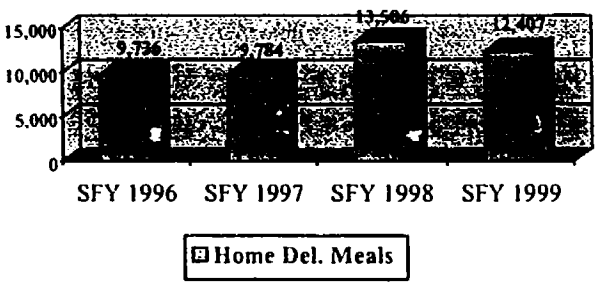
Adult Day Health (ADH)

The number of individuals utilizing ADH services has remained relatively consistent over this four your period of time.



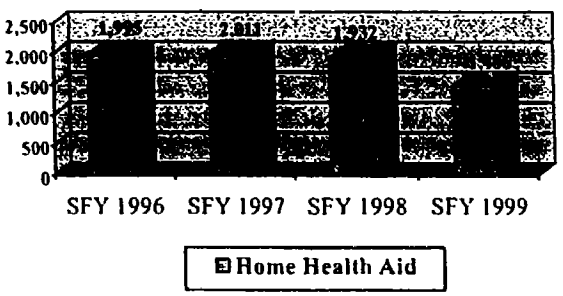
Home Delivered Meals (HDM)

The number of individuals utilizing HDM services has increased 8%. However, from 1998 to 1999, HDM services declined 1%.



Home Health Aid (HHA)

The number of individuals utilizing HHA services has declined by 26% from 1996 to 1999.



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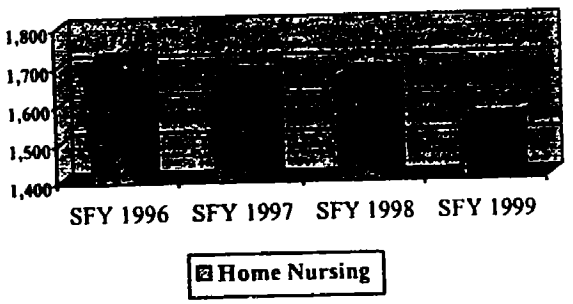
Appendix C: NMHCBS Enrollment Detail, Continued

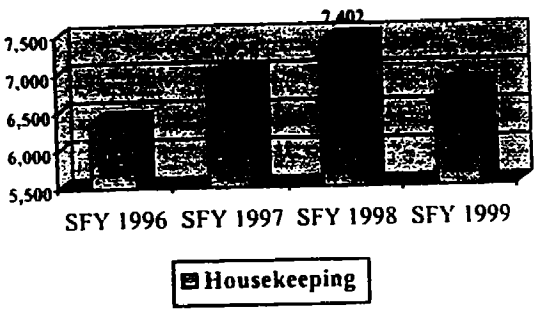
Home Nursing (NUR)

The number of individuals utilizing NUR services has declined by 26% from 1996 to 1999.



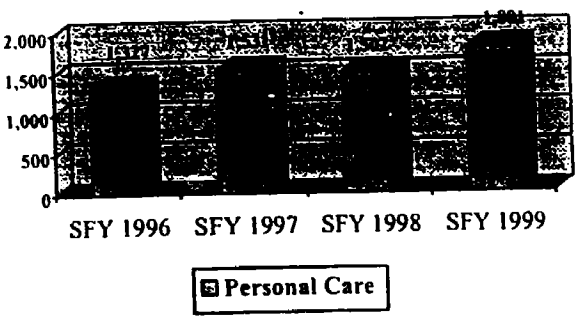
Housekeeping (HSK)

The number of individuals utilizing HSK services has increased 6%. However, there was an 8% decline of HSK services from 1998 to 1999.



Personal Care (PC)

The number of individuals utilizing PC services has increased 26%. However, from 1998 to 1999, PC services declined 8%.



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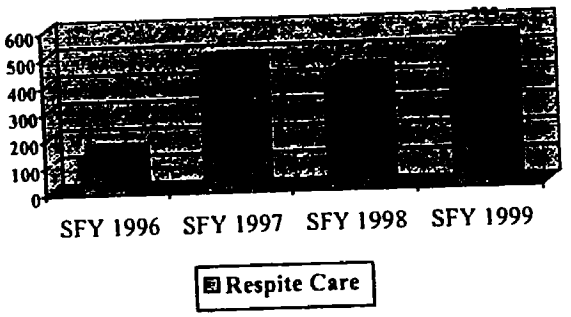
Appendix C: NMHCBS Enrollment Detail, Continued

Respite Care (RC)

The number of individuals receiving RC services has increased by 73%.



Appendix D: Copies of the Report

Availability

This report can be obtained through following options:

1. Viewing the Arizona Health Care Cost Containment System (AHCCCS) website: http:\\www.ahcccs.state.az.us;

2. Viewing the Arizona Department of Economic Security (ADES) website: http:\\www.de.state.az.us;

3. Writing to:
   Claire Sinay, Federal/State Policy Manager
   Office of Policy Analysis and Coordination
   801 East Jefferson Street, MD 4200
   Phoenix, Arizona 85034
   Fax Number: (602) 256-6756
   cxsinay@ahcccs.state.az.us; or

4. Calling:
   Melissa Brickey, AHCCCS/Administrative Assistant, at (602) 417-4146.

Appendix E: Acknowledgements

Taskforce Members

Below is a list of all the taskforce members and their organizations.

Name	Organization
Bercaw, Sharon	AHCCCS
Blanco, Henry	Aging and Adult Administration
Dean, Gwen	Arizona Bridge to Independent Living
Duncan, Gerry	Maricopa Managed Care System
Engan, Janet	Western Arizona Council of Governments
Fields, Karen	Pima Health Systems
Grabel, Stew	Pima Council on Aging
Guerrero, Olivia	Pinal/Gila Council for Senior Citizens
Heard, Kathleen	SouthEastern AZ Government Organization
Lupe Solis	Governor' s Council on Aging
Mercado, Jose	Aging & Adult Administration
Park, Carol	Cochise Health Systems
Schafer, Alan	AHCCCS
Skinner, Linda	AHCCCS
Stanley-Robb, Donna	Pinal County Long Term Care
Stewart, Laraine	Area Agency on Aging, Region One
Tomlinson, Cheri	AHCCCS
Wauneka, Theron A.	Inter-Tribal Council of Arizona, Incorporated

Arizona Population by Age

	1990		2000		2010		2020		2030	
	People	Percent Change	People	Percent Change	People	Percent Change	People	Percent Change	People	Percent Change
65-74	290,044		363,841	25.44%	465,855	28.04%	747,151	60.38%	1,017,301	36.16%
75-84	151,013		235,473	55.93%	309,749	31.54%	383,063	23.67%	612,245	59.83%
85 plus	37,717		68,525	81.68%	132,950	94.02%	166,664	25.36%	206,631	23.98%
Total	3,665,228		5,130,632	39.98%	6,145,108	19.77%	7,363,604	19.83%	8,621,114	17.08%

Source: Arizona Department of Economic Security
Research Administration
July 2001

Attachment C

Based on 1990 U.S. Census Bureau Population Estimates

Total Population.....3,665,228
Total Arizonans ages 60 and above.....631,648 . (17%)

Based on 1999 U.S. Census Bureau Population Estimates:

Total Population.....4,778,332
Total Arizonans ages 60 and above.....814,570 . (17%)

Cultural Diversity:
White Non-Hispanic..... 694,031 (85%)
Hispanic.....76,197 (9%)
Native American 19,913 (3%)
African American 16,109 (2%)
Asian/Pacific Islander 8,320 (1%)

Gender:
Males.....401,382 (49%)
Females.....413,188 (51%)

Based on 2000 U.S. Census Bureau Population Estimates:

Total Arizona Population 5,130,632
Total Arizonans ages 60 and above.....871,536 . (17%)

County 60+	Number	Percentage
Apache	8,195	1%
Cochise	23,512	2.6%
Coconino	11,804	1%
Gila	13,333	1.5%
Graham	5,236	1%
Greenlee	1,159	0.1%
La Paz	6,574	0.7%
Maricopa	466,269	53%
Mohave	42,491	5%
Navajo	13,780	1.6%
Pima	153,232	17.5%
Pinal	38,858	5%
Santa Cruz	5,673	1%
Yavapai	47,361	5%
Yuma	34,059	4%

Age Group	Number	Percentage
60-64	203,697	23%
65-74	363,841	42%
75-84	235,473	27%
85+	68,525	8%

According to AHCCCS, as of June 2001 there were approximately 20,000 Arizonans enrolled in the AHCCCS Elderly/Physically Disabled Program (EPD). In order to be eligible for the EPD, an individual must require institutional care. However, through the EPD Program, the individual may choose between Home and Community Based Services (HCBS) or an institutional care setting. The EPD Program provides services not only to the elderly, but also to individuals of any age who are physically disabled. (Source: Carol Sanders, AHCCCS).

In 2000, the Aging and Adult Administration conducted a customer satisfaction survey of older Arizonans receiving Non-Medical Home and Community Based Services (NMHCBS), which provides a choice of eleven service options (home delivered meals, home health aid, assistive devices, personal care, adult day care, attendant care, housekeeping, visiting nurse, respite care, case management and shopping.) Sixty-five percent of the clients served in the NMHCBS program are female and 35 percent are male. The majority, 35.3 percent, were between the ages of 70 and 79. Ten percent, or 1,200, of the current client population was surveyed, with a response rate of 39% (465 clients). Survey results indicated 83.2 percent of the current client population felt that NMHCBS helped them retain their independence and 85.1 percent felt that NMHCBS helped them to remain in their home.

The AARP Profile of Older Americans 2000 report states that "The majority (67%) of older non-institutionalized persons lived in a family setting in 1998. Approximately 10.8 million or 80% of older men, and 10.7 million or 58% of older women, lived in families. The proportion living in a family setting decreased with age. Only 45% of those 85+ years old lived in family setting. About 13% of older persons (7% of men, 17% of women) were not living with a spouse but were living with children, siblings, or other relatives. An additional 3% of men and 2% of women, or 718,000 older persons, lived with non-relatives. About 31% (9.9 million) of all non-institutionalized older persons in 1998 lived alone (7.6 million women, 2.3 million men). They represented 41% of older women and 17% of older men. Living alone correlates with advanced age. Among women aged 85 and over, for example, three of every five lived outside a family setting. While a small number (1.47 million) and percentage (4.3%) of the 65+ population lived in

nursing homes in 1997, the percentage increases dramatically with age, ranging from 1.1% for persons 65-74 years to 4.5% for persons 75-84 years and 19.0% for persons 85+."

According to the 1990 Census, 13% older male Arizonans lived alone, while 35% older female Arizonans lived alone. As of June 2000, there were 1,200 licensed assisted living facilities in Arizona providing care to older persons who are no longer able to live independently.

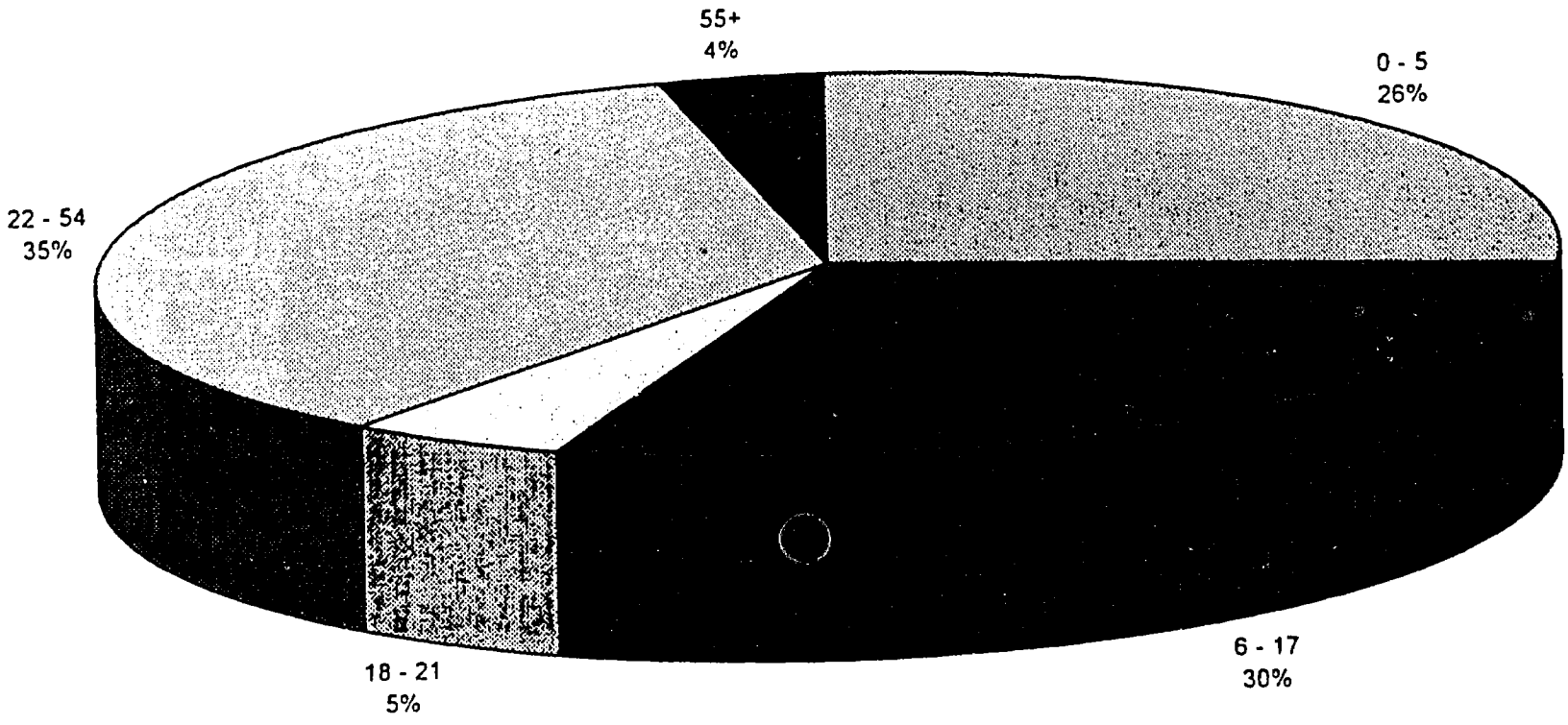
DES Population Statistics advised that Census 2000 data is not yet available on the numbers of individuals living in nursing homes. According to DES Population Statistics, those reports will not be available until the end of next year.

Division of Developmental Disabilities

	Actual 6/30/99	Actual 6/30/00	Estimated 6/30/01	Estimated 6/30/02	Estimated 6/30/03
DD Clients					
0 up to 3	1,416	1,568	1,757	1,757	1,757
3 up to 6	1,123	1,098	1,183	1,183	1,183
6 up to 18	1,397	1,362	1,329	1,329	1,329
18 up to 21	318	296	298	298	298
21 up to 55	2,438	2,384	2,349	2,349	2,349
55 and over	200	219	219	219	219
Total	6,892	6,927	7,135	7,135	7,135
Title XIX Clients					
0 up to 3	584	639	686	748	815
3 up to 6	1,325	1,475	1,678	1,829	1,993
6 up to 18	3,579	3,982	4,351	4,742	5,167
18 up to 21	592	626	714	778	848
21 up to 55	3,711	4,004	4,385	4,778	5,206
55 and over	389	432	481	524	571
Total	10,180	11,158	12,295	13,399	14,600
Total Clients					
0 up to 3	2,000	2,207	2,443	2,505	2,572
3 up to 6	2,448	2,573	2,861	3,012	3,176
6 up to 18	4,976	5,344	5,680	6,071	6,496
18 up to 21	910	922	1,012	1,076	1,146
21 up to 55	6,149	6,388	6,734	7,127	7,555
55 and over	589	651	700	743	790
Total	17,072	18,085	19,430	20,534	21,735

DIVISION OF DEVELOPMENTAL DISABILITIES

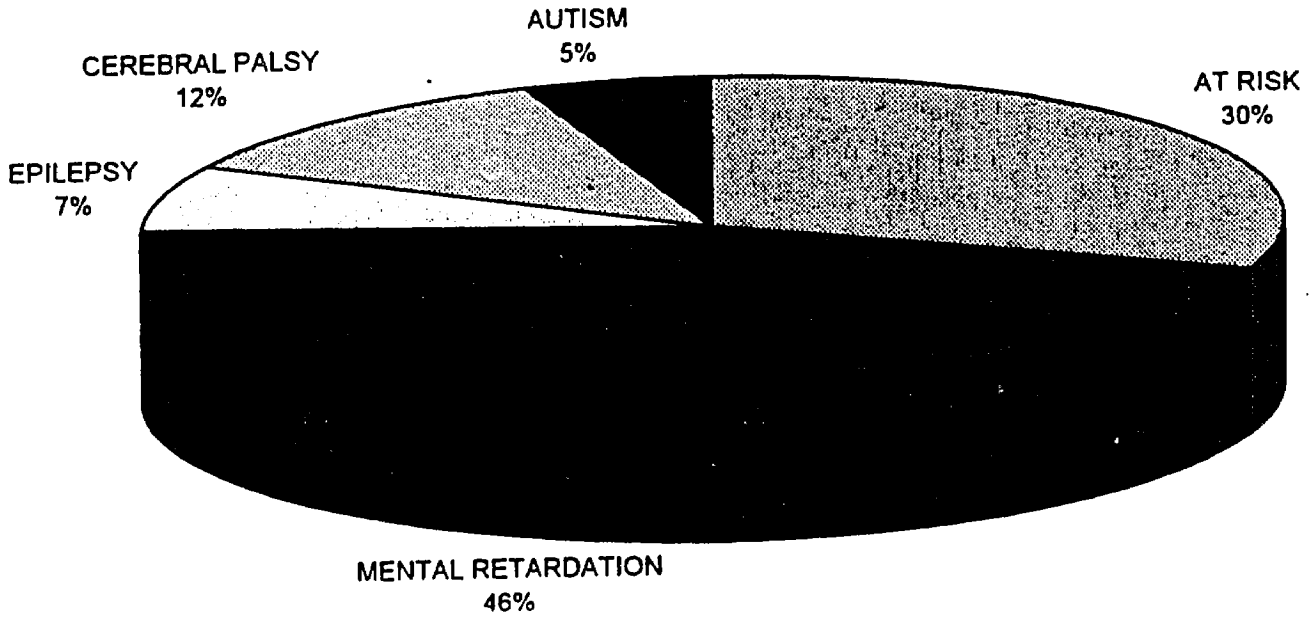
AGE GROUPS



AS OF JUNE 2000

DIVISION OF DEVELOPMENTAL DISABILITIES

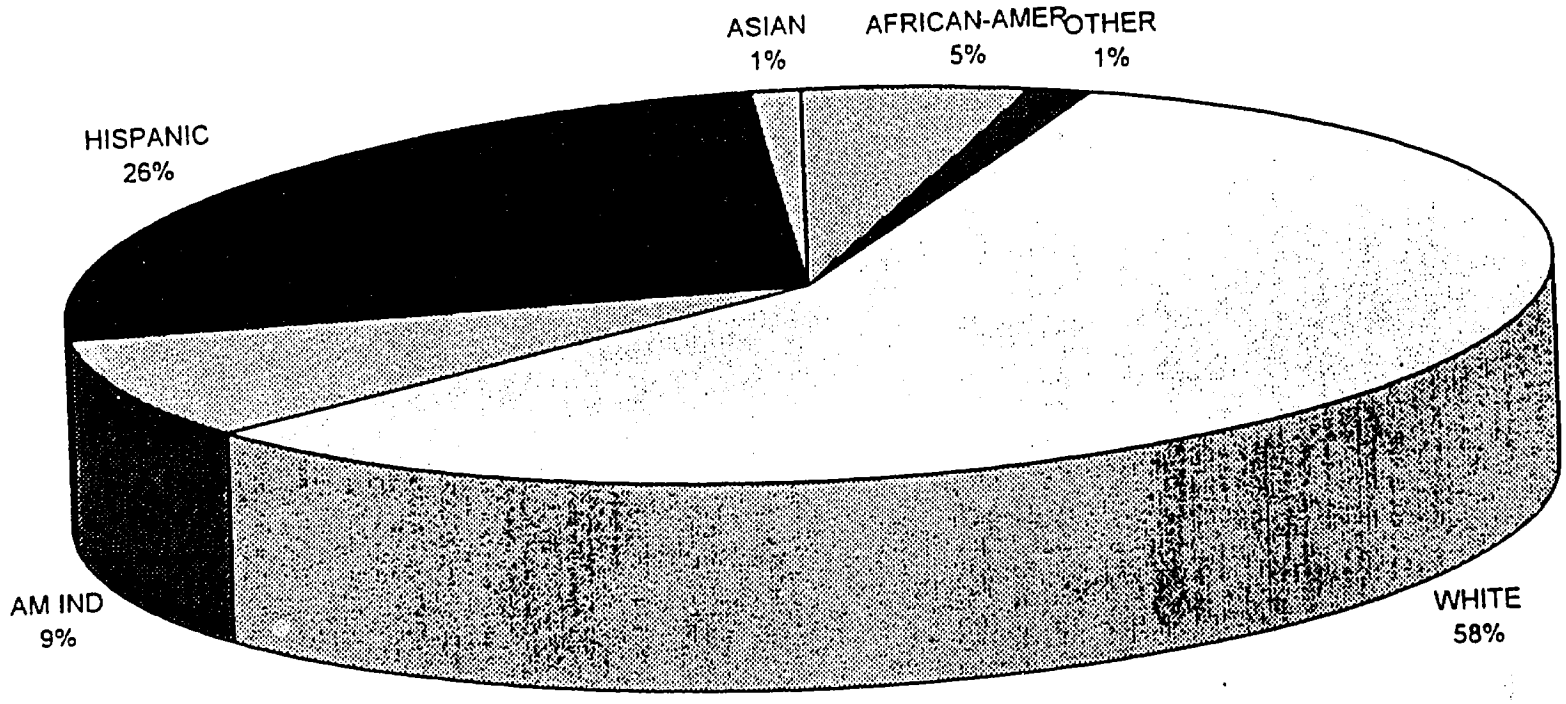
PRIMARY DISABILITY



AS OF JUNE 2000

DIVISION OF DEVELOPMENTAL DISABILITIES

ETHNIC POPULATION



AS OF JUNE 2000

SENATE AD HOC COMMITTEE ON CAREGIVER WAGES AND WORKFORCE DEVELOPMENT

PURPOSE: To define critical policy concerns and emerging issues regarding long-term care and caregiving, and develop cost-effective strategies to promote and encourage caregiver workforce development that support and strengthen family and informal caregiving as a key component of long-term care. The Committee shall submit a written report of its recommendations to the President of the Senate, and provide a copy of its report to the Secretary of State and the Director of the Arizona State Library, Archives and Public Records by December 15, 2001.

Attachment B