TYING NASHVILLE TOGETHER
HEALTH ACTION TEAM

CITIZENS' HEARING AND PANEL DISCUSSION

ON HOME AND COMMUNITY-BASED CARE

PANEL 3:

LOCAL GOVERNMENT OFFICIALS

MARCH 29, 2007
WEST END UNITED METHODIST CHURCH
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TNT PARTICIPANTS:

GERALD TAYLOR, Industrial Areas Foundation

RAY SELLS, Tying Nashville Together

1 MR. TAYLOR: I'm Gerald
2 Taylor with the Industrial Areas Foundation.
3 I'm working with TNT.
4 MR. SELLS: I'm Ray Sells.
5 I am a member here at West End United
6 Methodist and have been with TNT as a member
7 and part-time staff for twelve to fifteen
8 years.
9 MR. TAYLOR: Okay. Thank
10 you. We would like to ask each of you to
11 introduce yourselves and tell what
12 organization you're with and tell a little
13 bit about why this is important to you and
14 what you're doing.
15 You have five minutes to
16 make whatever opening comments you would
17 like to make on this question. So with
18 that, why don't we start over here. Use the
19 microphone, please.
20 MS. HOWELL: I'm Melanie
21 Howell. I am with the Greater Nashville
22 Regional Council Area Agency on Aging and
23 Disability. I'm the service
24 coordinator/supervisor. I oversee the
25 Medicaid Waiver and the Options Program.

1 These services are very important to me.
2 This is why I'm working in this area,
3 because I feel that we need to support the
4 more vulnerable population in these days and
5 time.
6 The Area Agency on Aging
7 and Disability is charged with doing the
8 planning and for channeling of funds to the
9 different providers we work with. We work
10 with home-delivered meals. We work with the
11 home- and community-based services. We work
12 with senior centers. We work with a number
13 of different programs, the ombudsman, to
14 name a few.
15 My expertise is more in
16 home- and community-based services, but we
17 basically have a case management unit at the
18 Area Agency on Aging level, and I oversee
19 that. And what we do is eligibility. We do
20 the assessment eligibility of individuals
21 who are needing to be assessed for services.
22 After we do an assessment,
23 we review it. We have a team meeting to
24 make sure that the plan of care that we
25 develop from the assessment, which is very

1 important to us, is appropriate and
2 accurate. Then, we are able to implement
3 services.
4 Now, I work both with the
5 Options for Community Living and the other
6 funded source, the Non-Medicaid Waiver
7 program, versus the Medicaid Waiver Program,
8 which has two different sets of eligibility.
9 The Non-Medicaid Waiver
10 program includes the State Options for
11 Community Living. It includes in-home
12 services, which are services to support
13 individuals in the home. We work with the
14 Family Caregiver Respite Program, which
15 provides respite to caregivers who are
16 taking care of these individuals, and we
17 work with home-delivered meals, which is
18 supported by the Federal Government. And
19 those services, we do not have to --
20 MR. TAYLOR: Okay. I'm
21 going to ask you to -- you've been very,
22 very specific. This panel is really focused
23 on the policy questions that we're trying to
24 address and look at. Would you state what
25 some of the impediment questions, issues you

1 see facing what you do?
2 MS. HOWELL: As far as
3 accessibility --
4 MR. TAYLOR: Accessibility,
5 resources, whatever that is -- talk about
6 that from your perspective, what's
7 happening.
8 MS. HOWELL: Okay. Well,
9 for one thing, we don't have enough dollars
10 for the safety net programs. The Medicaid
11 Waiver Program has sufficient dollars. We
12 have sufficient slots to implement services,
13 but the Non-Medicaid Waiver programs do not
14 have sufficient dollars.
15 We're only able to support,
16 under the Options -- in the 13-county area
17 that we work with, we're only able to
18 support about 200 people during the year,
19 and it's less for in-home services for the
20 Older Americans Act.
21 As far as home-delivered
22 meals, it's about 725, but that's just one
23 service. So it's the dollars -- in order to
24 support the individuals in the home, which
25 might be a range of services, not just one

1 service.
2 MR. TAYLOR: Okay. Thank
3 you.
4 MR. BONNYMAN: My name is
5 Gordon Bonnyman. I'm an attorney with the
6 Tennessee Justice Center, a nonprofit public
7 interest law firm here in Nashville that
8 serves low-income healthcare consumers,
9 including long-term care consumers across
10 the state, and I've been involved, in one
11 capacity or another, advocating for
12 long-term care consumers for about twenty
13 years.
14 I think, to understand this
15 issue, you have to follow the money. And my
16 former pastor, who is sitting right here,
17 used to admonish us on Sunday mornings and
18 say, "Don't tell me what your values are.
19 Show me your checkbook." That will express
20 your values better than anything else. A
21 budget is a moral document. It's a
22 statement of our values.
23 So I think, on this issue,
24 we need to look at what the budgets say and
25 express about our actual values. And if you

1 want to follow the money, you're going to
2 follow it to the State, because,
3 overwhelmingly, that's where the money comes
4 from. It comes specifically from TennCare
5 or Medicaid. They are two terms for the
6 same program.
7 We spend, in rough terms,
8 about a billion -- that's with a "b" -- a
9 billion dollars a year on institutional
10 care, for long-term care. We spend a tiny
11 fraction of that, less than 100 million for
12 long-term care for seniors and adults with
13 disabilities other than developmental
14 disabilities.
15 So clearly, our checkbook
16 here says that what we value is
17 institutionalization. What we devalue is
18 personal autonomy, family integrity, and
19 humane care. Again, don't tell me what you
20 think; show me. Show me your checkbook.
21 We are fiftieth in the
22 nation in terms of that mix of what we spend
23 on institutional care versus what we spend
24 enabling families to care for loved ones at
25 home. It doesn't have to be there. It's a

1 matter of political choices that have been
2 made, either explicitly or by default.
3 Four years ago, the
4 then-new governor created a new program that
5 would align political and financial
6 incentives in a way that would encourage the
7 shift of dollars away from institutional
8 care, out of that billion-dollar pot into
9 home- and community-based services.
10 Unfortunately, that has not happened. Those
11 commitments have not been fulfilled.
12 Clearly, given the budget
13 constraints at the federal and state level,
14 we cannot afford to continue spending
15 billions on this institutionally and add on
16 home- and community-based services as we're
17 able to afford it, as afterthoughts, when
18 it's available, et cetera.
19 We have got to get real
20 about shifting people who don't want to be
21 in institutions out of institutions. We
22 have this bizarre situation where people
23 are, unwillingly, being forced to accept
24 more costly services than they want. Their
25 preference is for cheaper services that are

1 more in line with family values and their
2 personal autonomy. What is wrong with this
3 picture?
4 It's a matter of political
5 will. There are two big obstacles; one is
6 the nursing home industry, and the other is,
7 at the highest level of state government,
8 great antipathy to anything that could be
9 characterized as a personal legal
10 entitlement. We don't want people to be
11 able come in and say, as a matter of law, as
12 a matter of policy written down, "I should
13 be able to draw this service." We might be
14 willing to be generous around the margins,
15 but we don't ever want to be held
16 accountable.
17 Ultimately, this comes down
18 to political will. It comes down to people
19 assuming responsibility for government and
20 public policy and saying these are not --
21 this budget is not consistent with our
22 values; we are not spending money in
23 accordance with most people's health needs.
24 Thank you.
25 MS. LIPPARD: This is my

1 worst nightmare, to follow Gordon Bonnyman,
2 but I'll be okay; I'm in a church.
3 (Laughter from the
4 audience.)
5 MS. LIPPARD: My name is
6 Adrienne Lippard. I'm the director of
7 Living at Home Services for Senior Citizens,
8 Inc., which is a private nonprofit
9 organization serving Davidson and Williamson
10 County. Our primary goal is to help people
11 live independently for as long as possible
12 with a high quality of life, while promoting
13 dignity and self-worth in aging.
14 Our Living at Home Services
15 provide care management, in-home counseling,
16 adult day services, Meals On Wheels, respite
17 and companion care, conservatorship, and
18 in-home support services for victims of
19 crime.
20 We also are very active in
21 the public policy arena in addressing the
22 needs of seniors. We're sponsored by the
23 Government to appropriately and adequately
24 provide services to address the inequities
25 in the financing of long-term care and also,

1 to collect date to inform and educate our
2 community about the needs of senior
3 citizens.
4 We've been delivering case
5 management services for twenty years and
6 have been in existence for over fifty years,
7 as an agency. Without care management
8 services and good assessment, many senior
9 adults would go without needed services.
10 They inappropriately manage
11 their scarce resources due to lack of
12 knowledge about what's available in the
13 community. And, obviously, they fail to
14 remain living in their homes for as long as
15 possible, which is their desired live-in
16 location.
17 Some of the impediments to
18 what we try to do are, obviously, limited
19 caseloads due to small staff numbers and the
20 intensity of services that are needed by the
21 people in the community. Also, there are
22 few resources in the community to address
23 the needs of customers, particularly
24 homemaker, personal care, and transportation
25 services.

1 I always say case
2 management, unfortunately, is only as good
3 as what's available out there to meet the
4 needs. We can make referrals, but the needs
5 don't go away if they are put on a waiting
6 list. Financial limitations also,
7 obviously, make hiring additional staff to
8 meet more needs unrealistic.
9 Under current reimbursement
10 rates for provision of contracted services
11 through the Options for Community Living
12 Program, Senior Citizens, Inc. was precluded
13 from participating. We cannot pay living
14 wages to our staff, provide them the
15 benefits that they need, and be able to
16 recoup enough to be able to cover even the
17 cost of what we were doing.
18 We certainly applaud the
19 state government, Greater Nashville Regional
20 Council, and all the advocates for their
21 commitment to delivery of home- and
22 community-based services in Tennessee.
23 While advancements have occurred, senior
24 adults really deserve and need much, much
25 more than what they are getting.

1 Obviously, suggested
2 recommendations for improving accessibility
3 to home- and community-based care, things
4 that all of us have heard before but that we
5 really need to commit to, are continuing to
6 learn from other states about what has
7 worked and actually implementing those types
8 of programs; additional and/or redirection
9 of funding for home- and community-based
10 options, making sure there is more equity in
11 where long-term care can be delivered;
12 promoting self-direction of care, as Gordon
13 said, allowing people to use the dollars to
14 purchase what they need rather than having
15 to pay a higher price for it because it's
16 only available through certain places;
17 incentives for nonprofits to be able to
18 participate in government-funded service
19 delivery.
20 We're obviously committed
21 to doing what we do, but we have to be able
22 to break even doing it. We're in the
23 process of doing a strategic planning
24 process, and what we're finding is there is
25 this matrix that we've been using and all

1 the living-at-home programs keep being the
2 heart and soul of what our agency does, but
3 how many heart-and-soul agency programs can
4 you have before you realize you can't pay
5 for them?
6 In addition, also,
7 marketing all long-term care options to
8 insure that senior adults and their families
9 know what is available and can explore
10 services prior to emergencies; and lastly,
11 also focusing on infrastructure needs,
12 having trained and affordable direct service
13 staff, low overhead costs, and streamlined
14 and accelerated enrollment into the program.
15 I think the one thing that
16 has to happen -- just like Gordon said,
17 "Show us the checkbook" -- is making this a
18 number one priority of the Government, not
19 something that can continue to be on the
20 back burner for ten, twenty, thirty more
21 years. We have to apply the heat to make
22 this happen. Thank you.
23 (Applause from the
24 audience.)
25 MS. ROBINSON: Good

1 morning. I'm Gerri Robinson, the executive
2 director of Metro Social Services. I'm just
3 going to do a very sweeping overview of my
4 department, because you had the benefit of
5 the expertise of what I call "my experts" on
6 the previous panel.
7 Basically, Metro Social
8 Services is a locally-funded department. We
9 are the major -- the largest providers of
10 homemaker and nutrition services in Davidson
11 County. In response to a question that came
12 up earlier, we do have a small privatization
13 project that was contracted with
14 Mid Cumberland Human Resources Agency to
15 provide some homemaker services.
16 And yes, our turnover is
17 very low. We have 100 employees. About
18 85 percent of those employees are devoted to
19 delivering nutrition and homemaker services.
20 We have broadened our
21 support to seniors to include services to
22 relative caretakers in a range of ways. We
23 provide stipends for children who are placed
24 with kin and relative caretakers.
25 Basically, I think it's in all of your

1 congregations. It's probably in some of
2 your families. Everywhere you look, you can
3 touch them. And they are grandmas,
4 grandpas, aunts and uncles who are parenting
5 a second time around.
6 We began to see an increase
7 in this type of surrogate parenting back in
8 the '80s with the crack epidemic, and it has
9 continued to grow. So we are providing some
10 services there. Primarily, we outsource
11 those or contract then out. We have a
12 contract with Family and Children Services
13 to provide training. Homemaker staff also
14 provides homemaker services, and we try to
15 involve them in as many ways as we can.
16 In terms of the boomers --
17 I'm a boomer, myself -- a significant number
18 of boomers will not be retiring. They will
19 need to continue to work for a simple
20 reason, to support the families they
21 continue to parent. Some of those who
22 indeed thought they had a good retirement
23 planned are finding "My 401K does not speak
24 to my grandchildren. My Social Security, I
25 hope it's there when I retire in five or six

1 years, but they do not speak to my
2 grandchildren." So those are the kinds of
3 things, in addition to the health issues
4 that we need to be paying very close
5 attention to.
6 In terms of our low
7 turnover, I think Pat said it was about 9
8 percent or lower. We have -- and I
9 attribute it to the things Pat said earlier.
10 I think Metro Government, as well as Metro
11 Council, has indeed shown their checkbooks
12 for the simple reason that we don't do what
13 we do based on the reimbursement rates from
14 the Block Grant or the reimbursement rate
15 from GNRC.
16 Metro Government
17 supplements by adding $3 million to our
18 homemaker nutrition budget, which is about
19 $6 million. Half of that is local dollars.
20 The other dollars come through the
21 contracting relationships we have.
22 In terms of Metro
23 Government, my staff are Metro employees.
24 They receive an excellent benefits package.
25 They receive an excellent living wage. So I

1 can always say if folks are committed to
2 doing this and committed to having us
3 provide the services that seniors need, it
4 can't be done on the cheap. It can't be
5 done with training and retraining the same
6 people.
7 I think there's another
8 phenomenon when you begin to look at it;
9 that is, where do those staff come from?
10 Where are we recruiting? If you look in
11 terms of welfare reform, a significant
12 number of those people that left Families
13 First went into the service industry. They
14 are in the nursing homes. They are in the
15 fast food shops.
16 Those are the very people
17 who barely can survive, and now, we're
18 asking them -- as a previous speaker spoke,
19 you have to have people that come to work on
20 time and be committed. You can do that;
21 there's no reason for you not to come to
22 work on time. My kids are adults; I'm
23 focused, whatever. But if you're a single
24 parent with four children, there are days
25 when sometimes, you just can't hack it.

1 I think there's a resource
2 development issue, staff development issue.
3 We need to work closely with Families First
4 to provide people the necessary skill sets
5 to do the work. And I, indeed, want
6 somebody to be well-trained. After I come
7 back and haunt my kids because they didn't
8 take care of me in my old age --
9 (Laughter from the
10 audience.)
11 MS. ROBINSON: But I want
12 somebody who is caring for me to be
13 well-trained. So having said that, that's
14 where we are at.
15 (Applause from the
16 audience.)
17 MR. SELLS: Okay. Thank
18 you. Ms. Gilmore?
19 MS. GILMORE: Good morning.
20 I'm Brenda Gilmore, and I'm a Metro Council
21 member here in Nashville and just recently
22 was elected as the State Representative,
23 District 54. I guess, as part of what I do,
24 just somehow, because of my personality, I
25 think, I have become drawn into issues for

1 those who cannot speak for themselves.
2 I have served as
3 chairperson of the Senior Citizen's board,
4 where Adrienne works, for a period, and had
5 previously been on the board for about six
6 or seven years and served in a number of
7 capacities involving senior activities.
8 More recently, I had a
9 personal experience with an aunt of 81 years
10 old who I was the guardian for. She was
11 very active and began to have some health
12 issues. I personally felt that had we been
13 able to find someone to have been able to go
14 to her home a few days a week, we probably
15 could have kept her from the nursing home
16 much, much longer.
17 She is still living. She's
18 been a in a nursing home setting for about
19 four years now, but of course, her health
20 has deteriorated even further since she's
21 been in the nursing home setting.
22 So from my personal
23 perspective, I would say we started off --
24 let me back up. We did start off putting
25 her in a day care setting, but because she's

1 been so active in her earlier years, she
2 found that was very boring for her. It was
3 hard to keep her in there. There weren't
4 enough diverse activities in the day care
5 setting.
6 There weren't very many
7 options other than that, and because she had
8 been a working person all her life, just
9 working class, there weren't very many
10 options in terms of financial -- because of
11 finances, also, where we were not able to
12 bring someone into the house.
13 MR. TAYLOR: Since you're
14 here earlier than the afternoon session, I
15 would ask you if you would be so kind as to
16 comment, from a legislative standpoint --
17 you are on the Metro Council. What do you
18 see or what has been your experience on
19 these kinds of questions, from that
20 perspective?
21 MS. GILMORE: Well, first
22 of all, (inaudible) has already given me an
23 overview of her department, and they are a
24 great department. I made copies of that,
25 because I thought you might want to know

1 something about Metro Legal and how she was
2 going to be on the panel.
3 On the state level, there
4 are fourteen bills pending presently that
5 have to do with the aged population, some of
6 which I think will have a direct impact on
7 assisted living or trying to keep our
8 elderly at home long before they go into the
9 nursing home setting.
10 I think that probably the
11 biggest issue is just competing resources.
12 For every good project or cause, there are
13 probably another twenty-five or thirty that
14 we get bombarded with on a daily basis.
15 As a new legislator, I
16 would say that what I think is needed most
17 is just more collaboration on this issue,
18 finding other agencies who have the same
19 message and will help get that message out,
20 and maybe contact with legislators, giving
21 us talking points to help carry that
22 message, articulating very succinctly what
23 the issue is and what needs to happen,
24 giving us suggestions on what needs to
25 happen, and then helping us to go the word

1 out.

2 I think AARP does an

3 excellent job with this. I see them at the

4 legislature, almost on a weekly basis, and

5 it's people who look like ... what they are

6 trying to influence us to do. So those

7 would be some of my suggestions:

8 Collaboration, meeting with legislators on

9 an individual basis, telling us what needs

10 to be done and giving us suggestions.

11 MR. TAYLOR: Okay. Thank

12 you. We'll come back to you.

13 MS. O'NEAL: Hello,

14 everyone. I'm Lynne O'Neal. I'm very

15 pleased to be here today to represent the

16 Tennessee Department of Health. My specific

17 role is that of patient care advocacy. So

18 all the topics today are of much interest to

19 me.

20 I'm sorry. I'm not going

21 to be able to see everybody. I hate that my

22 back is to you guys.

23 As patient care advocate,

24 my whole focus is the best interest of the

25 patient. Of course, it must be. The

1 department has a major responsibility,
2 however, also, of regulating and licensing
3 health care facilities throughout the state
4 of Tennessee. Those health care facilities
5 include nursing homes, as you well know, and
6 assisted care living facilities, et cetera.
7 Actually, approximately
8 seven years ago, when I first interviewed
9 for this position as patient care advocate,
10 I was pleased to discover the emphasis on
11 the rights of patients, in addition to the
12 regulatory function. I find advocating for
13 the long-term care patients and those in
14 need of special health care to be most
15 fulfilling.
16 I am pleased that you're
17 doing these panel discussions today. I
18 think you're bringing out a lot of important
19 issues and those that are very dear to most
20 of us who are trying to provide services or
21 advocate for individuals with special health
22 care needs. It's very easy to become very
23 passionate about various service options,
24 and I can tell that most of you in this room
25 are very passionate.

1 The frustrating thing is
2 that it is very, very frustrating not to
3 find appropriate service options and not to
4 be able to offer those to the many callers
5 seeking help for their family members.
6 However, that frustration is oftentimes
7 alleviated -- or my personal frustration is
8 alleviated by the fact that I can guide and
9 refer them to some appropriate services and
10 to also identify areas of need for various
11 populations needing good health care.
12 Effecting change which can
13 enhance the quality of life for individuals
14 with major health care needs is a major and
15 very important role for me. And that's a
16 long-term goal for me. In the meantime,
17 assisting and sharing information and
18 assisting families, patients, and staff
19 remains as a daily goal.
20 MR. SELLS: Okay. Thank
21 you. One of the statements made a moment
22 ago -- and maybe one of you would like to
23 respond to this. How many of you are making
24 referrals to where there are long waiting
25 lists for services that, as someone said,

1 basically means the service isn't provided
2 because you're referred to a waiting list,
3 which means that there are not resources for
4 that?
5 MS. LIPPARD: Well, we, as
6 an agency -- our care managers make
7 referrals almost on a daily basis. Every
8 client that comes into our program, or
9 customer, no matter what their needs are, if
10 they have current needs for home- and
11 community-based services or we know they are
12 going to in the future, a referral is made
13 to the Options for Community Living Program.
14 Anyone that asks for
15 housecleaning assistance, personal care, any
16 of the services that they offer, they go on
17 that waiting list. We also, if it's
18 housecleaning, make referrals to Metro
19 Social Services. So all of our clients are
20 basically referred to those programs.
21 We provide some services
22 that are very, very limited to try to help
23 them until they can come up on that waiting
24 list, and once they do come up on the
25 waiting list, they are discharged from our

1 care.
2 MR. SELLS: How long are
3 they likely to be on a waiting list if they
4 are in need of the services now? What
5 happens in the --
6 MS. LIPPARD: It could be
7 three years. I'm not sure -- roughly, three
8 years.
9 MR. SELLS: So what happens
10 in the meantime?
11 MS. LIPPARD: They don't
12 receive the services they need. Families
13 end up losing jobs because they are taking
14 care of them. They do without and don't
15 live safely.
16 MR. SELLS: Do we have any
17 idea how many people are not applying
18 because they understand there's a waiting
19 list?
20 MS. LIPPARD: I'm sure
21 there are a number of people that don't
22 apply. My response to that is if somebody
23 says they don't want to go on the waiting
24 list, we basically say if you don't want to
25 wait, you'll never receive the services.

1 And it's basically a precursor to enrollment
2 in our program that you will go on those
3 waiting lists if you need those services.
4 MR. BONNYMAN: If I could
5 just speak to that, it's important to
6 understand how Medicaid and TennCare
7 eligibility work and the dynamics around
8 people being institutionalized.
9 People who need long-term
10 care typically need it now. And evidence
11 from other states shows that if you want to
12 successfully divert people from
13 institutions, you don't wait until after
14 they are institutionalized and they have
15 lost -- their whole social support system
16 has crumbled. You intervene at the point
17 where they have broken their hip and they
18 are about to be discharged from the
19 hospital, as an example.
20 If you put them on the
21 waiting list, the only place that has
22 immediate accommodations for them is an
23 institution. So we've got to move away from
24 this waiting list mentality for the services
25 that people want, but immediate service and

1 availability for the services that they
2 don't want and that cost more.
3 MS. O'NEAL: I would just
4 like to add that I definitely concur with
5 that. Many of the calls that I receive as a
6 patient care advocate are from hospitals
7 trying to immediately place someone who no
8 longer needs acute medical care but needs
9 the availability of 24-hour care. So that's
10 tough to find, except in an nursing home,
11 when there is a long waiting list for
12 services.
13 MS. LIPPARD: I would like
14 to share one quick story, and then I'll let
15 Gerri share. One thing that happened to me
16 recently was that I received a call from a
17 woman who was just all upset. Her mother
18 had been removed from the home by adult
19 protective services because she, herself,
20 had to go to a doctor's appointment. Her
21 mother would tend to wander, would not get
22 dressed, was not willing to go to the
23 appointment with her.
24 Unfortunately, what she did
25 was she moved a dresser in front of the door

1 to the mother's bedroom because she was
2 afraid she would wander off while she was
3 away. Well, she comes home and finds out
4 that this person was going to be removed
5 from the home. She said, "I didn't have any
6 options. I want to take care of my mom, but
7 she's on waiting lists. I can't get the
8 services that I need."
9 This woman ended up in an
10 institution, where she didn't want to be,
11 where her daughter didn't want her to be,
12 but unfortunately, the financial limitations
13 and the limitations in our system made that
14 happen.
15 MS. ROBINSON: It's also
16 important -- all these are excellent points,
17 and I agree with them. It's very important
18 that we're very careful and continue our
19 advocacy to make sure the resources are
20 there, because there is a possibility -- if
21 you look in terms of our homeless
22 population, it's growing, and it's growing
23 because when people are institutionalized --
24 and we don't have mental institution -- the
25 capacity wasn't there. So those people are

1 on the street.
2 There are no substance
3 abuse programs that can accommodate all of
4 the homeless. I would hate to see this
5 happen. Yes, we do want to prevent
6 institutionalization, but we really do want
7 to make sure that the resources within the
8 community are at the capacity to absorb all
9 those persons who are eligible.
10 MS. HOWELL: I agree that
11 we definitely need to put resources into
12 that. I work with GNRC, and we have --
13 MR. SELLS: Would you
14 please explain what that is for people --
15 MS. HOWELL: Greater
16 Nashville Regional Council Area Agency on
17 Aging and Disability. And we have, at last
18 count, 1,910 people in 13 counties waiting
19 for services.
20 We clearly do not have the
21 dollars to help these people, and we've done
22 everything we could to go through that
23 waiting list and make sure it's up to date,
24 as best as we could, and refer them out to
25 other services where they may be able to get

1 home-delivered meals or something a little
2 bit quicker, to work with them about private
3 pay capabilities, if they have that
4 potential.
5 Basically, the dollars are
6 not there. Each one of our plans of care,
7 for a year, averages $3,100 a year for
8 Options. Now, compare that to a nursing
9 home, which is 40-something thousand
10 dollars.
11 Now, I would rather see a
12 rebalancing of long-term care. It does not
13 need to be -- now, there's always room for
14 nursing home because it is an important,
15 integral part of it, but we need to
16 definitely rebalance this. And we're
17 looking at this nationwide as well.
18 (Applause from the
19 audience.)
20 AUDIENCE MEMBER: I'm
21 Sherry Lawler (phonetic), and I'm a
22 discharge planner in a rehab hospital, and
23 what I've found is -- I've been doing this
24 for a lot of years, and what I find is that
25 the Medicaid Waiver Program, in particular

1 -- you know, most of my patients, they don't
2 want to go into a nursing home. They would
3 like some kind of service at home.
4 With the waiting list -- I
5 get calls back. I'll refer people, and then
6 two and three months later, I'll get calls
7 back from them, and they will say, "What's
8 happening? Can you talk to somebody there?"
9 The financial eligibility is bogged down.
10 And so I just wondered about that. It takes
11 so long that, in effect, it is a useless
12 program, from a hospital discharge planner's
13 perspective.
14 And just one other thing --
15 presumptive eligibility. I had a question
16 about that. I understood, back in October
17 or at the end of last year, that the process
18 would be streamlined and that people who
19 already had gone through some kind of a --
20 you know, their finances had already been
21 looked at, and you could go ahead and
22 provide services immediately, once the PAE
23 was approved. Then you have 45 days to do
24 the financial piece. But, I mean, how
25 effective is it? How many people have

1 actually -- because I still haven't had
2 anybody who I've been able to get services
3 for quickly.
4 MS. HOWELL: Well, I'll
5 speak to both. First of all, the Medicaid
6 Waiver Program is labor-intensive. They
7 have to go through, basically, three prongs
8 with the PAEs, the nursing home level of
9 care. This depends on how long it takes for
10 the doctor -- because this is a
11 physician-driven document -- how long it
12 takes for the doctor to respond and fax that
13 back to us.
14 We have to also get the
15 financial eligibility, which, you know, a
16 lot of the counties are thinking that they
17 have to hold the application for 30 days,
18 because that's what they do for
19 institutions. So they have been operating
20 on that particular -- and then the third is
21 health and safety.
22 So it's a very bureaucratic
23 kind of thing to get people through. And
24 depending on the person's potential to
25 respond and depending on the physician's

1 ability to respond immediately, we're at the
2 mercy of, you know, other people's
3 timetables. So it has been roughly two to
4 three months before we can get someone
5 enrolled into the program.
6 Now, when I did this in
7 Florida, it was the same thing, but they
8 streamlined it a bit. And I know other
9 states have developed PAEs, or nursing home
10 level of care instruments, that would
11 streamline that process, as well.
12 In Florida, they don't
13 require a physician to sign off on the
14 document. This is done by a case manager.
15 There is a review, but it does not -- the
16 actual assessment for nursing home level of
17 care does not have to be completed by the
18 physician. So there are things that we can
19 do.
20 Now, as far as presumptive
21 eligibility, that's -- the way it's
22 implemented is that, you know, we can do
23 presumptive eligibility, but the way it was
24 set up, certain groups of the population
25 were not allowed to participate. And we're

1 talking about Supplemental Security,
2 SSI-level individuals who definitely have
3 low income, anybody that's been on long-term
4 care, you know, within the past few months
5 and they are still on the rolls.
6 What happens is that the
7 agency has to take the risk of the amount of
8 presumptive eligibilities that we submit.
9 So anything over a certain amount, then
10 we're going to have to figure out how to pay
11 for it.
12 MR. TAYLOR: We're going to
13 move on. I'm going to ask a question of
14 Ms. Robinson and Ms. Gilmore. What needs to
15 be done at the Metro/local level to make
16 more services available for people? I
17 understand there's a waiting list for your
18 services. What are the policy or budget
19 issues that have to be addressed so that we
20 don't have these waiting lists for people
21 who need services immediately?
22 MS. ROBINSON: You know,
23 they are just demanding, you know,
24 competition, competing demand, I guess I
25 would say, in terms of the budget. As you

1 are aware, all Metro department heads are
2 required to submit a budget to show the 10
3 percent decrease. And I would say that the
4 resources that are there and how one choses
5 to prioritize it -- and I'm not saying --
6 given that I'm a boomer, yes, I, Gerri
7 Robinson, individual, am very high on having
8 the resources there, but when they reach the
9 level at which things get funded, there are
10 competing demands.
11 The issue becomes: Is it
12 schools, or is it something else? And I
13 think the taxpayers made an interesting
14 statement about that, when I first moved to
15 Nashville, regarding schools. So if there
16 is a community will and a community push for
17 those resources, then communities prioritize
18 it. And to quote Mr. Bonnyman, who quoted
19 his minister, citizens will have to show
20 their checkbook.
21 MS. GILMORE: I think my
22 situation is probably no different than the
23 other 35 other council members, that when we
24 get inquiries from constituents, we address
25 those issues on a individual basis. When I

1 get a call -- the most recent call was from
2 an elderly person that's on Meals On Wheels,
3 and she's also on dialysis. The Meals On
4 Wheels does not come late enough for her, so
5 she misses her meal. I approach that from
6 an individual basis.
7 Listening to the discussion
8 today, though, has been helpful, and maybe
9 one of the things -- because we don't know
10 the severity of the issue, we can probably
11 request an annual report from the agencies
12 that provide these services, such as social
13 work, that would give us an indication of
14 how broad the issue is. That would give us
15 statistics about the waiting list and some
16 of those other issues.
17 So from a public policy
18 standpoint, we could probably do that
19 through a report style so that we could
20 know, collectively, what all of us are
21 dealing with rather than just zeroing in on
22 a district basis.
23 MR. TAYLOR: I would ask
24 Mr. Bonnyman if he would be so kind as to
25 tell us what he believes to be the political

1 questions, impediments. Why hasn't this
2 been more central to the debate?
3 MR. BONNYMAN: If I could
4 just segue from the previous question,
5 you've got to triage here and you've got to
6 pick your targets. Metro, I think, is doing
7 as well as it can, given the constraints,
8 like the nonprofit sector is.
9 State policy drives this.
10 It's no accident that you've got cities like
11 Nashville and Portland, Oregon, very
12 comparable in some ways, and you've got
13 totally different long-term care systems in
14 those two cities. And it's not because of
15 city policy. It's because of state policy.
16 So we've got to focus on
17 where the money is. The big money is at the
18 state level. It's controlled by a handful
19 of state policy-makers. That leaves Metro
20 and the nonprofit sector, really, just
21 trying to play catch-up. To give you an
22 example, there's been a lot of talk at the
23 state level about new TennCare initiatives
24 to expand home- and community-based
25 services.

1 We're talking really about
2 what I heard one senator in state government
3 refer to as "budget dust," in terms of the
4 amount of resources that really reflects.
5 In the same period, we have literally
6 extracted hundreds of millions of dollars
7 from the TennCare program for pharmacy.
8 What's the connection? Because you're
9 taking away prescription drugs that help
10 someone who is hypertensive not have a
11 stroke. You think that doesn't have
12 anything to do with home- and
13 community-based services?
14 The State continues to make
15 policy with an utter disregard to the impact
16 downstream for what happens to people and,
17 ultimately, families and communities when
18 they make a decision in TennCare that is
19 either going to debilitate people and force
20 them to now need long-term care that, if
21 they had gotten the time and care, they
22 wouldn't have needed or, when they need
23 long-term care, keeps them from getting it
24 in a home- and community-based setting.
25 So I understand the

1 question about Metro. I just want to
2 applaud what Metro has done, and I would say
3 to Representative Gilmore, we thank you for
4 what you are doing on the Council. You need
5 to do more in the legislature, because
6 that's where you need to get the "most juice
7 for the squeeze."
8 The reason it hasn't
9 happened politically is because there are
10 folks who sit on that billion dollars and
11 don't want to give it up. They are the
12 long-term care industry, the nursing homes,
13 and then there's also this whole resistance
14 to -- "we don't want anybody drawing
15 TennCare that might be able to make a claim
16 for services that we just don't want out
17 there. We don't want to create new
18 services, because then people will use
19 them."
20 That mind-set ignores the
21 fact that we are already spending way more
22 than enough to deliver an elaborate array of
23 home- and community-based services across
24 the state. Other states are the proof of
25 that.

1 MS. ROBINSON: I would like
2 to just reiterate and support what Council
3 Member Gilmore has just said. Lee Stewart
4 preceded me on the panel. He spoke about
5 his role in Metro Social Services.
6 Metro Social Services has a
7 planning and coordinating function, and a
8 majority of what Lee and his colleagues in
9 that unit do is collect data, collect
10 information, and it should culminate in a
11 plan, in a social services plan, a
12 comprehensive social services plan for
13 Davidson County.
14 This discussion, for one,
15 should be a part of that. A draft of that
16 plan will be presented in the April board
17 meeting. I think it is a plan that we
18 indeed should share with the Councilwoman
19 and, if you would, ask us to bring that
20 forth, and it should reflect -- I'm hopeful
21 that we can have the transcript from today's
22 meeting. You've raised some cogent points,
23 particularly in terms of bringing people
24 together.
25 The faith community has

1 done a significant job, particularly in
2 terms of helping us work with homeless
3 individuals, and those funds and the
4 knowledge that we put together are now
5 there. And I'm quite sure all of you have
6 sought to have senior ministries and those
7 kinds of things.
8 In this discussion, this
9 rich discussion, all of those things should
10 be a part of our plan. So yes, indeed, it
11 won't be just another plan. It will be, I
12 think, one of the most important ones that
13 will come out of that division in our
14 department.
15 MR. TAYLOR: Let me ask a
16 question I haven't had a chance to ask. The
17 private sector of the home care industry
18 that provides home-based care to people like
19 visiting nurses, do any of your have any
20 experience working with them or where do you
21 think they would stand on these questions
22 that we're raising today? If you have any
23 insights into that, take a minute to address
24 that. Have you had any contact with the
25 private side of this equation?

1 MR. BONNYMAN: I hate to
2 sound like Johnny One-Note, but the money
3 drives this thing, and people need to
4 understand that it's not just about Medicaid
5 or TennCare beneficiaries. What Medicaid
6 does and TennCare does affects everybody,
7 including very affluent people, because if
8 you have a billion-dollar industry and all
9 but a pittance of that goes into
10 institutional care, that's what people are
11 going to respond to, and those are the
12 services that are going to get generated.
13 So when Adrienne talks
14 about developing the infrastructure, that's
15 something that's very difficult to do if the
16 dollars are going someplace else. That
17 infrastructure is drawn on by people like my
18 mother, who needs long-term care right now.
19 She has the means to pay. She lives in
20 Knoxville where those services don't exist.
21 It's basically one flavor. It's
22 institutional care.
23 I think the home health
24 agency, other agencies -- there are
25 providers out there, including the nonprofit

1 sector, that would be responsive, but the
2 dollars are what not only keeps the money
3 going in the institutional direction but
4 really stunts the growth of infrastructure
5 in the other sectors.
6 MS. ROBINSON: Can I just
7 add to that? I personally think it might be
8 somewhat cynical. There's no such thing as
9 the private sector. There are contractors
10 to some public entity. There is no such
11 thing as a private sector. Adrienne, you
12 guys, in some way, have a contract with a
13 public entity. So what you're saying is 100
14 percent correct.
15 MR. TAYLOR: So you're
16 saying there's no industry to service
17 wealthy senior citizens on their own?
18 Medicare doesn't --
19 MS. ROBINSON: When it
20 comes to my customer base, which I
21 consider -- we serve the poorest of the
22 poor.
23 MR. TAYLOR: I understand.
24 Part of the political issue is that it's not
25 just simply the poorest elderly that are

1 facing this crisis. There are middle-class
2 homeowners, middle-class families like mine
3 or my mother, who I'm trying to take care
4 of, and others who are facing this crisis
5 who don't qualify for any public programs
6 presently.
7 This question has got to be
8 about more than just the poor elderly,
9 because the middle class, who have elderly
10 issues in terms of home-based care -- if
11 they are not brought into this fight, you're
12 not going to have enough political base and
13 will to win this fight. So I'm trying to
14 get an answer on the issue of middle-class
15 families trying to address the issue of
16 taking care of --
17 MR. SELLS: Let me just
18 address one thing that I talked about with a
19 member of our congregation who runs a
20 nursing home assisted-living facility here
21 in the city. He said to me, "We are the
22 most expensive nursing home in the city.
23 It's $84,000 a year." Now, I went home to
24 my wife and said we better be looking for a
25 bridge, because if we both needed nursing

1 home care at that cost -- and it could be 90
2 or 100 in just a few years -- we're going to
3 be living under a bridge.
4 So this is not just an
5 issue for the poorest. The middle class and
6 other folks are not going to be prepared for
7 these kinds of costs.
8 Now, I want to ask a policy
9 issue of Ms. O'Neal for a moment and see if
10 you have any connection. We've heard that
11 this PAE, which is a medical document which
12 determines one's eligible for either going
13 into a nursing home or having long-term care
14 assigned -- that document is the same and
15 it's a medical document and it's signed by a
16 doctor, correct, and the understanding is
17 that it's signed by a doctor at TennCare, by
18 the State?
19 MS. O'NEAL: The
20 pre-admission evaluation unit of the Bureau
21 of TennCare.
22 MR. SELLS: So what are
23 your thoughts about changing the procedure
24 of this document to make it less demanding
25 so that people could have a way to get into

1 home-based care? What is your role in that?
2 MS. O'NEAL: I really don't
3 have a role in that.
4 MR. SELLS: But you're an
5 advocate.
6 MS. O'NEAL: Yes. And from
7 that standpoint, let me tell you what I
8 think. We have great rapport with the
9 pre-admission evaluation unit. They do
10 review those things very rapidly from the
11 nursing homes, and I've not had any
12 difficulty or any complaints or concerns
13 about the PAEs for the Waiver Program
14 either.
15 Again, from a personal
16 advocate point of view, I don't get called
17 regarding that. I do get calls and concerns
18 from people out in the community who do not
19 get enough home health visits from home
20 health agencies. To try to answer your
21 question just a little bit, to touch upon
22 yours, Mr. Taylor -- Reverend Taylor?
23 MR. TAYLOR: No.
24 MS. O'NEAL: I'm sorry,
25 Mr. Taylor. Okay. I just gave you a higher

1 calling. Mr. Taylor, to relate to your
2 earlier question just a little bit about
3 what is there for individuals and what
4 Medicare does and doesn't do, et cetera,
5 home health visits, of course, can be
6 ordered by doctors, by your primary care
7 physician, as we all know.
8 The calls and concerns that
9 I receive quite frequently, however, state
10 that staff, home health agency staff, are
11 not coming at scheduled times. So that
12 causes great problems for families and
13 people who are in the homes, those people
14 who are going to that doctor's appointment
15 that have the dresser in front of the door,
16 et cetera, that we heard about earlier. So
17 there are lots of concerns and questions
18 regarding current home health service
19 provisions.
20 MR. TAYLOR: We have one
21 last comment. We're going to have to wrap
22 this up.
23 AUDIENCE MEMBER: Well, I
24 just also wanted to speak to what Gerald
25 said because the congregation that I'm a

1 member of has a lot of elderly people in it,
2 and I think that it is the matter of they
3 don't try to go to anybody for any help. I
4 think there's a point of pride too.
5 Many of them have some
6 resources and they have a lot of family in
7 the city, so they piece together ways to
8 take care of themselves, but they are
9 spending so much money to stay at home, and
10 right now -- like the woman in my
11 congregation that works with the senior
12 community who was going to be here today.
13 The caregiver who takes care of her husband
14 wasn't able to show up. She is always
15 having trouble with having to change things
16 and having to move things, and her husband,
17 whose mind is very sharp -- but can't do
18 things because a caregiver doesn't show up,
19 one person doesn't show up. She's spending
20 hundreds of dollars a month which, right
21 now, she has. She doesn't know how long --
22 you know, it's going to run out.
23 As people talked about
24 before, as we're living longer, even people
25 with resources -- and I think Gerald is

1 absolutely correct that --
2 MR. TAYLOR: Hold on. You
3 have 30 seconds on this. We're going to get
4 your question in. Just give me a second.
5 MS. ROBINSON: What I
6 believe is happening to a lot of
7 middle-class individuals is the same thing
8 that my 90-year-old mother-in-law did. She
9 did a spend-down, reassigned her resources,
10 self-induced poverty, and is on medical
11 assistance.
12 AUDIENCE MEMBER: I would
13 invite you to talk to us about that a little
14 more.
15 MS. LIPPARD: That is the
16 other thing I was thinking too, that a lot
17 of people do exactly what she said, asset
18 protection, for folks that can do that far
19 enough in advance that there's not the
20 look-back that they get affected by.
21 Also, for middle-class
22 families, what's happening a lot of the time
23 is that they do put their person in the
24 nursing home because it's the only option.
25 They spend down their money. They get to

1 the point that they are ready to be
2 Medicaid-eligible. Then they don't pass the
3 PAE. And so they are told you either have
4 to take this person out of the nursing home
5 or you have to continue to privately pay for
6 it. Where do these people go? And they
7 have already spent down.
8 MS. HOWELL: I would like
9 to speak to the PAE. I think it's important
10 because the threshold for the PAE in the
11 state of Tennessee is very restrictive. You
12 have to be at a very high level of
13 dysfunction in order to qualify.
14 What you have to do, in
15 other states -- you would be surprised. All
16 the other states do not have as restrictive
17 a PAE threshold. So we need to look at
18 other states on how they are handling it.
19 MR. TAYLOR: Okay. Your
20 question. Go ahead.
21 AUDIENCE MEMBER: I would
22 like to ask Representative Gilmore, since
23 you're new, to find out from other
24 legislators what became of the wheelchair
25 protestors wanting to stay in their homes.

1 And if nothing has happened, would you put
2 legislation in to do some of these things?
3 MS. GILMORE: Yes, I'll do
4 that research on that, but again, I want to
5 say there are fourteen pieces of
6 legislation.
7 MR. TAYLOR: You'll leave
8 those for us, also?
9 MS. GILMORE: Yes, I will.
10 MR. TAYLOR: Any last
11 comment before we break? You said you've
12 got a 10-second question.
13 AUDIENCE MEMBER: Mr. Bonny
14 man, do you think that there would be any
15 utility to a class-action type of lawsuit
16 from nursing home residents who -- on behalf
17 of nursing home residents who would like to
18 live back in the community, that is, the
19 community of their origin, not in the
20 nursing home community?
21 MR. BONNYMAN: Actually, we
22 did that years ago, and we settled with the
23 Governor three years ago. That's the
24 agreement that I referred to. There was a
25 commission that was created out of that. An

1 expert was brought in from Denver, someone
2 from Oregon, all the programs. They came up
3 with the answers to all these PAE wait list
4 issues, came up with a great plan, and two
5 years ago, the State trashed it, disbanded
6 the commission. It's a political issue of
7 holding policy-makers accountable for
8 situations. It does not have to be this
9 way.
10 MR. TAYLOR: We'll ask for
11 a copy of what Gordon has just referenced.
12 Thank you so much for coming. We appreciate
13 it. We're just at the beginning of what we
14 hope will be a long-term fight for change.
15 Thank you very much.
16 (Applause from the
17 audience.)
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