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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	re: phone number (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20472

FOLDER TITLE:
Nursing Homes [Folder 2]

2012-0463-S
rc799

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

September
Twenty Seven
2000

Christopher C. Jennings
Special Assistant to the President for
Health Policy Development
Old Executive Office Building, Room 212
17th Street & Pennsylvania Avenue, NW
Washington, DC 20502

Dear Chris:

I am writing to provide some additional thoughts regarding the allocation of dollars to states and facilities under the Administration's proposed $1 billion grant program to increase nursing home staffing levels.

In our previous letter, we emphasized that it is critical that the allocation formula not disadvantage states that have maintained higher relative staffing levels. We continue to be concerned that, by channeling 75% of the proposed staff recruitment, retention and training funds to states with low staffing levels, the Administration's initiative, as outlined on September 16, would inappropriately penalize states with high proportions of not-for-profit facilities that have struggled financially to provide staffing levels appropriate to meeting the needs of their residents. We therefore urge you to revise the allocation formula to ensure that more than 50% of the available funding is directed to states in which facilities have worked to achieve higher than average staffing levels.

In this vein, we further recommend that you modify your proposal to ensure that funds are targeted to facilities with the greatest financial need for assistance. Specifically, we would recommend that preference in funding be given to facilities with operating margins below 5%, and that eligibility for funding be strictly limited to facilities with operating margins below 15%. Not-for-profit facilities in New York staff at higher levels than their for-profit counterparts, yet survive with average operating margins of under 1% - levels significantly below those found in the for-profit sector. This approach would free up scarce funding for assistance to those facilities with the greatest demonstrated need, and would protect against inappropriately providing a windfall to those facilities that have accumulated the highest profits.

Finally, we want to continue to stress the importance of the Administration's active support for a provision in this year's Medicare relief package offering fiscal relief for facilities with high capital costs that are not adequately covered under the Medicare SNF PPS. While the administration's $1 billion staffing initiative would give every nursing home approximately $11,600 for staffing enhancement if the dollars were distributed equally, our analysis indicates that, for 52% of the nursing homes in the U.S., these new dollars would be offset by losses of over $35,000 on average annually due to the inadequacy of capital reimbursement in the SNF PPS, and that, for 20% of the affected facilities, the losses will average over $117,000 annually. Before these facilities can make a meaningful investment in additional direct care staff, it is vital that steps are taken to address the tremendous shortfall in capital reimbursement under the PPS.

Once again, I thank you for your interest in these important issues and I look forward to working with you on these matters over the coming days. Please feel free to call on my staff for assistance as you continue to develop and refine your nursing home initiative.

My best.

Sincerely,

Kenneth E. Raske
President

Cc: Dennis Rivera

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 – 0001

FAX COVER SHEET

HCFA'S OFFICE OF LEGISLATION

200 independence Avenue S.W. 341-H

TO: Devorah Adler ***FAX NO:*** _____

NO. of PAGES: _____ ***DATE:*** _____

FROM: Dan Johnson ***Phone:*** _____

Remarks: Senate Aging Draft Bill on Nurse Staffing Issues

Fax Number 202-690-8168

Problems with transmission please call 202-690-5444

O:\ERN\ERN00.634 S.L.C.

106TH CONGRESS
2D SESSION

S. _____

IN THE SENATE OF THE UNITED STATES

Mr. GRASSLEY introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To require the Secretary of Health and Human to establish minimum nursing staff levels for nursing facilities, to provide for grants to improve the quality of care furnished in nursing facilities, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Nursing Staff Improvement Act of 2000".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Part I of the Health Care Financing Administration's Report to Congress: Appropriateness

(2)(A) A minimum of 2.9 nurse aide hours per resident day are necessary to deliver 5 necessary daily care services.

(B) Over 92 percent of nursing home facilities fall below the 2.9 nurse aide hours per resident day standard and would require a 50 percent increase in staffing to meet this standard.

(C) The 2.9 nurse aide hours per resident day standard is based on a conservative assumption and understates the real staffing levels necessary for a nurse aide to complete all tasks that constitute adequate care.

(3)(A) Facilities that serve residents with more complex medical conditions will require higher staffing levels.

(B) Minimum staffing levels that take into account case mix have not yet been established.

(C) Part II of the Health Care Financing Administration report, which has not yet been completed, will report to Congress on minimum staffing levels according to the facility's resident acuity level.

SEC. 5. GRANTS TO IMPROVE STAFFING LEVELS AND THE QUALITY OF CARE IN NURSING FACILITIES.

(a) AUTHORITY TO AWARD GRANTS.—The Secretary of Health and Human Services shall award grants to States on a competitive basis for the purpose of improving staffing levels in nursing facilities in order to improve the quality of care to residents of such facilities.

(b) APPLICATIONS.—Each State that wishes to receive a grant under this section shall submit an application at such time, in such form, and complete with such information as the Secretary may require, except that any such application shall include at least a certification that the application was developed through an open, public process.

(c) REQUIREMENTS FOR USE OF FUNDS.—

(1) PERMISSIBLE USES.—

(A) IN GENERAL.—A State awarded a grant under this section shall use funds provided under the grant to provide financial support or technical assistance for projects operated by nursing facilities, labor organizations, nonprofit organizations, community colleges, or other organizations, or through joint efforts of such entities and organizations, that are designed to do any or all of the following:

(i) Enhance staff recruitment and retention efforts.

(ii) Establish centers of expertise and training.

(iii) Establish career ladders for certified nurse assistants, including additional or advanced training opportunities.

(iv) Provide additional training for nursing facility direct care staff.

(v) Improve workplace safety.

(vi) Improve nursing facility management.

(vii) Conduct other staffing initiatives to improve patient outcomes, as approved by the Secretary.

(B) APPLICABILITY OF NURSING HOME REFORM PROVISIONS.—Funds made available under a grant awarded to a State under this section may only be used to provide financial support or technical assistance for any project described in paragraph (1) to the extent that the activities conducted under the project are consistent with the requirements of sections 1818 and 1919 of the Social Security Act (42 U.S.C. 1395i–3, 1396r).

(C) PROHIBITION.—No funds made available under a grant awarded to a State under

this section may be used to provide financial support or technical assistance for any project described in paragraph (1) that is conducted at, or for the benefit of, a publicly owned or operated nursing facility.

(2) NO SUPPLANTATION OF FUNDS.—Funds made available under a grant awarded to a State under this section may only be used to supplement, not supplant, other funds that the State expends to carry out activities described in paragraph (1)(A).

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary for purposes of carrying out this section $500,000,000 for each of fiscal years 2001 and 2002.

(e) EVALUATION AND REPORT.—The Secretary shall evaluate the extent to which the grant program established under this section assists States in improving staffing levels in nursing facilities. Not later than 1 year after the completion of the grant program established under this section, the Secretary shall submit to Congress a report containing the conclusions of such evaluation.

(f) DEFINITIONS.—In this section:

(1) NURSING FACILITY.—The term "nursing facility" means a skilled nursing facility participating in the medicare program established under

title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or a nursing facility receiving payments under the medicaid program established under title XIX of such Act (42 U.S.C. 1396 et seq.).

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

SEC. 6. PROVIDING ACCURATE INFORMATION ON STAFFING.

(a) MEDICARE.—Section 1819(b) of the Social Security Act (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following new paragraph:

"(8) SUBMISSION OF DATA ON STAFFING LEVELS.—

"(A) IN GENERAL.—A skilled nursing facility shall submit not less than quarterly to the Secretary, on a standard reporting format developed by the Secretary, data with respect to nursing staff that—

"(i) includes the total number of nursing staff hours and coverage levels per shift furnished by the facility to residents for which payment is made under section 1888(e), broken down by total certified nurse aide hours, total licensed practical or

vocational nurse hours, and total registered nurse hours; and

"(ii) is attested to in writing by the facility as accurate.

"(B) PUBLICATION OF DATA.—The Secretary shall provide for the publication on the Internet Site of the Department of Health and Human Services known as Nursing Home Compare the facility-specific nursing staff information described in subparagraph (A). The Secretary shall update such information periodically.".

(b) MEDICAID.—Section 1919(h) of the Social Security Act (42 U.S.C. 1396r(b)) is amended by adding at the end the following new paragraph:

"(8) SUBMISSION OF DATA ON STAFFING LEVELS.—

"(A) IN GENERAL.—A nursing facility shall submit not less than quarterly to the Secretary, on a standard reporting format developed by the Secretary, data with respect to nursing staff that—

"(i) includes the total number of nursing staff hours and coverage levels per shift furnished by the facility to residents

for which payment is made under the State plan, broken down by total certified nurse aide hours, total licensed practical or vocational nurse hours, and total registered nurse hours; and

"(ii) is attested to in writing by the facility as accurate.

"(B) PUBLICATION OF DATA.—The Secretary shall provide for the publication on the Internet Site of the Department of Health and Human Services known as Nursing Home Compare the facility-specific nursing staff information described in subparagraph (A). The Secretary shall update such information periodically.".

SEC. 7. INFORMATION ON NURSING FACILITY STAFFING.

(a) MEDICARE AMENDMENTS.—Section 1819(b) of the Social Security Act (42 U.S.C. 1395i–3(b)), as amended by section 6(a), is further amended by adding at the end the following new paragraph:

"(9) INFORMATION ON NURSE STAFFING.—A skilled nursing facility shall post daily for each nursing unit of the facility and for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care and the number

of residents per unit and per shift. The information shall be displayed in a uniform manner and in a clearly visible place.".

(b) MEDICAID AMENDMENTS.—Section 1919(b) of the Social Security Act (42 U.S.C. 1396r(b)), as amended by section 6(b), is amended by adding at the end the following new paragraph:

"(9) INFORMATION ON NURSE STAFFING.—A nursing facility shall post daily for each nursing unit of the facility and for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care and the number of residents per unit and per shift. The information shall be displayed in a uniform manner and in a clearly visible place.".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the first day of the first month that begins at least 6 months after the date of the enactment of this Act.

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HCPA standards

ANDREW L. STERN
International President

BETTY EDNARCZYK
International Secretary-Treasurer

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8105-1000

FAX TRANSMITTAL

To: **Devora Adler**

Knollwood Manor DC

Fax Number: 202-456-5557

From: **Ingrid McDonald**
SEIU Health Care Division
Phone) 202-898-3263 Fax) 202-898-3348
Mcdonali@seiu.org

Re: **Nursing Home Initiative**

Date: September 12, 2000

Number of Pages:
(including cover)

MESSAGE

Devora – here is a 1-pager on our ideas on how best to design the grants. These suggestions include ways to include consumers and workers in the design of how grant money will be used and accountability mechanisms to ensure that the grant funds are used for the intended purposes.

There are many variables that impact quality outcomes for residents (such as acuity levels) and many technical obstacles to getting accurate outcomes data. We believe that the criteria spelled out here will be most effective in assuring that any new money actually addresses the inter-related problems of short staffing and poor quality care.

I put check-marks next to the points most important to SEIU.

Thanks and I hope this is helpful.

Grants to Improve Recruitment, Training & Retention of Nursing Home Workers

Use of Grant Funds

- **Recruiting**: Funding for new models for recruiting Certified Nurse Aides (CNAs).
- **Training:** Funding for new models for more comprehensive CNA training (at least 160 hrs)
- **Retention:** Funding to subsidize child-care, transportation costs and other work-related expenses for direct care workers.
- **Staffing Levels:** Bonus payments to nursing facilities who will commit to the "optimal" level of staffing indicated by HCFA's recent research (2.9 nursing assistant hours per resident day)
- **Turnover:** Bonus payments to nursing facilities that achieve turnover rates below a threshold level (30%).

Recipients of Grant Funds

- Nursing Facilities, unions, non-profit organizations and community colleges should all be eligible for applying for grants. such as
- Preferences should be given to applications submitted jointly by nursing facilities and unions (labor-management partnership proposals)
- The following individuals should not be eligible to receive funds:
  - Nursing facilities who spend Medicare or Medicaid funds on anti-union activities.
  - Nursing facilities with a record of frequent and numerous labor violations.
  - Nursing facilities deemed by the Secretary as 'worst offenders' for the inability to meet nursing home quality standards.

Accountability Mechanisms

- An application process for entities to apply for grants, and a reporting process on how funds were spent.
- A public process for developing the a state plan for use of funds with participation from key stakeholders, providers, nursing home residents and their advocates and workers and labor representatives.
- Refunds of grant funds from nursing facilities and other entities who can not illustrate through the reporting process that funds were used for the purposes that they described in their applications.
- Periodic audits on the use of grant funds to ensure that funds are being spent in ways that are consistent with those purposes outlined in the application and to determine that reported staffing levels and turnover rates are accurate.

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FAX TRANSMITTAL

To: **Chris Jennings**

Fax Number: 456-5557

From: Ingrid McDonald & Carol Regan
SEIU Health Care Division
Phone) 202-898-3366
Fax) 202-898-3348
mcdonali@seiu.org

Re: **Nursing Home Package for Fall**

Date: August 9, 2000

Number of Pages: 4
(including cover)

MESSAGE

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8105-1000

Memorandum

To: Chris Jennings

From: Ingrid McDonald and Carol Regan

Re: Nursing Home Package for Fall

Date: August 7, 2000

SEIU strongly supports an Administration initiative on nursing home issues this fall. Voters clearly want to see something done about the poor quality of care and chronic short staffing in nursing homes. At the same time, the industry is engaged in an expensive lobbying campaign for 10 billion in "Medicare Givebacks" with no strings attached. There should be no blank checks for this industry – any new Medicare money should be coupled with new accountability and quality improvements.

SEIU recommends that the Administration put forward a multi-faceted package to achieve this goal.

5-Point Plan for New Accountability & Quality Improvements

1) Require facilities to show that they are staffing at the level for which they are being reimbursed under Medicare.

2) Provide public disclosure of staffing levels and other information about nursing homes so that consumers can make informed decisions.

3) Prohibit nursing homes from spending Medicare dollars to influence employees on the choice of unionization.

4) More and better training for workers who provide the vast majority of hands on care to nursing home residents.

5) New grant programs and incentives to build a quality workforce through joint labor-management efforts.

We recommend that this incremental package be discussed in the context of the Administration's new findings through Phase I of the HCFA staffing study regarding the strong relationship between staffing levels and quality of care and the need for specific staffing standards. This package could be framed as a "down payment" on quality, to be followed by more comprehensive reform based on further research by HCFA.

Attached is a more detailed description of the 5-Point Plan. We look forward to discussing this further.

improved and the minimum amount of training required for Certified Nurse Aides should be increased to 160 hours.

Nursing home workers need more training -- not less. The industry wants Congress to waive training requirements for Certified Nurse Aides and allow facilities to hire lesser trained, part-time, lower paid, uncertified employees to provide certain nursing related tasks. (HR. 4547, Ryan) This bill is harmful to residents. It does nothing to provide more nursing care and assistance for residents, as the industry suggests. There is no new money attached. Instead, it would allow nursing home to re-allocate their labor costs by replacing fully trained aides with a cheaper staffing configuration. In addition, it would divide the care of nursing home residents into isolated tasks, leading to an "assembly line" culture in nursing homes and degrading the continuity of care that residents need. We urge the Administration to take a strong position against HR. 4547.

5) New grant programs and incentives to build a quality workforce through labor-management efforts.

The establishment of nursing home quality improvement block grants to states for the purpose of increasing the number of qualified staff needed to ensure quality care is critical. We support new funding targeted to three areas:

- Recruiting and Training: In a tight labor market it is increasingly difficult to recruit staff. Grant money should be made available to new and innovative programs focused on recruiting, job skills training and CNA certification.
- Retention: Turnover rates in nursing homes of nearly 100% endanger the quality and continuity of care for residents. Grant money could be used for bonus payments to nursing homes who achieve turnover rates significantly below their state average or to fund specific retention programs – such as covering the cost of child care, travel or education expenses for direct care workers.
- Increasing Staff: Use grant funds to reward facilities with staffing levels that meet a specific threshold, such as the "optimal staffing levels" recommended by the HCFA study.

Terms & Conditions:

- States would propose plans for use of grant funds and require recipients to illustrate that funds are used for the purposes outlined in this plan.
- Labor management partnerships should be given priority for receiving funds.
- Auditing mechanisms would be needed to monitor use of funds.
- Entities found to be using funds for purposes other than those outlined in the plan would be required to refund the money and pay penalties.
- Exclusions for receipt of new grant funds: facilities deemed to be "worst offenders" based on quality deficiencies or labor violations, facilities who use Medicare or Medicaid funds for the purposes of influencing employees on the question of unionization.

micro-managing ... minimal not optimal

No Blank Checks for Nursing Homes
5-Point Plan for New Accountability & Quality Improvements

1) Require facilities to show that they are staffing at the level for which they are being reimbursed under Medicare.
With the move to PPS under the BBA, the link between reimbursement and staffing levels was lost. Medicare now pays nursing homes based on the acuity level of the residents and the staffing levels deemed necessary to provide this level of care, but no one checks to see if this is what was actually provided.

Facilities should be required to report the total number of nursing staff hours furnished by the facility to all residents, broken down by payer. The Secretary could then compare the actual aggregate number of nursing hours provided to Medicare beneficiaries with the number of staffing hours that Medicare paid through the RUGS system and adjust reimbursement accordingly.

web → how web works post at facility level.

2) Provide public disclosure of staffing levels and other information about nursing homes so that consumers can make informed decisions.
Medicare beneficiaries have a right to know what type of care to expect from nursing home providers. To give consumers the tools they need to shop based on quality, facilities should be required to post information at the facility level and to provide information to be posted on the Internet for all consumers to access.

Information available to the public should include ratios of staff to residents, facility ownership and whether it is a non-profit or for-profit or part of a chain, the facilities' record of labor violations, money spent on to influence employees right to choose a voice at work, and quality deficiencies. Access to this information will give consumers and advocates tools to hold facilities accountable for providing the services Medicare is paying them to provide.

3) Prohibit nursing homes from spending Medicare dollars to influence employees on the choice of unionization.
Resident care should be the main mission of our country's nursing homes. Yet, the nursing home industry is using funds that are supposed to be used for resident care to pressure and intimidate employees who are forming unions so they can have a voice in improving staffing and care. Employers are ordering employees to take time away from resident care to attend mandatory meetings against employee representation. With the nursing home crisis in our country today, nursing home employers must be prohibited from diverting one penny of their Medicare funds from resident care.

4) More and better training for workers who provide the vast majority of hands on care to nursing home residents.
Currently, the Certified Nurse Aides who care for our nation's nursing home residents are required to complete just two weeks of training, far less than training requirements for beauticians, manicurists and even dog groomers. The very minimal training that aides receive does not prepare them to meet the needs of nursing home residents who are more sick and frail than in the past. To improve the quality of care for residents, curriculum standards should be

* language asking 160 hours.

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FAX TRANSMITTAL SHEET

DATE: 9/12/00

NUMBER OF PAGES (including cover sheet): ____

TO: Devorah Adler	FROM: Madeleine Jordan
ORGANIZATION:	DEPARTMENT:
FAX NO: 456-5557	FAX NO:
TELEPHONE NO:	TELEPHONE NO: 898-3264

COMMENTS: Could you please make sure this information is given to Edwin Park for The BBA "Giveback" note Bork he is preparing for Chris. This includes the nursing home and needlestick BBA "giveback" language and letters from nursing home advocacy groups on the "single track" issue. Thanks.

☐ URGENT! ☐ FOR YOUR INFORMATION ☐ PLEASE CALL

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NEEDLESTICK LEGISLATION AND PUBLIC SECTOR WORKERS IN THE BBA "GIVEBACK" BILL

Background

Last year, a bill was introduced in the House and Senate (H.R. 1899/S. 1140) to require employers to implement the use of safety-designed needles and sharps. The legislation is aimed at preventing needlestick injuries and the transmission of serious diseases from patients to nurses and other workers. While the bill establishes the requirement through the Occupational Safety and Health Act (OSHA), it includes a provision that requires public hospitals, that are not covered by OSHA, to meet the needlestick standard as a condition of participation in the Medicare program.

Recent Legislative and Agency Activity

On June 23, the House Education and Workforce Subcommittee on Workforce Protections held a hearing on needlestick injuries. On July 27, the Senate approved a Sense of the Senate calling for the adoption of legislation to reduce needlestick injuries. Both the Sense of the Senate and testimony offered during the hearing emphasized the need to protect public health care workers outside of the jurisdiction of OSHA.

Rep. Cass Ballenger is working with Rep. Major Owens to draft a new needlestick bill, similar to H.R. 1899/S. 1140, which would modify the OSHA *Bloodborne Pathogens Standard* to require employers to make a greater use of safety-designed needles and sharps. This new bill may be introduced the week of September 11th. It is also possible that Senators Jeffords and Enzi may introduce a companion bill.

In December 1999, OSHA issued a *compliance directive* that updates enforcement of the agency's Bloodborne Pathogens Standard. The new directive instructs OSHA compliance officers to enforce the use of safer devices in the workplace. The Ballenger-Owens legislation would codify and refine the directive. It would also prevent a weakening or withdrawal of the safer devices requirement by a future OSHA administration. Importantly, due to limits on OSHA's authority in the public sector, public workplaces in 27 states and the District of Columbia are not covered by the Bloodborne Pathogens Standard and the new directive.

Public Employee Gap in New Bill

Rep. Ballenger hopes to move the needlestick bill quickly. Because of the tight time frame, and due to committee jurisdiction complications, the bill will not include a Medicare provision to extend the needlestick requirement to public hospitals in states where the public sector is not covered by OSHA.

Addressing the Gap in the BBA "Giveback" Bill

We propose that language be added to the BBA "giveback" legislation that would require HHS to issue a regulation within six months which requires that public hospitals, not otherwise subject to the bloodborne pathogens standard under OSHA, must comply with the standard as a condition of participation under for Medicare.

OSHA AND PUBLIC EMPLOYEES

The federal Occupational Safety and Health Act (OSHA) does not cover state, county or municipal workers. However, state and local government employees can become covered by federal safety and health standards if a state establishes a federally approved OSHA program. There are federally approved programs in 23 states (plus Puerto Rico and the Virgin Islands). Below is a list of the states where public employees are not covered by federal OSHA standards.

States Where Public Employees are Not Covered by Federal OSHA Rules

Alabama	Kansas	New Jersey*
Arkansas	Louisiana	North Dakota
Colorado	Maine	Ohio
Delaware	Massachusetts	Oklahoma
District of Columbia	Mississippi	Pennsylvania
Florida	Missouri	Rhode Island
Georgia	Montana	South Dakota
Idaho	Nebraska	Texas
Illinois	New Hampshire	West Virginia
		Wisconsin

*The New Jersey legislature has adopted federal OSHA standards. The state is waiting for Congress to appropriate funding for the enforcement of its OSHA plan.

Non-Federal Safety and Health Coverage for Public Employees

A number of states have approved their own workplace safety and health laws to cover public workers. However, these states are not federally obligated to meet OSHA regulations, including the Bloodborne Pathogens Standard which is aimed at limiting worker exposure to bloodborne diseases.

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8105-1000

"Medicare Givebacks" for Nursing Homes

No New Funding Without New Accountability More Training Not Less: Reject "Single Task"

The nursing home industry is lobbying for billions of new Medicare dollars.

- They want rate increases that will cost taxpayers up to $10 billion dollars.
- But according to the General Accounting Office current Medicare reimbursement rates are "sufficient and in some cases generous."

The nursing home industry can not be trusted with Medicare money.

- Major nursing home chains have committed massive fraud, milking the government for Medicare dollars by over billing and billing for services they never provided to Medicare residents.
- Nursing homes are spending as little as possible on staff- 54% of nursing homes are staffing at levels below which bad outcomes for nursing home residents can be expected.
- When nursing home workers seek to form unions to address poor care and difficult working conditions, nursing homes administrators use Medicare dollars to hire high priced lawyers and consulting firms to intimidate employees interested in forming unions.

New Accountability Needed

- The government does not have the ability to hold providers accountable for providing the nursing care that residents need.
- There are no specific federal staffing standards.
- Medicare pays nursing homes based on the acuity level of the residents and the staffing levels deemed necessary to provide this level of care - but no one checks to see if this is what was actually provided.

No Blank Checks for the Nursing Home Industry:

1) Require nursing homes to illustrate that they are staffing at the level for which they are being reimbursed under Medicare and to provide more information to consumers about staffing levels.

2) Prohibit nursing homes from spending Medicare dollars to influence employees on the question of unionization.

3) Stop the industry's "Single Task" worker proposal and require more training for nursing home workers not less.

Say Yes! To New Accountability

Ask nursing homes to illustrate that they are staffing at the level for which they are being reimbursed under Medicare, here's how:

This could be done simply by requiring facilities to report the total number of nursing staff hours furnished by the facility to all residents, broken down by payer. The Secretary could then compare the actual aggregate number of nursing hours provided to Medicare beneficiaries with the number of staffing hours that Medicare paid through the RUGS system and adjust reimbursement accordingly. ***(HR. 4614, Stark)***

Provide consumers with easily accessible information about staffing levels and ownership of Medicare certified nursing homes, here's how:

Medicare beneficiaries have a right to know what level of care to expect from nursing homes. Posting information on the Internet and at the facility level about the ratios of staff to residents, who owns the facility (whether it is for-profit or non-profit) and the facilities' record of labor violations and deficiencies will enable consumers to shop on the basis of quality. Access to this information will give consumers and advocates tools to hold facilities accountable for providing the services Medicare is paying them to provide. ***(HR. 4949, Waxman)***

Protect workers right to organize unions.

Workers who wish to form their own organizations to advocate for better working conditions and resident care should have that right to make that decision. Employers should be strictly prohibited from using Medicare funds meant for resident care to influence employees on the question of unionization.

Say No! To The Single Task Worker Proposal

The industry wants Congress to waive training requirements for Certified Nurse Aides and allow facilities to hire lesser trained, part-time, lower paid, uncertified employees to provide certain nursing related tasks. ***(HR. 4547, Ryan)*** This bill is harmful to residents:

- **It does nothing to provide more nursing care and assistance for residents**, as the industry suggests. There is no new money attached. Instead, it would allow nursing home to re-allocate their labor costs by replacing fully trained aides with a cheaper staffing configuration.

- **It would divide the care of nursing home residents into isolated tasks, leading to an "assembly line" culture in nursing homes** and degradingt the continuity of care that residents need.

Experts agree that the existing training requirement for Certified Nurse Aides of just two weeks is already insufficient for preparing them to meet the needs of nursing home residents, who are more sick and frail than in the past. Instead of reducing this already inadequate standard, Congress should call on HCFA to update the current regulations and require a minimum of 160 hours of training to appropriately prepare CNAs to meet residents needs. ***(HR. 4614, Stark)***

It's Time to Set a Precedent

The policies outlined above are incremental measures that Congress can use to begin to strengthen the now weak link between reimbursement and quality of care. Coupling any new funding for the nursing home industry with these policies will illustrate that Medicare funds are not dispersed with no strings attached. Providers must be held accountable for how taxpayer dollars are spent so that Medicare beneficiaries who paid into the system their entire lives get the quality care they deserve.

August, 2000

For more information contact SEIU, 202-898-3366

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SEIU Opposes "Single Task" Bill for Nursing Homes (HR. 4547, Ryan)

The Service Employees International Union opposes HR. 4547 which would reduce already inadequate training requirements for nursing home workers. This proposals to create a new "single task" job classification in nursing homes would erode existing federal regulations which require that individuals who assist with nursing related services in nursing homes, such as assisting residents with eating and drinking, be Certified Nurse Aides (CNAs), licensed nurses, or registered dieticians. Ensuring that nursing home residents get the care and assistance they need will require strengthening not weakening federal quality standards.

- **Reducing training requirements is not the answer.** The federal government requires only 75 hours of training for Certified nurse aides. It is widely believed that this level of training is completely inadequate to prepare workers to meet the complex needs of today's nursing home residents. Feeding residents is not a simple task. It requires knowledge of the many different types of disorders that residents may suffer from that make it difficult for them to feed themselves, proper techniques for giving this assistance and careful monitoring of residents actual intake.

- **Creating a new sub-category of workers will not improve the quality of care.** Facilities have strong incentives to limit labor costs, their greatest cost of doing business. Absent minimum federal standards for Certified Nurse Aide staffing levels, facilities control costs and maximize profits by staffing at minimal levels. Aides are routinely assigned to a dozen or more residents at one time, making impossible for them to meet all of the residents needs. Creating a new category of lesser trained workers will not make the nursing home industry accountable for hiring sufficient numbers of staff to ensure good care.

- **Nursing homes already have the ability to get extra help at mealtimes if they need it.** Nothing prohibits facilities from hiring Certified Nurse Aides on a part time basis to assist with feedings. Volunteers such as family members are not barred from helping residents with their meals.

- **Adding staff at mealtimes only is not sufficient to protect against malnutrition and neglect.** There is a staffing crisis 24 hours a day, not solely at meal times. Even if some facilities do add extra staff at certain times, residents will still suffer from neglect and inadequate staff assistance with personal hygiene, medications and other areas of care. Residents who can not feed themselves or who have difficulty eating require assistance on an ongoing basis and at odd hours. If single task workers work only at meal times, malnutrition and weight loss would continue, if only at a slower rate.

- **Single Task Employees means Assembly Line Care.** Separating out the different tasks involved in caring for nursing home residents, such as feeding, transportation and bathing to different types of narrowly trained workers disrupts the continuity of care and weakens the personal connection between providers and residents.

- **Supervision and support is already inadequate.** Single task employees would add more unlicensed staff to the floor who require supervision. Already, CNAs are not getting the advice and mentoring they need from licensed nurses. Adding a layer of narrowly trained workers to the floor would exacerbate this problem and put resident care in the hands of people with little training and virtually no supervision.

National Citizens' Coalition for
NURSING HOME REFORM

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1975 - 2000
25
years of
protecting residents
NCCNHR

NCCNHR Position on HR 4547, "Medicare and Medicaid Nursing Services Quality Improvement Act of 2000" and Other Proposals To Authorize Single Task Workers in Nursing Homes

The National Citizens' Coalition for Nursing Home Reform (NCCNHR) strongly supports improved staffing in nursing homes, including adequate staffing levels to ensure that all residents receive enough to eat at every meal; however, HR 4547 and other proposals to authorize part-time, minimally trained workers to perform single tasks would **not** meet nursing home residents' multiple, 24-hour-a-day needs. Moreover, there are alternative means of achieving the proposals' goals without changing current Medicare and Medicaid law.

NCCNHR urges Congress to consider the following critical problems -- caused by chronic understaffing in nearly every nursing home in the United States -- that single task worker proposals do not solve:

- Single task workers have been proposed as a solution to **malnutrition**, now recognized as affecting an estimated 40 percent or more of nursing home residents. However, employing workers whose *only* job was to assist with meals would not address other causes of malnutrition perpetuated by inadequate staffing. For example: (1) poor oral health, which affects 70 to 80 percent of residents; (2) inadequate numbers of licensed nurses to supervise nursing assistants; (3) depression, which may occur in as many as 38 percent of residents and is often untreated; and (4) unappetizing food.
- **Dehydration** is an equally dangerous problem in nursing homes. Workers in understaffed facilities often withhold liquids so they will not have to take residents to the bathroom as often. Residents themselves often refuse liquids because they know no one will help them go to the bathroom. More full-time, fully trained nursing assistants who can toilet *and* hydrate residents are critically needed.
- **Pressure sores**, which cause severe pain and risk of dangerous infections, are not decreasing in nursing homes because there are not enough nursing assistants to provide the full range of preventive treatments.
- Painful, crippling muscle **contractures** increased from 16.7 percent to 23.2 percent between 1992 and 1998 because there are not enough staff to help residents exercise or to provide restorative care.
- **Basic care** is often neglected, such as changing incontinent residents' clothes; maintaining bath schedules; cleaning residents' teeth; and cleaning and clipping nails.

(More)

There are other reasons that proposals for single task workers are unworkable and inadvisable:

- Nursing home residents want – and in many cases need – helpers who are familiar to them and who understand all their needs. This is particularly true in the case of people with Alzheimer's disease and other dementias; these residents often are confused or frightened by unfamiliar workers.
- Employment of single task workers is likely to exacerbate conditions that make it difficult to retain nursing home employees. Pressure to improve wages and benefits will be reduced; nursing assistants will be assigned more residents to care for because of the perception that their workload has been lightened; full-time nursing assistants will be given the heaviest, most repetitive or least desirable tasks; and personal communication and contact between residents and nursing assistants will be further reduced.
- Introduction of single task workers is a step backward in efforts to develop a permanent, full-time, career-oriented nursing home workforce that is committed to caring for the elderly and disabled. Most of the serious problems in nursing homes today can be attributed to the fact that so many workers are poorly trained, inexperienced, and temporary.
- HR 4547 does not increase reimbursement to cover the cost of hiring new workers. Therefore, it appears that there is no intent to increase the overall number of staffing hours available to care for residents.

HR 4547 and other proposals for single task workers are unnecessary because:

- Nursing homes already are authorized to use individuals who provide a single service. All that is required is that they: (1) be volunteers, or (2) receive two weeks of instruction and pass a competency evaluation to become a nursing assistant.
- Many experts recommend staggering normal nursing assistant work schedules so that more full-time, permanent staff are on duty during meals.

Shortages of adequate, trained staff in nursing homes are not new and are not solely the result of today's competitive job market. (Congress heard testimony about inadequate staffing and addressed the issue as early as 1975 in a report called *Nursing Home Care in the United States: A Failure in Public Policy*.) NCCNHR urges this Congress to address the **complex issues** surrounding the nation's need to attract and to retain a permanent, well-trained, well-supervised, and fairly compensated long-term care workforce.

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CONCERNS ABOUT NUTRITION/FEEDING ASSISTANTS

Creating a new category of staff called nutrition/feeding assistants is a simplistic response to a complex problem with many causes and a long history. Such a classification of staff is unlikely to improve care for residents in the short-run (largely because of practical concerns) and will only exacerbate care problems in the long-run (because of policy concerns).

Practical concerns

What training will these staff get? Who will conduct the training? How many hours and with what content?

Who will monitor that these staff are actually trained and competent before they are assigned to residents?

What will be done to assure continuity of care for residents? How will these staff members be made aware of the specific physical and personal characteristics, medical diagnoses, and other needs of the people they are assigned to feed?

Will assignments be permanent?

How will these staff be oriented to the facility's policies, procedures, and staff? How will they know what to do in the case of an emergency?

How do we assure that nutrition assistants supplement, not replace, existing staff? Does the proposal for a new staff category also include a requirement for staffing ratios for CNAs and nutrition assistants? What is the budget for these staff members? If there is no budget, as there was not the last time this issue was discussed, then these staff members replace current staff; they are not, as promised, supplements to existing staff. If there is no additional budget, how do we assure that facilities actually hire additional people within existing reimbursement rates?

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What is the monitoring mechanism to assure compliance with (training and other) requirements related to the new category of staff?

What remedies are imposed, when, and by whom, if facilities do not comply with the (training and other) requirements for these staff members?

Policy concerns

Lack of sufficient numbers of staff to feed residents is only one of a number of problems with the poor quality of care for residents that result from short-staffing.

> Residents need assistance with additional activities of daily living – toileting, transferring, etc. – that will not be addressed by staff assigned to the single task of feeding residents. What is next? Toileting assistants? Transferring assistants? Having staff assigned to body parts is not an appropriate way to provide care.

Assigning staff to particular care needs also reverses the trend to cross-train and multi-train staff to perform all functions that residents need – to be residents' assistants, as some of the Pioneer facilities now call their paraprofessional caregivers, not nurses' assistants.

Assigning staff to particular care needs does not promote residents' stated request and need for continuity in caregiving. It also does not respond to what CNAs say is most rewarding in their jobs – their ongoing relationships with individual residents. Good managers recognize the need to stabilize the workforce, not degrade it with fill-in workers. The workforce is stabilized with practices that improve the quality of workers' jobs.

A new category of staff will not solve short-staffing in either the short-run or the long-run. Who will choose to work in these jobs, which would offer less salary than a full-time certified nurse assistant? There is tremendous turnover in CNA staff positions because the jobs are generally considered undesirable: workers receive insufficient wages, lack health insurance coverage, lack career ladders and opportunities to advance professionally, have dangerous workloads and poor working conditions, and are inadequately supervised. How are these negative factors changed or improved by having a part-time job feeding residents? What happens when the unemployment rate goes up?

Residents who need help with eating have physical or cognitive problems that prevent them from being able to feed themselves. Staff who assist such residents need the CNA's skills to provide services to these residents.

A new category of staff will inevitably be called upon to perform other tasks in the facility. As a consequence, the already-inadequate 75 hours of training for CNAs required by the reform law will be watered down, if not virtually eliminated.

Alternative proposals

Under existing law, facilities that want additional staff to help feed residents at mealtimes can hire CNAs on a part-time basis. No legislative change is needed for this solution.

A creative alternative would link nursing homes, which need staff, with home health agencies, whose employees are certified home health aides trained in personal caregiving and who, because they do not have full-time work, are available during lunch and early afternoon hours. The home health agencies' workers become part-time nursing home workers, assisting in nursing homes at mealtimes on a permanent basis with specific residents. Massachusetts providers have begun preliminary discussions to explore this possibility now. Such a proposal provides additional staff at mealtimes, assures those staff are trained and competent CNAs, and assists those CNAs by giving them more work.

See attached Issue Brief, "Health Care Workforce Issues in Massachusetts" (Jun. 22, 2000).

6/5/00
Toby S. Edelman

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August 24, 2000

The Honorable Congressman Dick Armey, Majority Leader
U.S. House of Representatives
301 Cannon Office Bldg
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Re: H.R. 4547 Medicare & Medicaid Nursing Services Quality Improvement Act

Dear Majority Leader Armey:

We are writing as individuals to express our opposition to H.R.4547 which proposes to allow "single task" workers to perform nursing-related functions in our nation's nursing facilities at lower wages and with less training than certified nursing assistants (CNAs). Although we would like to see increased CNAs staffing at special times, such as at mealtime, currently nursing homes can hire additional part-time staff as long as these direct care staff meet the minimum federal training and certification requirements. H.R.4547 would actually have a negative impact on nursing home quality for several reasons.

First, HCFA has not established a minimum staffing level for nursing homes and many nursing homes are currently operating with dangerously low staffing levels and are seriously jeopardizing the health and safety of residents as shown in the recent HCFA report on staffing. Rather than increasing the minimum number of direct care staff, H.R. 4547 would allow nursing facilities to substitute part-time and temporary workers with less training for CNAs. The substitution of "single task" workers for existing CNAs would be extremely difficult to prevent and monitor. Thus, single task workers as defined in this bill could well increase the problems of systemic understaffing and under-training of direct care workers in nursing homes.

Second, this legislation would allow nursing home staff to have less than 75 hours of training to carry out basic care activities at a time when many experts believe that the training hours for CNAs should be doubled. H.R. 4547 makes the false assumption that quality nursing care is a mere assembly of specific "tasks" that each require a few hours of training. To the contrary, quality requires special training in the overall care of vulnerable residents to identify, prevent, and treat resident problems. Tasks such as assisting residents with eating require skill and time to prevent residents from choking, special skills to encourage maximum independence, patience to allow sufficient time for residents to eat, and the knowledge of nutrition and hydration requirements. Appropriate training on nutrition and feeding alone could require 75 hours to ensure appropriate care. This legislation would further encourage a task-oriented approach, while ignoring the needs and preferences of the whole resident.

Third, the role of single task workers is not defined in the legislation and no provision is made to enforce the limitation of these workers to one task. Without definitions of single task workers and regulatory monitoring, how would residents and licensed nurses be assured that the workers were providing only the care for which they had been trained. Moreover, the legislation does not establish minimum training standards for single task workers, so that some training programs could be 2 hours and others could be 50 hours.

Fourth, this legislation would allow nursing facilities to reduce the wages and benefits of single task workers below the wages of CNAs. This proposal occurs at a time when the evidence shows that current CNA salaries are not adequate to attract and retain a qualified workforce and are contributing to a national shortage of staff. This bill virtually invites the nursing home industry to increase their reliance on under-trained, poorly paid, intermittent employees, thus undermining current efforts to develop permanent, full-time, well-trained, career-oriented nursing home workforce.

Although the intention of H.R. 4547 may be to alleviate current severe staffing shortages at peak hours, intermittent, poorly trained workers may actually lower the quality of care. These workers would require more supervision and may contribute to care at less than minimum standards. Many nursing homes lack sufficient licensed nurses to provide appropriate training and supervision of these new workers. In addition, reliance on intermittent, single-task workers may further fragment the care residents receive. Rather than ensuring continuity of care with regular direct care staff, this would introduce new part-time intermittent workers, which would be especially troublesome for residents with Alzheimer's disease and other types of dementia.

Finally, this bill increases the inconsistencies in standards of care among the states because states are allowed to establish and monitor their own training standards. This promotes variance from the federal standards for certified nurse assistant training and competency and encourages some states that have resisted compliance with the federal regulatory standards to deviate even further. In principle, the current federal regulatory standards established by OBRA in 1987 should be maintained and enforced by HCFA and not weakened.

In summary, we urge the House to take immediate steps to increase the training and the wages and benefits of nurse assistants in order to create stability and a sense of pride in the provision of quality care in nursing homes. Nursing homes should be required to be more accountable for providing sufficient well-trained staff. We urge you to oppose this bill which directly subverts current federal nursing facility standards and regulations and threatens the quality of nursing home care.

Sincerely,

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NORWOOD & TIME

Q low income

A: leaves out 1/2 currently units by excluding all above $14,600 & over 20 million seniors & people w/ disabilities get no help.

Uses welfare oriented. state based approach that is notorious in its low participation rate. Even benefit provided sub standard allows states to limit med

$15,000 widow

Really care about low income

90% ME participation.

Q: How are you going to work w Dicker.

CNN

SHOW: CNN WORLDVIEW 18:00

September 16, 2000; Saturday 6:23 PM Eastern Time

Transcript # 00091607V18

SHOW-TYPE: PACKAGE

SECTION: News; Domestic

LENGTH: 471 words

HEADLINE: President Clinton Calls for Additional $1 Billion in Funding for **Nursing Homes**

BYLINE: Andria hall, Kelly Wallace

HIGHLIGHT: In his weekly radio address, President Clinton called for a $1 billion increase in funding to **nursing homes.** He hopes the money would help correct under-staffing, the No. 1 cause of poor care.

BODY:

THIS IS A RUSH TRANSCRIPT. THIS COPY MAY NOT BE IN ITS FINAL FORM AND MAY BE UPDATED.

ANDRIA HALL, CNN ANCHOR: President Clinton is calling for improved care of the elderly. His weekly radio address, actually delivered from a **nursing home,** focused on chronic under-staffing and under-training at the nation's facilities. His proposal: one billion dollars to improve **nursing home** care.

CNN White House correspondent Kelly Wallace, now, with more on the state of America's **nursing homes.**

(BEGIN VIDEOTAPE)

KELLY WALLACE, CNN CORRESPONDENT (voice-over): William Jackson, a resident at Washington Home in the nation's capitol, says this **nursing home** stands out from the rest.

WILLIAM JACKSON, WASHINGTON HOME RESIDENT: Since I've been here, I've been going around to different ones, and I see why they say this is the best one.

WALLACE: President Clinton saluted Washington Home in a rare live broadcast of his weekly radio address, but said, in more than 50 percent of the other 17,000 **nursing homes** in the U.S., patients are not getting the minimum level of care they deserve.

WILLIAM J. CLINTON, PRESIDENT OF THE UNITED STATES: According to current research, the No. 1 culprit is chronic under-staffing. When there are too few caregivers for the number of patients, the quality of care goes down.

WALLACE: Patients who receive less than two hours of care daily are more likely to develop bed sores, lose weight, or end up in the hospital, according to a government report.

Dr. Harriet Fields, a long-term care advocate, has seen the neglect firsthand.

DR. HARRIET FIELDS, LONG-TERM CARE CONSULTANT: When they're slumped in their wheelchair, when there's no sparkle in their lives, when really -- in their eyes.

WALLACE: Mr. Clinton's plan calls for $1 billion over five years, and grants to states to hire more staffers and improve training. Immediate penalties would be imposed on **nursing homes** found to be endangering patients' safety.

A group representing 12,000 long-term care providers applauds the boost in funding, but worries more penalties will keep professionals out of the business.

RICK ABRAMS, AMERICAN HEALTH CARE ASSOCIATION: Given the punitive nature, given the fact that, at times, they're drawn away from their focus, which is providing the compassionate care to their patients, that punitive aspect does keep people away from the long- term care industry.

WALLACE (on camera): The White House says the president's plan already has bipartisan support and reflects a growing sentiment on Capitol Hill that any increase in funding must be matched with more accountability.

Kelly Wallace, CNN, The White House.

(END VIDEOTAPE)

LANGUAGE: ENGLISH

LOAD-DATE: September 17, 2000
