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TYING NASHVILLE TOGETHER
HEALTH ACTION TEAM

CITIZENS' HEARING AND PANEL DISCUSSION
ON HOME AND COMMUNITY-BASED CARE

PANEL 2:
NURSING HOME AND HOME HEALTHCARE OFFICIALS

MARCH 29, 2007
WEST END UNITED METHODIST CHURCH
2200 WEST END AVENUE
NASHVILLE, TENNESSEE 37203



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PANEL MEMBERS:

DIANE GRAMANN, Area Director, Alzheimer's
Association

LEE STEWART, Metro Social Services, Planning
and Coordination Division

STEVE ZAGORSKI, Centennial Adult Care Center

PAT WINGFIELD, Metro Social Services,
Program Manager, Homemaker Program

KAREN ROBERTS, The Martha O'Bryan Center,
Senior Services Coordinator, Meals On
Wheels

TNT PARTICIPANTS:

DR. MYRON TOWNS, St. Vincent de Paul
Catholic Church

BILL BARNES, Tying Nashville Together

MARGE LEWIS, Hillsboro Presbyterian Church

TINA THOMPSON, Chairperson, Healthcare
Committee, Tying Nashville Together

REV. JAY HARTLEY, Pastor, Eastwood
Christian Church, Disciples of Christ

1 REV. HARTLEY: All right.

2 Good morning, everybody. My name is
3 Reverend Jay Hartley. I'm the pastor of
4 Eastwood Christian Church, Disciples of
5 Christ, over in East Nashville.

6 We've been a member of TNT
7 for about six years now, and I have served
8 on the leadership team and chaired the
9 leadership team over the past several years.
10 And I'm going to pass the microphone down.
11 We will introduce ourselves.

12 MS. THOMSEN: Tina Thomsen,
13 chair of the healthcare committee for Tying
14 Nashville Together and a member of West End.

15 MS. LEWIS: I'm Marge
16 Lewis. I've been involved in TNT for about
17 seven or eight years, I guess, and I'm a
18 member of Hillsboro Presbyterian Church.

19 MR. BARNES: I'm Bill
20 Barnes. I'm one of the surviving dinosaurs
21 of TNT.

22 (Laughter from the
23 audience.)

24 MR. TOWNS: I'm Myron
25 Towns. I'm an aspiring dinosaur --

1 (Laughter from the
2 audience.)

3 MR. TOWNS: -- for about
4 four or five years, I've been an interested
5 person in social justice at St. Vincent de
6 Paul Catholic Church.

7 REV. HARTLEY: At this
8 point, we want to invite our panelists to
9 introduce themselves, the organization you
10 represent and any opening statement that you
11 have concerning the topic of long-term
12 healthcare. You have five minutes each for
13 your introduction. Later, when we ask you
14 questions, we'll give you two minutes for a
15 response to each question. So we'll start
16 here.

17 MS. WINGFIELD: My name is
18 Pat Wingfield, and I'm program manager for
19 Metro Social Services' Homemaker Program.
20 And what our program does is allow
21 individuals to stay in their household as
22 long as they possibly can by providing
23 homemaker services and personal care.

24 This way they do not have
25 to go into nursing home care, either because

1 they are unable to do so many things for
2 themselves that they can't live at home
3 independently, or for a longer period of
4 time until they get to that point and have
5 to go into nursing home care. I've been
6 with Metro Social Services for thirty-five
7 years. I've been with the homemaker program
8 for ten years.

9 MR. ZAGORSKI: I'll only
10 take five minutes. I'm Steve Zagorski. Our
11 organization is Centennial Adult Care
12 Center, which is an adult day care program.
13 We are also a provider of home- and
14 community-based services.

15 MR. L. STEWART: I'm Lee
16 Stewart with Metro Social Services' Planning
17 and Coordination Division. And I'll take
18 three minutes of your five. I do not
19 represent nursing homes. However, I also am
20 kind of a dinosaur like Bill. I've been
21 around the system for a long time. I've
22 worked in the field of adults with
23 disabilities, case management with families,
24 family support, aging with the Area Agency
25 on Aging and Disability, locally.

1 For the last fourteen
2 months, I've been with Metro Social Services
3 as the adult senior coordinator. My mission
4 is to assist community efforts to address
5 needs for the most vulnerable adults and
6 senior citizens in Nashville.

7 One message I carry now
8 everywhere I go is about baby boomers, but
9 not just baby boomers. We all know about
10 boomers. Boomers rule. We know that we've
11 influenced everything, especially in
12 America, all of our lives. We're getting
13 older. We're looking at retirement. And
14 we're looking at eventually beginning to
15 need services. The generation after us has
16 been called "the busters," and the one after
17 that is called "the boomlet." So we have
18 boomers and busters and boomlets, oh my.

19 America is aging. It will
20 never again be as young as it was before
21 World War II. We cannot build enough
22 nursing and residential facilities to take
23 care of everyone who is going to need
24 support. So I recommend that we change the
25 reimbursements for community and home

1 support and continue to encourage nursing
2 homes to get into the community and home
3 support business. It's good for them
4 marketing-wise. They establish a connection
5 with their consumers prior to need. It also
6 is good for them in a business sense in that
7 they diversify. The only problem that we
8 have is, as Steve has mentioned, the
9 reimbursement rates are too low. They don't
10 approach private pay rates. Families want
11 community-based care. It's cheaper. It's
12 best practices. There is nothing in the
13 world to prevent it except restructuring the
14 funding. Thank you.

15 MS. GRAMANN: My name is
16 Diane Gramann, and I'm the area director of
17 the Alzheimer's Association. We estimate
18 there are 7,000 people in Nashville, alone,
19 with Alzheimer's disease. That's one in
20 eight of everyone over the age of 65. That
21 number is going to just grow with everyone
22 coming into that population category. And
23 that doesn't even include those with early
24 onset disease under age 65. Most of those
25 folks are in the home, not necessarily in

1 nursing homes.

2 We have what is called a
3 Family Respite Fund for people who are
4 caregiving in the home. We provide \$200 a
5 month for those families to provide respite
6 services. They can choose to use that money
7 however they see fit, whether it's to use it
8 for adult day care services, sitter-type
9 services to come into the home, personal
10 care services, or even homemaker services.
11 It's their choice.

12 Obviously, we don't have
13 enough money to serve everyone. We're
14 currently serving fifteen families right
15 now. We cover twenty-two counties. We've
16 got twenty-five people on the waiting list,
17 and we're not taking any more applications.
18 We have had people on that list since 2001,
19 and many people will either go into a
20 nursing home or die before we can get to
21 them.

22 What we're doing now is
23 partnering with Senior Citizens,
24 Incorporated to collaborate on providing
25 senior companions at a lower rate so that we

1 can take this service into more rural
2 counties. And we hope that United Way will
3 begin to fund this program so we can bring
4 more of these services to more families out
5 in more rural areas, but it's still
6 underfunded and certainly needed. These
7 respite care programs that we provide are
8 only for those with a \$35,000 annual income
9 level or below.

10 I did want to make a
11 comment about the Medicaid Waiver Program.
12 There is a state pilot program going on at
13 the Ajax Turner Senior Citizen Center in
14 Clarksville. It's brand new. They are
15 providing case managers out there to help
16 streamline this process for those who live
17 in Montgomery, Houston, and Stewart
18 Counties. So they are trying this to help
19 get more people into that program to take
20 these slots that are available for services.

21 MS. ROBERTS: I'm Karen
22 Roberts, and I'm senior services coordinator
23 and the Meals on Wheels coordinator for
24 Martha O'Bryan. And I apologize for being
25 late, but I wear many hats. I only recently

1 started working with seniors. I have had a
2 long history of working with various
3 populations. And I must say that, in
4 speaking from my heart, my heart has been
5 broken many times.

6 In my recent employment
7 with my new job with Martha O'Bryan, we
8 serve -- right now, I have about 105 seniors
9 on my case load as part of Meals On Wheels.
10 And some of what I have witnessed is quite
11 disturbing, and unless we -- I'm glad to see
12 that we're here, that we're talking about
13 this issue, because if we don't deal with
14 this issue, it is only going to escalate.
15 And I'm not sure what the outcome will be,
16 but I think it's going to be tragic.

17 Many of the seniors that I
18 work with are unable to get out of their
19 homes. They are immobile. They do not have
20 transportation, incomes of \$500 or less, and
21 with very few resources, family resources.
22 They lack the ability, in many instances, to
23 advocate for themselves. And in I walk to
24 try to assist the seniors as best as I can,
25 but the needs are greater than one person or

1 two persons, three -- it's really going to
2 take a community's concerted effort in order
3 for us to really be able to address this
4 issue.

5 I have, for example --
6 let's take a senior -- her name is Ms. T.
7 Ms. T has glaucoma. She has arthritis. She
8 has hypertension. She has diabetes. And
9 she's on a fixed income of \$500 or less.
10 Ms. T is representative of many of the
11 families that I serve. Ms. T worked as a
12 domestic. She worked many years ago helping
13 -- thirty years of her life, working as a
14 domestic person working with families and
15 taking care of other families, and she has
16 no resources. So when Ms. T is not able to
17 get out, she's not able to speak for
18 herself. There's cognitive damage. There's
19 some cognitive decline.

20 So when I go in to work
21 with Ms. T., I do a comprehensive
22 assessment, and once I determine what those
23 needs are, we need to be able to access the
24 services that can be provided for that
25 person, for Ms. T. What I find is that

1 Ms. T has not gone to the doctor for months.
2 She has not taken a medication --

3 Ms. T is taking several
4 different types of medications. She can't
5 see the medications that she's taking.

6 Ms. T can't dial a number. She can't dial.
7 She can't get verification. Ms. T cannot
8 even advocate for herself. As I said,
9 there's some cognitive decline. Ms. T is
10 representative of many of the seniors that I
11 work with who are helpless and defenseless.

12 I'm glad to see we're
13 coming together and we're talking about
14 this. The individuals that I serve are low
15 income and marginalized. And, often, they
16 are thankful for what they have. They are
17 so grateful for the very little that they
18 have. They are afraid to complain. Many of
19 them are isolated and alone and live in
20 communities where they already feel unsafe.
21 So when they see someone like me come, they
22 are so glad and they are so thankful for
23 that person.

24 Yet, there is only so much
25 that my program can provide because we're

1 limited in the people resources and in the
2 funding in order to be able to provide what
3 is needed for our seniors. The other thing
4 is education. We do need education. So
5 care managers, possibly, that might be
6 trained to work with our seniors -- and I
7 think my time is up. I'm sure I answered
8 your question or addressed the issue, but
9 those are some of the things that I deal
10 with on a daily basis. Thank you.

11 REV. HARTLEY: Thank you.
12 We had also invited the nursing home
13 industry's state association to have
14 representatives here. And they initially
15 told us that they would be here, and then
16 they chose not to come.

17 We have a series of
18 questions now, and we would like you to keep
19 your responses to two minutes or less, and
20 it should be pretty clear when you run out
21 of time, with that little stop sign. Keep
22 an eye there. And Marge Lewis has our first
23 question.

24 MS. LEWIS: Some of you
25 have answered this part of this question

1 fairly well, but there are other parts that
2 have to do with funding. Explain your
3 service, how people access it, and what the
4 average cost is. Maybe we could start down
5 here with Diane. If you can, address the
6 part about explaining your service, then how
7 people access it and what the average cost
8 is.

9 MS. GRAMANN: The cost is
10 free for families. They access it by
11 filling out an application through us. Now,
12 they get referred to us by a number of
13 different ways. The service is explained in
14 our brochure, and that brochure is
15 distributed to everybody throughout the
16 Middle Tennessee region. So they just need
17 to call our office.

18 We're really hesitant to
19 send out those applications at this point.
20 We're really not encouraging people to make
21 application because we've had people on the
22 waiting list for so long. So we're really
23 not encouraging people to apply for the
24 service anymore.

25 They have to meet income

1 requirements for the service. They do have
2 to have their Alzheimer's or related
3 disorder patient in the home. They have to
4 be caregiving in the home for that person.

5 MR. L. STEWART: Pat
6 Wingfield, to my right, is the expert on
7 Metro Social Services, on home services, but
8 I'm not going to let this opportunity pass
9 without giving you a magic number and making
10 sure it's in the record in case no one else
11 mentions it.

12 The number in the Metro
13 calling area is 255-1010. There's a long
14 distance number that Clara can tell you.
15 This is the Aging and Disability Resource
16 Connection of the Area Agency on Aging and
17 Disability. They have counselors who are
18 nationally certified in information referral
19 and assistance. And for folks who are older
20 with support needs and adults with
21 disabilities, that's the number to call to
22 access government-funded programs in this
23 region and to find out what other resources
24 are available. I wanted to make sure
25 everybody here got that number and that it

1 was in the record.

2 MR. ZAGORSKI: Another
3 resource -- Clara, could you hold up the
4 Council on Aging's magic book? That book is
5 probably the most comprehensive resource on
6 how to access all services in the aging
7 field. And Mary Beth, the director of the
8 Council on Aging, is the source of that.

9 Let me talk about adult day
10 care. First of all, people don't even know
11 what adult day care is. There's a million
12 different versions of it. Our services are
13 open from 7:00 in the morning to 6:00 in the
14 evening and have a very structured program,
15 with a registered nurse on staff part-time.
16 Our goal is to be proactive and engaged
17 mentally, physically, and socially. I can
18 talk a lot about the therapeutic benefits of
19 all the cognitive therapy we do. It's
20 really about quality of life, not being home
21 by yourself being baby-sat by the TV.

22 The biggest problem with
23 adult day care is who is going to pay for
24 it? It's not covered by Medicare. It is
25 now covered by the Medicaid Waiver as of

1 October 1st. On February 20th, we became
2 the first, I think, center in the state to
3 be qualified. And we actually have two
4 people now.

5 If you're a veteran, it
6 will pay all the care for adult day care,
7 including transportation to and from the
8 home and bathing every day. They decided in
9 the '60s that adult day care kept people out
10 of nursing homes.

11 The Options Program will
12 pay for adult day care. Long-term care
13 insurance will qualify. A lot of people pay
14 for it privately. We charge \$62 a day,
15 which is dirt cheap for eleven hours, a
16 meal, two snacks, nursing services. But if
17 you're on a fixed income, \$62 a day is not
18 so cheap. We're the most expensive because
19 we're the most comprehensive center around.
20 We also do in-home care, personal care,
21 respite care, homemaker services, meals, all
22 those other things which have a fee
23 schedule, private pay between 19 and 23, but
24 fortunately, paid for by the Options
25 Program. Okay.

1 MS. WINGFIELD: With Metro
2 Social Service's Homemaker Program, the way
3 individuals are able to get into our program
4 is to call. They can call, themselves, to
5 be placed on a waiting list, or we have
6 received calls from social workers, other
7 agencies, physicians, relatives. Then we
8 place them on a waiting list.

9 The thing about our program
10 is we have a waiting list right now of 135
11 people. This service is a much needed
12 service, but we only have, you know, limited
13 staff in order to provide these services.
14 We're providing service, right now, to right
15 at 400 people in Davidson County because we
16 only service Davidson County. There are
17 other programs that service the other eleven
18 counties as well.

19 They have to fall within
20 income guidelines, and most do, but you
21 know, some of the ones -- like Lee said, we
22 have a lot of baby boomers, and their income
23 is much higher than the elderly population
24 that we've always had. So they, you know --
25 some of them will not be eligible. Some are

1 eligible, but we're getting a lot of baby
2 boomers in the older generation now.

3 A lot of the younger
4 generation, people in their 30s, are needing
5 this care. Someone goes into their home to
6 do light housekeeping, shopping, laundry,
7 mopping, dusting, vacuuming, personal care.
8 We do all this at no charge to the
9 individuals that fall within that criteria,
10 but because this is such a needed service,
11 it's hard to get the waiting list down, and
12 that's because of funding. I have two
13 funding sources that assist with providing
14 services; that's through the Metro Social
15 Services Program and also through GNRC, the
16 Options Program. And they send referrals to
17 us.

18 MS. ROBERTS: I think I
19 said this earlier, but Martha O'Bryan is
20 serving right now, through our Meals on
21 Wheels, about 100 people. We can actually
22 serve more. We get several referrals
23 throughout the course of a month, but
24 unfortunately -- and all our services are
25 free. We get referrals from Metro Social

1 Services. We get referrals from doctors.
2 We get referrals from volunteers, social
3 workers, et cetera.

4 Almost 100 percent, all of
5 them, are in need of a meal, so we provide a
6 hot meal daily, Monday through Friday. And
7 that is usually my initial contact with a
8 senior. From there, I go into the home.
9 Then I do an assessment to make a
10 determination of what some of the needs are.
11 And at that point, I try to access those
12 services.

13 That, of course, is where I
14 run into difficulties sometimes. I have
15 found, within our community, there are
16 many -- through Metro Social Services,
17 through Senior Citizens, Inc., through
18 Centerstone, through our clinic, there are
19 good folks out there who want to do
20 something, but once again, there is a
21 shortage of people resources.

22 A senior requires intensive
23 care management, not just "go in, and here's
24 what you need to do." They actually require
25 that someone is working directly with them

1 and stays with them until they are moved
2 into a stable place in their lives. And,
3 sometimes, that can take a while, and it can
4 definitely take a great deal of patience.
5 It takes a kind of know-how to somehow
6 understand what the senior is in need of.

7 Once I'm able to make a
8 determination about what their needs are,
9 then of course, I'm on the phone quite a bit
10 of the time, trying to find out what
11 resources are available within our
12 community. My suspicion is that -- and
13 again, I'm just an observer --

14 (Ms. Reed indicates allowed
15 time has lapsed.)

16 MS. ROBERTS: Okay.

17 REV. HARTLEY: We'll give
18 you a chance to tell us what you suspect in
19 just a moment. Thank y'all for your
20 responses. I wanted to ask a quick
21 follow-up question of Steve. Your services
22 are 7:00 a.m. to 6:00 in the afternoon.
23 People need to get their own ride there,
24 correct?

25 MR. ZAGORSKI: We provide

1 transportation at an additional fee. We
2 have some people that come through Access
3 Ride, if they are cognitively able to do
4 that. Most are brought by family members
5 going to and from work.

6 REV. HARTLEY: Are a lot of
7 people -- would they have to go into a
8 nursing home if they didn't come to your day
9 care?

10 MR. ZAGORSKI: A lot of
11 them would. We take them, both early-stage
12 and late-stage dementia. We have people
13 that are stroke survivors. They are
14 cognitively totally as good as you or I, but
15 they just need that someone to assist them
16 to the toilet a few times a day.

17 REV. HARTLEY: And if they
18 didn't come to adult day care, would they
19 likely go into a nursing home?

20 MR. ZAGORSKI: A lot of
21 them would be in a nursing home, because we
22 have people with late-stage Alzheimer's,
23 dementia.

24 REV. HARTLEY: I was just
25 doing some math, and your \$62-a-day amounts

1 to about \$15,000 a year. Can I ask the
2 question: If it comes to they would be in a
3 nursing home instead, is that going to cost
4 the government or the taxpayers --

5 MR. ZAGORSKI: Thirty-five
6 to fifty. We're roughly a third of the cost
7 of nursing home care.

8 REV. HARTLEY: Which,
9 initially, sounds like more adult day care
10 and fewer nursing homes save lots of money
11 and more people are cared for. To me -- I
12 mean, I'm not an expert in this --

13 MR. ZAGORSKI: Yes, you're
14 exactly right. The problem is legislators
15 and lobbyists. To put it in perspective,
16 when the Options Program was passed, it was
17 mostly due to AARP getting behind it. That
18 year, the nursing home lobby had three
19 people just to argue against this, this
20 whole program.

21 REV. HARTLEY: Maybe that's
22 why they didn't come today. I don't know.
23 Bill Barnes has our next question.

24 MR. BARNES: The question
25 is: What do you recommend as changes

1 necessary to provide quality, affordable
2 home-based care? What do you recommend as
3 changes?

4 MS. GRAMANN: What I
5 mentioned before, right now, we're
6 collaborating with Senior Citizens, Inc. to
7 provide more care out in rural areas by
8 teaming up with them and training senior
9 companions to do more respite care. So
10 that's one thing that we're looking at.
11 Fifty percent of all caregivers of
12 Alzheimer's patients die before their actual
13 Alzheimer's patients do. So that is one
14 concern that we actually have. That's a
15 documented figure, though, that we know is
16 true. So that's one concern that we do
17 have.

18 I'd like to see all of the
19 programs that provide self-directed funds
20 for respite get together and try to
21 negotiate lower rates with some of these
22 providers, so that our money that we're
23 providing for these families goes a little
24 bit further -- that would be one way -- and
25 to try to work with more of these funding

1 sources to help to support these programs,
2 to support respite care programs, United
3 Way, and some of these other private and
4 public foundations.

5 MR. L. STEWART: I'm going
6 to speak from an accumulation of some of my
7 experience. There are three things that I
8 think need to be done. I don't think they
9 are very difficult, but I'm not in the state
10 bureaucracy. One thing you need to remember
11 when you're talking about TennCare -- and
12 there have been several comments about
13 TennCare -- it's a very large operation.
14 They do health care. They are in the
15 newspaper all the time.

16 The long-term care part is
17 a very small part, and sometimes, the issues
18 of the smaller part, the long-term care
19 part, needs a lot more voices to make it
20 heard.

21 So the three things that I
22 would recommend, from everywhere I've been
23 and looked, is to change the eligibility
24 process for the federally-funded Medicaid
25 Waiver Program. I do not see the need for a

1 doctor's prescription for a homemaker.

2 Okay. I just don't see a need for that.

3 (Applause from the
4 audience.)

5 MR. L. STEWART: The second
6 thing is, as Steve and Clara have mentioned,
7 we have an existing State-funded program
8 that operates through the Tennessee
9 Commission On Aging and Disability and the
10 area agencies on aging and disability and
11 providers like Metro Social Services. It
12 works extremely well and efficiently.
13 Perhaps, the State should move some of the
14 waiver responsibilities to the area
15 agencies, so they could run that program
16 just as efficiently.

17 And the third thing is the
18 thing I mentioned before, which is to bring
19 the rates for in-home services higher to
20 match a little closer -- to make them more
21 like the private pay rates to encourage a
22 lot more providers in, including nursing
23 homes. Nursing homes need to remain part of
24 the continuum, part of the continuum that
25 has all the steps filled in, including the

1 in-home part.

2 MR. ZAGORSKI: I would like
3 to thank you for giving me a half hour to
4 say what needs to be done. Seriously,
5 number one, more money in the Options
6 Program. That's where TNT can be so, so
7 valuable. I'm a provider. When I say, we
8 need more money, they say, well, you want to
9 make more money. When GNRC says you need
10 more money, they say, well, you just want to
11 build your bureaucracy.

12 The consumers are the ones
13 that the lawmakers and the legislature and
14 the governor listen to. When we went
15 through this process, it was absolutely
16 amazing, testifying at hearings, what the
17 lawmakers don't know about home- and
18 community-based care. That's number one.

19 Number two, I believe, is
20 to streamline the TennCare process, but in
21 two ways; one, for the consumer. In other
22 words, trying to figure out what the
23 consumer -- figure out why -- it shouldn't
24 take three to four months. Get it down to a
25 week or two. The second is for the

1 providers. We're inspected. We're
2 licensed. We're expected to train somebody
3 twenty hours to do homemaker services. Now,
4 I don't want to say it's real difficult
5 sweeping floors and changing bed linens and
6 cooking a meal, but a twenty-hour training
7 program? Now, fortunately, there are some
8 ways around that, but if somebody doesn't
9 have pre-existing knowledge of supervised
10 care, we're expected -- twenty hours, forty
11 hours for a personal care assistant.

12 The third thing is to
13 emphasize a single point of entry. The
14 number Lee gave, 255-1010, is great, but not
15 everybody knows to call it. And it's just
16 for the Options and Waiver Program. It
17 doesn't count the VA. Most veterans we
18 serve don't know what's available for them
19 until we tell them. It's just that people
20 don't know. And there's a lot of services
21 out there that are available that we need a
22 point of entry for.

23 If the poor consumer, an
24 82-year-old -- a man or a wife caring for a
25 85-year-old father, they don't know where to

1 call. They don't know how to get on the
2 internet. They can't read the book Mary
3 Beth puts out. And if a social worker in a
4 doctor's office doesn't do something
5 proactively, they usually don't get
6 services.

7 MS. GRAMANN: Some of the
8 changes that need to be made are changes
9 with the state and local government for
10 eligibility, because it's individuals that
11 need the services, but they might be one or
12 two dollars over the scale, and just because
13 they are one or two dollars over the scale
14 does not mean that they don't need the
15 service. They need it just as much as
16 everybody else.

17 The thing is, you know,
18 with the Department of Human Services,
19 people can get in and -- they can get into
20 their program if they are picked up as what
21 they call "without regard to income." So it
22 doesn't matter what your income is if you
23 get in through the Department of Human
24 Services, but any of the other services that
25 you have -- we have an income guideline that

1 you have to meet.

2 I don't think it's fair to
3 those that need these services and are one
4 or two dollars over the scale, and we can't
5 provide the services to them. They need to
6 change some of the eligibility requirements
7 in order for us to provide the service to
8 the most needy, the frail, the elderly,
9 because income -- there are some out there
10 that -- some doctors out there have found
11 themselves in a situation that they need the
12 service and thought that they would never
13 have to be dependent upon somebody else to
14 provide services to them.

15 I have a person that called
16 last week for he and his wife. He's the
17 caregiver for his wife, but he's ill also.
18 And he's trying to get homemaker services,
19 but he's at the point where he said, If I
20 can't get something, I just might as well
21 kill myself. When you hear someone tell you
22 they might as well kill themselves -- I
23 mean, let's not go there. I said, there is
24 a program.

25 I told him about the

1 Department of Human Services and that he
2 needed to contact them in order for APS to
3 open up the case. We can come out and start
4 servicing you. And then after talking to
5 him, I also call APS and made them aware of
6 the situation, so that if -- this was a case
7 that I felt they really needed to get help,
8 because when somebody talks about killing
9 themselves, we need to deal with that.

10 MS. ROBERTS: I don't know
11 how much more that I can add to what's
12 already been said, except to say that I
13 think that we need to pay attention to
14 economic disparities. Those individuals who
15 are silent, whose voices are silent, which
16 pretty much, really, is all of our
17 seniors -- it doesn't matter what their
18 economic backgrounds are, because what I'm
19 finding is that age is a great equalizer.
20 It's going to get all of us sooner or later.

21 I want to make sure that
22 those who are under-served, those whose
23 voices have been silent, those who are just
24 grateful for the little that they do have,
25 have fair access to all of the services that

1 are out there, whatever is out there,
2 because what I'm seeing is that those
3 individuals do not know about those services
4 and they do not know how to find those
5 services. And you're correct, an
6 82-year-old who has insurmountable chronic
7 health needs does not -- they don't know how
8 to access those services, and just dealing
9 with the illness alone is enough. So where
10 is the entry point? Where is the initial
11 point that we actually do a comprehensive
12 assessment or determine what the needs are?

13 We have a lot of services,
14 which is what I was going to say earlier, in
15 the community. I think what we need is some
16 way of being able to come together to figure
17 out how we can pool the resources of what we
18 do have together and make it work more
19 effectively and efficiently, because it's
20 out there.

21 The other thing that we
22 need is accountability. We need
23 accountability for what we're saying, what
24 we do, because the elderly, as I said, they
25 just accept whatever is given to them, and

1 they are so -- with the little that you
2 offer them, they are just so grateful. I
3 mean, we offer free meals, hot meals, and
4 they are just so grateful for that.

5 Any amount of attention
6 they get is a surprise, particularly
7 attention that shows that you really do care
8 about them. Many of them have fallen
9 through the system, because they have a
10 history of dealing with the system,
11 unfortunately. And our system isn't
12 perfect. Nothing is perfect, but surely, we
13 could do better with what we have in our
14 community. Surely, we have enough expertise
15 within the Nashville community to be able to
16 answer the problems that we are facing with
17 our elderly.

18 REV. HARTLEY: Thank you.
19 I'm seeing a couple issues that are coming
20 to my mind. Each one of you talked about
21 your services and how to access them.
22 Stories came in my mind about people in my
23 congregation that could use some of that,
24 and I never even thought of it.

25 I mean, if between pastors

1 and other community leaders, there's some
2 way we could figure out how to
3 educate pastors, whether that means in
4 seminary or the ordination process or
5 something -- but it's one idea I have for us
6 in TNT. If we can provide well-framed,
7 really clear little training manuals for
8 pastors and other community leaders on how
9 to -- you know, I mean, 255-1010, I never
10 heard of it.

11 So one issue is knowing
12 it's out there and how to access it. It
13 sounds like another major issue is -- you
14 know, frequently there's good programs, but
15 they are full and there's waiting lists, so
16 essentially, there's not a program for a lot
17 of people out there.

18 So changing policies
19 between funding and how you do things would
20 be -- you know, one is knowing there are
21 services; two is making sure there are
22 services, which means money to fund it,
23 money to pay the staff. And we're going to
24 move into some questions right now that deal
25 with staff.

1 And, Myron, if you'll ask
2 Questions 4, 5, and, 6, maybe altogether as
3 a package, because I think it's all kind of
4 dealing with staffing these programs.

5 MR. TOWNS: I've noticed
6 that there's a big emphasis on being an
7 intermediary, as the agencies are actually
8 trying to connect consumers with the
9 services, direct service providers and
10 indirect service providers.

11 So your staff is probably
12 principally administrative. So as to
13 whether that is true or not, what kind of --
14 some of you mentioned training of staff.
15 What kind of training is required for your
16 staff? Just starting with Ms. Gramann, do
17 you have a staff?

18 MS. GRAMANN: Yes, we have
19 a staff. We provide many programs and
20 services out in the community. We have a
21 wealth of information about Alzheimer's
22 disease. We do provide staff training for
23 facilities, for clergy about Alzheimer's
24 disease all over the community. We provide
25 "Maintain your Brain" workshops, "Partnering

1 with Your Doctor." We provide free law
2 enforcement education. I'm doing a workshop
3 at the Nashville Police Academy tomorrow.

4 We do these informational
5 sessions and rigorous trainings on
6 Alzheimer's disease all over the community,
7 and we can provide staff trainings for
8 homemaker services, ombudsman training
9 everywhere. So I'm an MSW, myself. We
10 provide care consultations for family
11 members. We have help-line services. We
12 have -- yes?

13 REV. HARTLEY: We're really
14 after training, you know, for the staffs.
15 So if you have people, the homemakers, that
16 work for you --

17 MS. GRAMANN: No, we do
18 not. We administer the family respite
19 program. That is a self-directed program
20 where we provide the funds for the families
21 to make choices about how they spend that
22 money.

23 MR. TOWNS: So you're also
24 a training provider? Is that one of the
25 things you --

1 MS. GRAMANN: Yes, we are a
2 training provider.

3 MR. TOWNS: So if other
4 people's staff --

5 MS. GRAMANN: Yes.

6 MR. TOWNS: So if someone
7 was trying to provide homemaker --

8 MS. GRAMANN: Yes, we do
9 provide the training.

10 MR. TOWNS: You can take
11 care of that training --

12 MS. GRAMANN: Yes.

13 MR. TOWNS: Or your agency
14 can?

15 MS. GRAMANN: Yes, sir.

16 MR. TOWNS: So is your
17 agency understaffed, in itself? Do you have
18 need for additional staff or --

19 MS. GRAMANN: I'm the
20 trainer. I'm the trainer. Give me a call.
21 I'm the trainer. And right now, if my
22 calendar allows it, I'll fit you in. I'll
23 be there. At this point in time, it has not
24 been a problem.

25 MR. TOWNS: Thank you.

1 MR. L. STEWART: I want to
2 mention two things. Please invite me to
3 your -- all the congregations. Our division
4 is making a concerted effort to get
5 information out to faith communities who,
6 like many other nonprofit organizations,
7 sometimes are so busy taking care of the
8 issues and needs of their particular
9 constituency and congregants, it's really
10 difficult to take a breath and step back and
11 look at the system and look at what else is
12 happening.

13 I applaud you all for doing
14 that today. It's very needed, but one of
15 the things I do is go around in churches and
16 not only provide information but seek input
17 from the people about how Metro Social
18 Services and other community agencies can be
19 of help.

20 The second thing I wanted
21 to say is that one of the things we're
22 looking for is workforce development for
23 in-home care workers. And this is a
24 nationwide need. There is a lot of
25 turnover.

1 There are two issues that
2 are of importance. There's low pay and
3 governmental training requirements. If they
4 are still using the same waiver training
5 manual as they did a couple of years ago, it
6 tells a homemaker -- you train a homemaker
7 how to heat up a can of soup. The first
8 instruction says "Select a pot of the
9 appropriate size for the burner you plan to
10 use."

11 I really believe in
12 training, but I believe, perhaps, the
13 medical people ought not be the ones to
14 develop the training programs for nonmedical
15 in-home services. So if we had appropriate
16 training and better reimbursement, we could
17 then pay more for better quality in-home
18 workers, reduce turnover, and have a much
19 better system.

20 MR. ZAGORSKI: That's a
21 147-page manual, by the way, which cannot be
22 read by the average person working in a
23 home, because even the wording is totally
24 wrong.

25 Let me answer to the

1 training. I'm going into two different ways
2 to address this, first, with the adult day
3 care program, then in the in-home care, and
4 probably over the regulatory area. When I
5 hire people for the adult day care program,
6 I want somebody that likes old people and
7 disabled people. I don't care about the
8 rest.

9 Now, regulatorily, I have
10 got to follow a lot of rules, but in
11 seventeen years -- four of us have been
12 there for seventeen years, one has been
13 there for fifteen years. People love the
14 adult day care program because they are
15 really making a major contribution.

16 So we've got a lot of
17 regulations. The VA will have a team of six
18 people inspecting us. We do a lot of
19 continuing education, but if I have had a
20 staff member for seventeen years, I'd say I
21 don't have to do a lot of training because
22 they probably know what they are doing by
23 now. And that's the key to keeping stable
24 staffing.

25 The elderly -- the young

1 don't like change; and the elderly don't
2 like it any better. They like the same
3 caregiver -- I'm going to go over the time
4 on this one. I'm sorry.

5 The in-home side of work is
6 a major issue. For our in-home work -- and
7 I think we're in about 150 homes a day and
8 probably have 45 people doing this. My role
9 is as an employment agency. We look for
10 people that have CNT training. That's
11 great. But most people don't.

12 We go through the training,
13 but we have to go back to the basics -- and
14 Lee used to inspect me in days past. But I
15 want people that are out on time, do a good
16 job, fill out their paperwork -- so that
17 when the "Lees" of the world come to inspect
18 me, I'm not all screwed up -- but most
19 importantly, do it with a smile on their
20 face and bring a little sunshine into these
21 people's lives.

22 It's a terrible problem.
23 The fellow from Vanderbilt -- I wish I had
24 had a chance to talk to him, because the
25 problem is going to get a lot worse. We

1 start people out at \$9 an hour. Now,
2 that's, you know, not real high, but for
3 this type of work, it's not real low. We
4 have a very large turnover rate, because
5 with this job, people are either good at it
6 or bad at it. There's very, very little in
7 between.

8 Unfortunately, you have
9 great workers and, all of a sudden, a new
10 boyfriend comes into their life or, you
11 know, we have this issue or we have a child
12 that gets sick -- because most of our people
13 are single moms.

14 That is where the
15 reimbursement rates are so critical, because
16 if you try to pay somebody \$7, \$8, \$9 an
17 hour, it's tough. And if I'm only getting
18 paid \$16, \$17 an hour and have to wait
19 months to get it, it won't work.

20 MR. TOWNS: Let me take a
21 break in between here. Mr. Stewart, is that
22 part of what you were talking about, with
23 workforce development?

24 MR. L. STEWART: Yes, it's
25 to be able to provide people that do like to

1 do this kind of work and are intent upon
2 being good at it and can make it on the \$9
3 or \$10 or \$12 an hour.

4 MR. ZAGORSKI: Yet it's
5 inconsistent to demand a high level of
6 training with a low level of pay. That just
7 doesn't work. And there are people who want
8 to do this, who enjoy it, who are very good
9 at it, but I mean, they have the same
10 expenses that you and I do.

11 They have to drive 20 miles
12 to a home at \$2.50-something a gallon of
13 gas. They have to provide insurance, with a
14 lot of the companies. They are contract
15 workers, so they have health care issues.

16 MR. TOWNS: No benefits?

17 MR. L. STEWART: Even
18 working full-time, many of them are at the
19 federal poverty level. And if you want a
20 good, competent, trained workforce for the
21 boomers and the ones that are coming up --
22 I'm going to want somebody who's friendly
23 and trained, and I'm going to vote for the
24 reimbursement for that person to be
25 adequate.

1 MR. TOWNS: Thank you.

2 MR. ZAGORSKI: Just to back
3 up, we really do have a very structured
4 training program for our people, both in the
5 home and the adult day care program, but
6 really what Lee will say and what I am going
7 to tell you is that you can't mandate a
8 147-page manual. There has to be some
9 practicality in taking care of people.

10 They need to be educated on
11 how to give a sponge bath, how to properly
12 lift and transfer. There are hard issues
13 that require good training, but the other
14 side of it -- you know, to open a cap of
15 soup ... and Lee was right. It's "Select
16 the right size pot. Select the right size
17 burner. You've got to open the can with a
18 can-opener and put it in ..." and I'm
19 supposed to test them on this? I think they
20 understand.

21 MR. TOWNS: So maybe a
22 commission constructed of the agency
23 executives or managers would be effective in
24 determining what the training manual or the
25 training itself ought to be.

1 MR. L. STEWART: Thank you
2 very much. That's been requested. And
3 we'll have some questions for the TennCare
4 people. They don't invite the input of the
5 Area Agencies on Aging, and they certainly
6 don't ask the key providers' input.

7 MS. WINGFIELD: With our
8 program with Metro, the salaries are a
9 little bit better than with other companies,
10 and our training, when they come in --

11 REV. HARTLEY: Could you
12 move closer to the mike, please?

13 MS. WINGFIELD: When they
14 come in, they have to have forty hours of
15 orientation in the program and what is
16 required of the program. And then there is
17 required training that they have to have,
18 the Title VI training, diversity training,
19 defensive driving, because if you're going
20 to be transporting individuals to the
21 grocery store or where they have to go, then
22 you have to be certified and have defensive
23 driving.

24 We have back safety
25 training, because if you're assisting

1 someone in giving them personal care and
2 you're trying to maneuver them if they are
3 getting a tub bath, you know, getting them
4 in and out of the tub, then you have to know
5 how to lift an individual properly to keep
6 from injuring yourself. And we also have --
7 I mean, we have so much training, it's
8 unreal.

9 We can do that, since we --
10 like I said, with it being the Government,
11 most, 95 percent of our homemakers have
12 their CNA certification. Those that don't,
13 we will be sending them to get theirs. When
14 we hire people in, we try to hire people who
15 already have it.

16 At one time, none of them
17 had it, but when we started providing
18 personal care, they needed it, so we sent
19 everybody to school, and they were certified
20 in order to provide the type of services
21 that we knew these individuals needed.

22 So they did so much
23 training -- and as I said, part of it is
24 through our contract, that we're required to
25 have at least 25 hours a year in training,

1 but most of it is to make sure that each and
2 every one is getting the type of training
3 that they need to provide --

4 MS. THOMSEN: What is your
5 turnover rate?

6 MS. REED: She can answer
7 the turnover question.

8 MS. WINGFIELD: Okay. Our
9 turnover rate is very low, per se. Last
10 year, when we went into the new business
11 model, we did have a little turnover, but
12 our average homemaker has been with our
13 agency for fourteen years, average. We have
14 some people that have been there since it
15 opened up in 1981, but our average -- of all
16 of the employees we have in the homemaker
17 program, the average is fourteen years.

18 MR. TOWNS: They are Metro
19 employees, right?

20 MS. WINGFIELD: They are
21 Metro employees, right.

22 MS. REED: Why don't they
23 leave, Pat?

24 MS. WINGFIELD: They enjoy
25 what they are doing, for one thing, and the

1 benefits of Metro are better than the
2 benefits out in the community.

3 MR. TOWNS: Can you tell us
4 what the average salary is of all the
5 workers?

6 MS. WINGFIELD: They start
7 out about \$11 or \$12 an hour.

8 MS. THOMSEN: Can you say
9 something about outsourcing?

10 MS. ROBERTS: Martha
11 O'Bryan is a community-based agency, so we
12 don't provide training. We all try to work
13 together at the center to support each
14 other. We have been fortunate in that we
15 have numerous volunteers that serve our
16 meals, that deliver our meals daily.

17 Those volunteers need to
18 be -- we train them. We have a volunteer
19 coordinator that actually provides training.
20 You say, why do we need training? Well, it
21 depends on what kind of care you're
22 providing to the elderly.

23 If you're providing just
24 some assistance services with heating a meal
25 or -- not just going to the bathroom, but

1 those kinds of needs, that's one set of
2 needs, but even if -- whoever is touching
3 the elderly needs to be able to identify
4 certain issues such as addiction issues.

5 We have a high prevalence
6 of addiction in our elderly population. We
7 have a high prevalence of mental illness,
8 undiagnosed depression. We have elder abuse
9 by family members, by other people in the
10 community.

11 Many of our elders are
12 being preyed upon by individuals who are
13 addicted themselves, family members, and
14 just people in the community who see the
15 elderly as someone they can prey on, that
16 they can take advantage of. And I'm
17 beginning to see that. So that kind of
18 training, we need.

19 We need eyes who can see
20 there is something going on here; I'm not
21 certain about what it is, but let me check
22 things out and let me ask some questions
23 maybe that might be appropriate in helping
24 me find out what's going on. So whoever
25 that person is, they need to have enough

1 information about that.

2 One of the reason why I
3 said that is because you don't want to do
4 the wrong thing. You don't want to make the
5 wrong kind of assessment, you know, or at
6 least have sense enough to know you need to
7 refer to someone or go seek help from
8 someone who may be able to assist you with
9 that and don't step in and take it upon
10 yourself, particularly with addiction and
11 mental health issues, because you could do
12 more harm than good.

13 REV. HARTLEY: Thank you.

14 As we look at this, we're looking at the
15 care for the elderly. We're also looking at
16 salaries and wages for people that are
17 working. I'm encouraged and surprised,
18 actually, to hear that the average Metro
19 homemaker has been with you for fourteen
20 years. It makes it sound like a fairly
21 stable job.

22 In your adult day care
23 service, it's like seventeen years, fifteen
24 years? Is it the same for your homemakers?
25 Do you have more turnover with homemakers?

1 MR. ZAGORSKI: We have
2 significant turnover in our homemaker,
3 personal care. Some is because the employee
4 does not meet our standards. Some is
5 because these people are not good at what
6 they thought they were good at. But it is a
7 very high turnover rate.

8 Could I make a comment for
9 the record? Here we have a program that has
10 good, stable people, but they start at \$11
11 an hour, and 40 percent for benefits
12 probably takes it up to \$15.40. They
13 probably do a criminal background check
14 before everyone starts, which is \$12 to \$50
15 an hour. They are probably trained before
16 they go into the field.

17 How are we, under the
18 Waiver, supposed to do this for \$18.50 an
19 hour? You cannot. You just cannot do it,
20 because you have to wait three months for
21 the money. And, again, that goes back to
22 the fundamental problem of the Medicaid
23 Waiver.

24 REV. HARTLEY: So the
25 Government is able to provide a better job

1 because they get a different reimbursement
2 rate than you get?

3 MR. L. STEWART: Yes, sir.
4 They are a division of Metro Government.

5 REV. HARTLEY: So the
6 Government supplements --

7 MS. WINGFIELD: The
8 Government supplements \$3 million.

9 REV. HARTLEY: At this
10 point, we just have a few minutes left for
11 the panel. We want to ask if there is any
12 one burning question out there in the
13 audience. Convince me that you have the
14 most burning, important question, because
15 we're really hurting on time here.

16 AUDIENCE MEMBER: Pat, I
17 just wanted to know -- I'm sure there's a
18 scale according to an income that you charge
19 your client. Is that accurate?

20 MS. WINGFIELD: We don't
21 charge anything.

22 AUDIENCE MEMBER: Okay. So
23 it's free?

24 MS. WINGFIELD: If you fall
25 within the income guidelines to receive the

1 service.

2 REV. HARTLEY: But you do
3 have a waiting list?

4 MS. WINGFIELD: We do have
5 a waiting list.

6 AUDIENCE MEMBER: I'm with
7 the Council on Aging, and during the break,
8 I'll bring in a box of the directories that
9 were referred to. But one thing I think
10 it's important to say is that nursing homes
11 have a role.

12 It can't be us against
13 them, so just -- and I think we all realize
14 that, but sometimes, what we say sounds very
15 different, and we've got make sure that for
16 people who can't stay at home or whose
17 families can't help them at home, we have
18 good nursing home care available also.

19 And just to kind of
20 reiterate, the last question had to do with
21 retention rates. I heard that the
22 retention -- the turnover in nursing homes
23 is like 300 percent a year for the aides.
24 So you can kind of see the difference there
25 too.

1 There's some perception
2 that nursing homes are just the pits, and
3 sometimes they are, but we just can't forget
4 that element that -- there are people who
5 can't stay at their home, even if we had all
6 the services in the world. And since we
7 don't have all the services, there are more
8 that are there. So we've got to remember
9 that's part of it.

10 AUDIENCE MEMBER: I wish to
11 put another arrow in Mr. Lee's quiver. It's
12 not just a question of the baby boom, of
13 which I'm the first year, but there is a
14 longer life span. And along with that --
15 and more importantly, there is a longer
16 health span. So thirty years ago, people
17 spent a dozen years, and then it got down to
18 about eight or nine in a nursing home. Now,
19 it's down to about eighteen to six months.
20 And so, there's not a great need for an
21 expansion of nursing homes, but there is a
22 great need for the alternative services.

23 The second point I want to
24 make is we really have to stop saying,
25 Tennessee, you could this on the cheap. If

1 it means more taxes, our elderly deserve
2 that we have more taxes for them. You
3 cannot propose doing important things on the
4 cheap. And I think even the nursing home
5 industry would be on our side on that.

6 REV. HARTLEY: We ask for
7 your questions, not comments. We're running
8 out of time. If there's one question back
9 there, I'll let you ask it.

10 AUDIENCE MEMBER: This is a
11 question for Steve. In the program about
12 the Waiver, did you mention that the
13 veterans receive the services free? And the
14 \$62 a day, is that per individual attending
15 the day care?

16 MR. ZAGORSKI: The \$62 is
17 the multi-day rate of the adult day care
18 program. The Veterans Administration -- of
19 which we're the only ones in the state that
20 qualify for their program -- decided in the
21 '60s that adult day care health care kept
22 people out of nursing homes, out of the
23 clinics, and it was a very cost-effective
24 service.

25 If a person is under the

1 care of the Veterans Administration and the
2 doctors say they are appropriate, they will
3 send them to the adult day care program five
4 days a week, transportation to and from the
5 home, bathed every day, if necessary. We've
6 been working with them --

7 AUDIENCE MEMBER: Who pays
8 for that?

9 MR. ZAGORSKI: It's part of
10 the Veterans Administration budget.

11 MR. TOWNS: Is there a
12 delay in getting reimbursed?

13 MR. ZAGORSKI: There is a
14 delay, but again, we bill at the end of the
15 month. You probably are paid within 45
16 days, and it's actually mandated that if
17 they don't pay, they have to pay us
18 interest. Payment with the Veterans
19 Administration is only a problem when the
20 government doesn't fund -- when the federal
21 government doesn't fund the federal
22 programs. Then we have some delay issues.

23 REV. HARTLEY: Thank you,
24 Steve. Thank you, everybody, for
25 participating in this panel.

1 (Applause from the
2 audience.)

3 MS. REED: TNT, being a
4 faith-based institution, we certainly --
5 many of us in our faith backgrounds and our
6 Scriptures clearly have a mandate and a call
7 to care for the elderly, to care for the
8 poor, and to raise that up publicly as a
9 concern in this changing world.

10 We're living longer. We
11 are more mobile. We're not living with our
12 families on our farms, in our community
13 homesteads. It's exciting to have some
14 conversation, at least, about a community
15 coming together and raising that up as an
16 important value.

17 We're going to take a ten
18 or fifteen-minute break. We want the
19 panelists for the next panel to be here at
20 11:40, and we'll start the panel promptly at
21 11:45. Thank you all.

22
23
24
25