

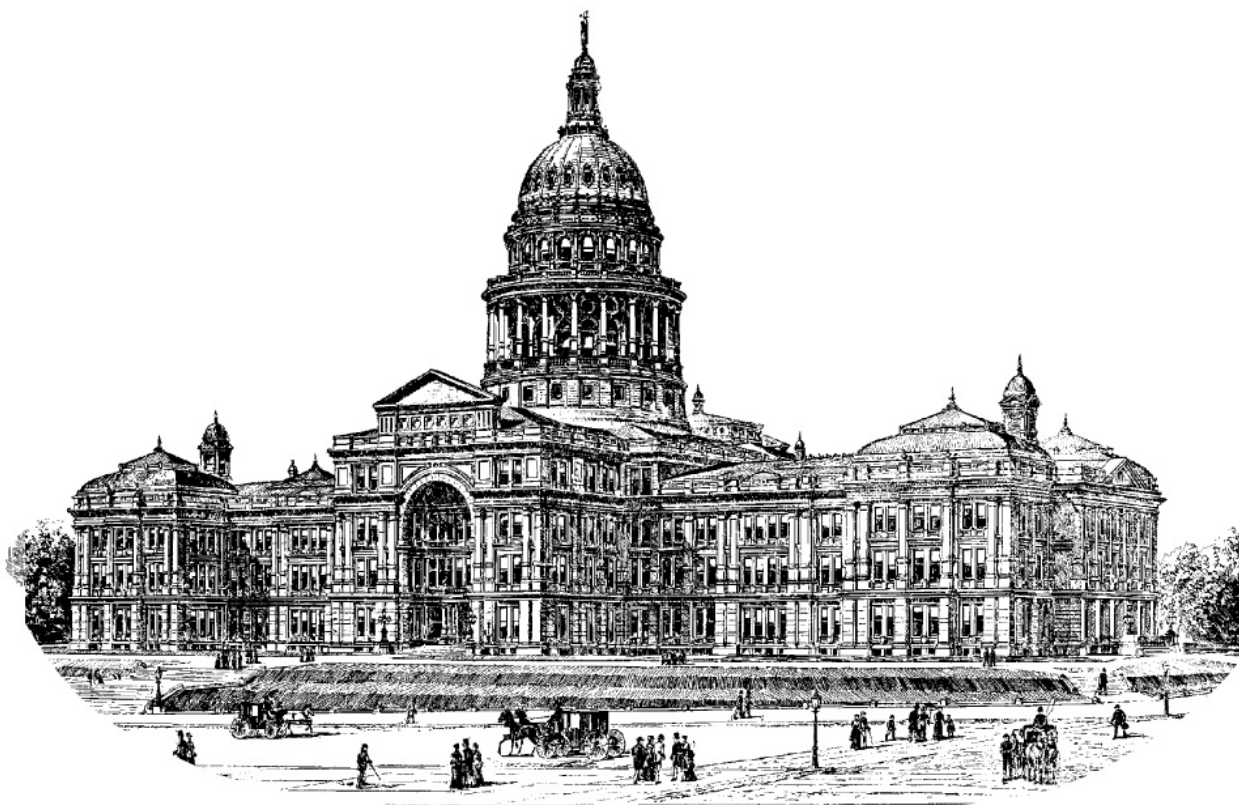


# INTERIM REPORT

## TO THE 83RD TEXAS LEGISLATURE

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JOINT COMMITTEE ON AGING  
JANUARY 2013

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**JOINT LEGISLATIVE COMMITTEE ON AGING  
INTERIM REPORT 2012**

**A REPORT TO THE  
83RD TEXAS LEGISLATURE**

**REPRESENTATIVE ELLIOTT NAISHTAT  
CHAIRMAN**

**COMMITTEE CLERKS  
CLAYTON TRAVIS  
APRIL YOUNG**

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Legislative Committee on Aging

January 10, 2013

Elliott Naishtat  
Chairman

P.O. Box 2910  
Austin, Texas 78768-2910

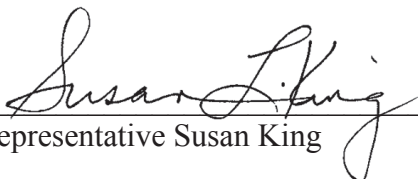
The Honorable Joe Straus  
Speaker, Texas House of Representatives  
Members of the Texas House of Representatives  
Texas State Capitol, Rm. 2W.13  
Austin, Texas 78701


Dear Mr. Speaker and Fellow Members:

The Joint Legislative Committee on Aging of the Eighty-second Legislature hereby submits its interim report including recommendations for consideration by the Eighty-third Legislature.

Respectfully submitted,

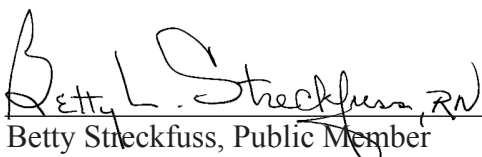
  
Representative Elliott Naishtat, Chair

  
Representative Susan King

  
Senator Eddie Lucio, Jr.

  
Senator Joan Huffman

  
Homer Lear, Public Member

  
Betty Streckfuss, Public Member

CC: The Honorable Rick Perry, Governor  
The Honorable David Dewhurst, Lt. Governor  
The Honorable Joe Straus, Speaker of the House  
The Honorable Jane Nelson, Chair, Senate Health & Human Services Committee  
The Honorable Lois Kolkhorst, Chair, House Public Health Committee  
The Honorable Richard Raymond, Chair, House Human Services Committee

Members: [Representative Susan King, Senator Joan Huffman, Senator Eddie Lucio Jr., Betty Streckfuss, Homer Lear]

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## **ACKNOWLEDGMENTS**

The Joint Legislative Committee on Aging would like to thank two key legislative staff who helped in preparing this interim report.

Nancy Walker, Legislative Director, Representative Elliott Naishtat

Sara Gonzalez, Legislative Director, Senator Eddie Lucio Jr.

## IN MEMORIAM

The Legislative Committee on Aging would like to dedicate this interim report to the 83rd Texas Legislature in honor of Homer W. Lear, one of the Committee's treasured members who passed away on September 23, 2012 at the age of 92. He was a co-author of the 12th Resolution 33 of the Texas Silver-Haired Legislature requesting that the Texas Legislature create the Texas Legislative Committee on Aging. Mr. Lear was appointed by Governor Rick Perry to serve as one of the public members on the Committee in 2009 and was an active member at the time of his death.

Mr. Lear was a proud member of the United States Air Force. He received his commission and pilot rating at Kelly Field in San Antonio, Texas on August 15, 1941. He soon became qualified as an aircraft commander in the 19th Bomb Group on Guam. After World War II, then Colonel Lear spent the next 23 years in Strategic Air Command and the Pentagon until he retired from the Regular Air Force.

After retiring from the Air Force, Mr. Lear spent the next 19 years working as an executive at the Weyerhaeuser Company. He later worked with the International Executive Service Corps where he had the opportunities to work on projects in the Dominican Republic, the Philippines and Lebanon.

Committee members know that Mr. Lear was a dedicated family member, especially with respect to caring for his wife when she became ill. His wife, Mary Jane Griggs, was his childhood sweetheart; they were married for 69 years prior to her passing.

Mr. Lear was an active member of the Texas Silver-Haired Legislature. He served as the Speaker Emeritus, and as the Chair of the State Affairs Committee of the Texas Silver-Haired Legislature. He was appointed to the 1995 and the 2005 White House Conference on Aging. He was also elected to the first National Silver-Haired Congress in 1995, and elected four times as the Chair of the Board of Directors.

Mr. Lear helped to establish a voting precinct in Bexar County accessible to seniors and individuals with disabilities. He also served as a Bexar County Election Judge, was a member of the Board of Directors of Air Force Villages, and an active member of his local Rotary Club.

It is apparent that Mr. Lear lived a full and active life. He was always looking for ways to improve the quality of care for those in the aging population, as well as raising concerns about the needs of long-term care workers who we rely on to care for our loved ones when there is no family to take on that responsibility.

Colonel Homer Lear, Mr. Speaker Emeritus, you will be greatly missed. Thank you for your many years of service to the State of Texas, and to the United States of America.

## INTRODUCTION

The Joint Legislative Committee on Aging was established by House Bill 610, 81st Legislature, Regular Session.<sup>1</sup> The Committee is tasked with studying issues relating to the aging population of Texas, including health care, income, transportation, housing, education, and employment needs, as well as making recommendations to address those issues.

Prior to its creation, there was another legislative committee, the Long-Term Care Legislative Oversight Committee, that had specific oversight responsibilities to ensure the safety and well-being of aging Texans. The Long-Term Care Legislative Oversight Committee, created by the 75th Legislature, was charged to study issues related to the nursing facility regulatory system as well as abuse and neglect of nursing home residents, and to develop recommendations for a continuum of long-term care services for our senior citizens. In the 79th Legislative Session, the statutory requirement of the Long-Term Care Legislative Oversight Committee was repealed despite the growing numbers of seniors and baby boomers in the state.

In 2005, Steve Murdock, the State Demographer of Texas at the time, estimated that the number of Texans 65 years or older would increase from 2.1 million to 6.3 million between 2000 and 2040. This suggests that Texans will live longer, be more diverse, and have increasingly complex needs. Given the projections of a Texas senior tsunami, the 81st Texas Legislature found it important to establish a legislative committee to ensure the state's readiness to meet associated challenges and coordinate resources.

The Legislative Committee on Aging is comprised of two members of the Senate appointed by the Lieutenant Governor, two members of the House of Representatives appointed by the Speaker of the House, and two public members appointed by the Governor. The presiding officer, appointed by the Lieutenant Governor and Speaker of the House on an alternating basis, serves a two-year term, expiring February 1 of each odd-numbered year.

The Committee is required to meet at least twice a year, conduct studies of issues affecting the aging population, and report to the standing committees of the Senate and the House of Representatives by November 15 of each even-numbered year.

## EXECUTIVE SUMMARY

The Legislative Committee on Aging was not assigned any formal interim charges, but the enacting legislation directed the Committee to study transportation, education, income, employment needs, housing, and health care issues as they pertain to the aging population. The Committee elected to focus on innovative long-term care strategies of caring for seniors, issues related to the direct care workforce, and transportation issues of the aging population.

The Committee held two hearings, March 22, 2012 and April 26, 2012, in Austin to hear invited and public testimony. The testimony and information provided to the Committee during these hearings can be organized into three general findings.

First, long-term care in Texas makes up a large portion of the state's Medicaid expenses and overall budget. It is imperative that we look for ways to create an efficient system that rewards performance of nursing facilities, and serves our aging population in the least restrictive environment that promotes their quality of life and overall well-being. This includes looking for new and innovative ways to provide long-term care such as the small home model of care, and refinancing our long-term care system to provide more services in the community.

Second, in order to ensure that our aging population is receiving the best quality of care possible, Texas must invest in the workforce that cares for them on a daily basis. Strategies that address this need include proper training and payment of direct care workers, geriatric medical training, and continuing education throughout the career of health professionals on the unique needs of the aging population.

Finally, testimony during Committee hearings made it clear that there needs to be a comprehensive system to provide access to transportation for the aging population. Local communities are encouraged to develop systems through the use of public/private partnerships to increase access to transportation and improve mobility access of seniors. Additionally, part of a comprehensive system needs to involve community and transportation planning that is conducive to enhancing mobility, not only for the aging population, but for everyone. There is not one solution to address the needs of older Texans as they lose their ability to safely drive, nor is there one solution that will ensure they are in close walking distance to all of the places they need to be. It will require collaboration, coordination, and sharing of resources at the community, local, state and federal levels, to develop and implement a comprehensive system of transportation and mobility access that protects and supports the independence and dignity of Texans as they age.

Overall, the needs of the senior population in Texas are prevalent and will continue to grow exponentially as the baby boomer population enters retirement. In its evaluation of these findings, the Legislative Committee on Aging developed fourteen recommendations, which are presented starting on page 51 of this report.



## JOINT LEGISLATIVE COMMITTEE ON AGING

### HEARINGS

The Committee held two hearings in Austin, Texas. Invited testimony of experts in the field, commissioners of the state agencies that have jurisdiction and oversight of programs serving the aging population, and advocacy and professional groups was presented to the Committee. Public testimony was also provided at each hearing.

*Hearing #1: Innovative Strategies for Long-Term Care for Seniors  
March 22, 2012, Room 2E.20 (Betty King Committee Room)*

The Legislative Committee on Aging held a hearing on March 22, 2012 to learn about innovative approaches to long-term care for seniors.

The Committee heard invited testimony from:

- Chris Traylor, Commissioner, Texas Department of Aging and Disability Services (DADS)
- Amanda Fredriksen, Manager of Advocacy, AARP
- Tim Graves, President and CEO, Texas Health Care Association (THCA)
- Darlene Evans, Board Member and Operator, Autumn Winds Retirement Lodge
- Robert Jenkins, Director, Green House Project
- Patrick Crump, Vice President of Operations, Buckner Retirement Services, Inc.
- Britta Strickland, R.N., L.N.F.A., Senior Vice President of Small House and Operations, Touchstone Communities
- Sandy Klein, L.N.F.A., Senior Vice President of Management Services, Touchstone Communities

The Committee received public testimony from:

- Sue Milam, Ph.D., LMSW, Government Relations Director, National Association of Social Workers (NASW)
- Eric Ndubueze Ufom, President, Equal Rights for Persons with Disabilities International, Inc. (ERPDI) (submitted written testimony)

*Audio/Video recordings, minutes, witness lists and presentations for the above referenced hearings may be found online at:*

<http://www.senate.state.tx.us/75r/senate/commit/c802/c802.htm>

*Hearing #2: Innovative Strategies for Transportation and Workforce Issues*  
*April 26, 2012, Room 2E.20 (Betty King Committee Room)*

A second hearing was held on April 26, 2012 to explore innovative strategies to address transportation needs of seniors, and to strengthen the workforce that serves the aging population.

The Committee heard invited testimony from:

- Katherine Freund, Founder and President, ITN America
- Jim Hine, CEO and President, Public Policy Solutions
- Jon Weizenbaum, Deputy Commissioner, Department of Aging and Disability Services
- Anita Bradberry, Executive Director, Texas Association for Home Care and Hospice
- Dr. Cheryl Grenweldge, Professor and Co-Director, PATHS: Texas A&M University
- Eric Roberts, Coordinator, PATHS: Texas A&M University
- Dr. Carmel Dyer, Professor and Director, Division of Geriatric and Palliative Medicine at The University of Texas Medical School at Houston

The Committee received public testimony from:

- Amanda Fredrikson, Manager of Advocacy, AARP
- Nancy Crowther, Personal Attendant Coalition of Texas (submitted written testimony)
- Texas Medical Association (submitted written testimony)

*Audio/Video recordings, minutes, witness lists and presentations for the above referenced hearings may be found online at:*

<http://www.senate.state.tx.us/75r/senate/commit/c802/c802.htm>

## **INNOVATIVE LONG-TERM CARE STRATEGIES - MARCH 22, 2012**

### **Defining Long-Term Care**

Long-term care refers to the array of health services provided to persons with chronic illness and/or physical, developmental, or cognitive disabilities, including those who have lost the ability to care for themselves due to age-related disabilities. The type and intensity of long-term care services needed by Texas' elderly population vary greatly. Long-term care can refer to the informal and even intermittent care provided by a spouse, adult child or neighbor. It includes services that non-profit and faith-based agencies provide daily to support the elderly who wish to age in place, including home-delivered meals, transportation to the grocery store, or help with home maintenance. More familiarly to many, long-term care services also encompass the formal care available in assisted living facilities (ALFs), as well as intensive services provided by personal care attendants, home health workers, and nursing facility staff.<sup>2</sup>

### **Brief Legislative History of Long-Term Care**

The Social Security Act Amendments of 1965 created the Medicare and Medicaid programs. Medicare is a federal program that provides health coverage to those sixty-five years or older, and younger individuals with disabilities as well as those with end stage renal disease. Medicaid is a health program for certain low-income families and individuals with disabilities. The program is jointly funded by the state and the federal government, and is administered by the state. Medicare and Medicaid cover different types of long-term care services. Medicare provides payment for up to 100 days of rehabilitative care in a long-term care facility after a hospitalization. Medicaid provides payment for low-income individuals to reside and receive services in a long-term care facility after they have spent down their assets.

Historically, long-term care policies have been moving away from institutional care and focusing instead on allowing individuals to stay in the community and receive services in the home. The push for community-based services in long-term care began with the federal Omnibus Budget Reconciliation Act of 1981. Signed by Ronald Reagan, the Act created the Medicaid Home and Community-Based Services (HCBS) waiver program. This allowed states to use long-term care money available through Medicaid to pay for home and community-based services instead of institutional care. Despite states' flexibility to use funds for the provision of community services, some individuals who wanted to live in a community setting but who required services traditionally provided in an institutional setting were denied the choice. In 1999, the U.S. Supreme Court ruled in *Olmstead v. L.C. and E.W.* that the State of Georgia was in violation of the Americans with Disabilities Act by not allowing two mentally disabled women to live and receive necessary services in a less restrictive community setting. This ruling reinforced the notion that individuals who desire to live in the community while receiving services should be provided with the option to do so. In response, then Governor George W. Bush issued an executive order directing the Texas Health and Human Services Commission (HHSC) to review

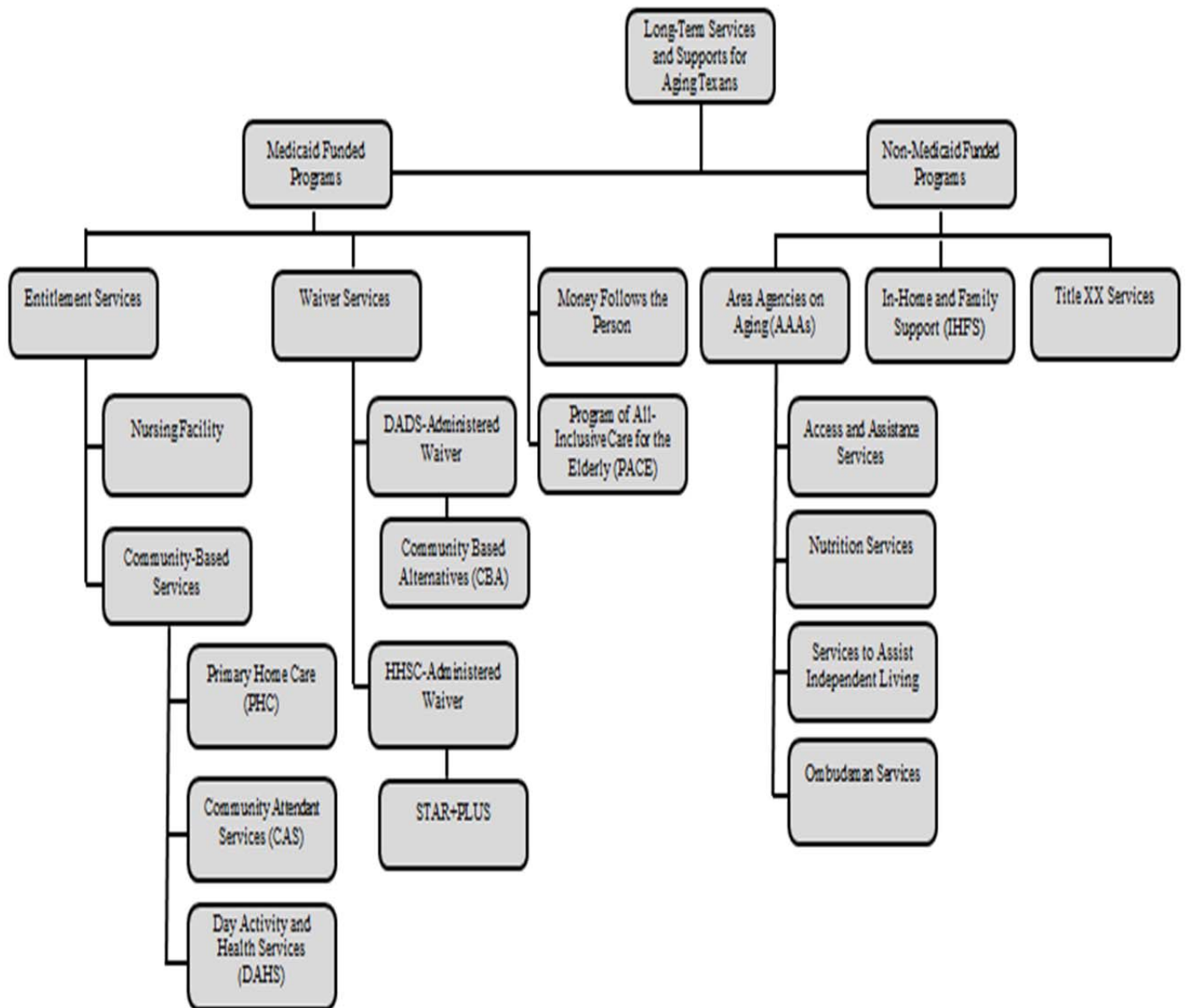
"all services and support systems available to people with disabilities in Texas"<sup>3</sup> and to "examine these issues in light" of the *Olmstead* decision.<sup>4</sup> To further demonstrate its support for providing individuals with disabilities the choice of living in the community while receiving services, the 77th Texas Legislature passed legislation to authorize funding of services to be tied to the individual rather than to the institution. This initiative was, and is today, called the Money Follows the Person policy. Texas' Money Follows the Person initiative has been recognized nationally as a model for other states and was eventually used as a model for a federal initiative.

In 2001, President George W. Bush and his administration attempted to further support and expand upon states' efforts to meet the goals of the 1999 Supreme Court *Olmstead* ruling by announcing the New Freedom Initiative, with the goal of removing barriers to community living for people of all ages with disabilities and long term illness. As a part of the federal Deficit Reduction Act of 2005, the federal Money Follows the Person Demonstration Project awarded grants to states to provide long-term care services in an individual's home. Finally, with the passage of the federal Patient Protection and Affordable Care Act in 2010, financial incentives have been established for states to develop more home and community-based programs through the Community Living Assistance Services and Supports Act (CLASS).

## Long-Term Care for the Aging in Texas

Texas provides an array of Medicaid funded long-term care services for the aging including free-standing nursing homes, hospital-based nursing homes, assisted living facilities, and residential care facilities for persons with intellectual and cognitive disabilities. Each of these provides a particular type of service specifically oriented to the needs of the individual. Figure 1.1 provides a visual representation of long-term care services for the aging population in Texas.

Figure 1.1 Publicly Funded Long-Term Care Services for Aging Texans<sup>5</sup>



## Nursing Facilities in Texas

The chart below offers basic facts about Texas nursing facilities. The data does not include assisted living facilities or personal care homes.<sup>6</sup>

Figure 1.2

<b>Texas Skilled Nursing Facilities, 2010</b>	
Total Number of Certified Nursing Homes	1,191
Total Number of Residents	91,717
Total Number of Nursing Home Beds	129,030
Texas Occupancy Rate (Residents/Beds)	71% (U.S. Average = 83%)
Percent of Residents Funded by Medicare	15% - 13,758 people
Percent of Residents Privately Funded	22% - 20,178 people
Percent of Residents Who Get Help from Medicaid	63% - 57,781 people

## Quality of Nursing Home Care in Texas

Medicaid funded nursing home admissions have declined over the last ten years despite the growing senior population in Texas. This is partly due to the Money Follows the Person initiative as well as the availability of long-term care community programs, and partly due to individual preference to remain in the community as people age. While the trajectory of long-term care is heading towards more home and community-based programs, it is important to note the role that institutional care can play for the aging population. Some individuals require comprehensive, 24-hour care including social services, skilled nursing, medical supplies and equipment, and personal care. These individuals include many of Texas' oldest and most frail residents, especially those who suffer from Alzheimer's and other types of dementia.

When individuals require the level of care and services of long-term care nursing homes, it is incumbent upon the state to ensure they receive the highest quality of services and supports. In Texas, the Department of Aging and Disability Services (DADS) is the regulatory and licensing authority with oversight responsibilities for long-term care nursing homes, in addition to certain community-based providers who provide long-term care services. Both DADS and the Center for Medicare & Medicaid Services (CMS), the federal agency responsible for monitoring and regulating Medicare and Medicaid, manage databases accessible online that allow the public to obtain information about nursing homes, including their quality. The federal website,<sup>7</sup> [www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare), includes information pertaining to the quality of nursing homes throughout the country while the data on DADS<sup>8</sup> website applies to long-term care providers and nursing homes only in Texas. This can be useful information when faced with a decision of placing a loved one in a nursing home.

The information on the CMS Medicare.gov website provides quality ratings on each home and is presented in a consumer-friendly, easy to understand format. It uses a five-star rating system that is based on health inspections, staffing, and other quality measures for each home. The website includes an easy-to-read chart that provides a rating for each of the three areas, and combines the three ratings to calculate an overall rating of each home. Since nursing homes can

vary in the quality of care and services they provide, reviewing health inspections, staffing data and quality measure data are good ways to measure nursing home quality.<sup>9</sup> The quality measures allow consumers to compare facilities against statewide and national averages on 15 outcome measures that include increased need for help with Activities of Daily Living (ADLs), residents with moderate to severe pain, pressure sores, percentage of residents receiving catheter care, weight loss, urinary tract infections, and other measures. The staffing results present the number of staff minutes per resident for registered nurses, licensed practical nurses, and certified nursing assistants. The inspection results describe any citations, the date the violation was corrected, the level of harm, and the scope of harm or potential harm. A summary table presents the number of deficiencies for the facility compared to the average for all nursing homes in the state and the nation.

The rating system that DADS uses is called the Quality Reporting System (QRS). There are many dimensions to quality. According to DADS, "the quality of care provided to nursing home residents, the quality of life each resident experiences, the ability of a facility to meet all regulatory requirements, and customer satisfaction are all important aspects of quality."<sup>10</sup> The QRS uses two quality dimensions to rate nursing homes. QRS uses comparison tables to show ratings for nursing facilities that accept Medicaid or Medicare. These comparison tables include an overall rating score for each home.<sup>11</sup> The sum of the two quality dimensions divided by the total possible points is how the overall rating is calculated.

Nursing home investigations and inspection scores are also used as measurements of quality in the QRS. Investigations are conducted whenever there is a complaint against a nursing home. If an allegation is substantiated and it is determined the nursing home violated state or federal regulations, the nursing home is usually cited by DADS for deficiencies. The investigations score that is used in the QRS is determined based on the nature, severity and scope of deficiencies a nursing home has been cited for in the preceding six months.<sup>12</sup> Inspection scores come from the most recent inspection, which is part of the routine nursing home survey process that usually occurs on an annual basis.

Current average scores investigations and inspections for all nursing homes in Texas are 67 out of a range of scores of 0-100.

- 65% of facilities with a score of 75 or higher
- 26% of facilities with scores between 50 and 63
- 9% of facilities with scores lower than 50<sup>13</sup>

Using the QRS system, DADS has noted the following trends in quality indicators in Texas nursing homes from 2001-2010:

Figure 1.3

... improved for	... remained the same for	... worsened for
Behavioral Symptoms	Incidence of New Fractures	Falls
Indwelling Catheter	Incontinence	Symptoms of Depression
Weight Loss	New Onset Cognitive Impairment	Depression with no Medication Treatment
Prevalence of Bedfast Residents	Incontinence and No Toileting Plan	Use of 9 or more Medications
Tube Feeding	Fecal Impaction	Urinary Tract Infection
Decline in ROM	Dehydration	Anti-Anxiety/Hypnotic Use
Anti-psychotic Use	Decline in ADLs	Hypnotics Use > 2 days
Physical Restraints		
Little or No Daily Activity		
Pressure Ulcers		

A 2011 study comparing states' long-term care systems, state-by-state, ranked each state based on several measures. Out of the study came the State Long-Term Services and Supports (LTSS) Scorecard, which ranked states on many measures, one of which was nursing home quality. While Texas ranks in the middle of the pack for metrics associated with affordability and access (20th), choice of setting and provider (19th), and support for family caregivers (19th), the state does not do very well on indicators concerning quality of life and quality of care (42nd). Some of the indicators that contributed to this ranking were the high number of high-risk nursing home residents with pressure sores (11.8% vs. top five states average of 7.2%), the high rate of hospitalization for long-stay nursing home residents (25% vs. top five states average of 10.4%) and the high amount of long-stay nursing home residents who were physically restrained (2.9% vs. top five states average of 1.3%). It should be noted that data from the LTSS Scorecard for Texas was based on 2008 data.<sup>14</sup> A recent analysis by the American Health Care Association (AHCA) of nursing home care quality indicates that gains have been made in care quality between 2009 and 2011.<sup>15</sup>

In a 2011 Texas State Auditor's report<sup>16</sup> on nursing homes, it was noted that the Texas Department of Aging and Disability Services (DADS) "rarely terminates contracts with nursing facilities [nursing homes] that have a pattern of serious deficiencies."<sup>17</sup> Furthermore, between September 2007 and February 2011, 452 nursing facilities were found to have three or more repeated serious deficiencies within a 24-month period. Of the 452 nursing homes surveyed in



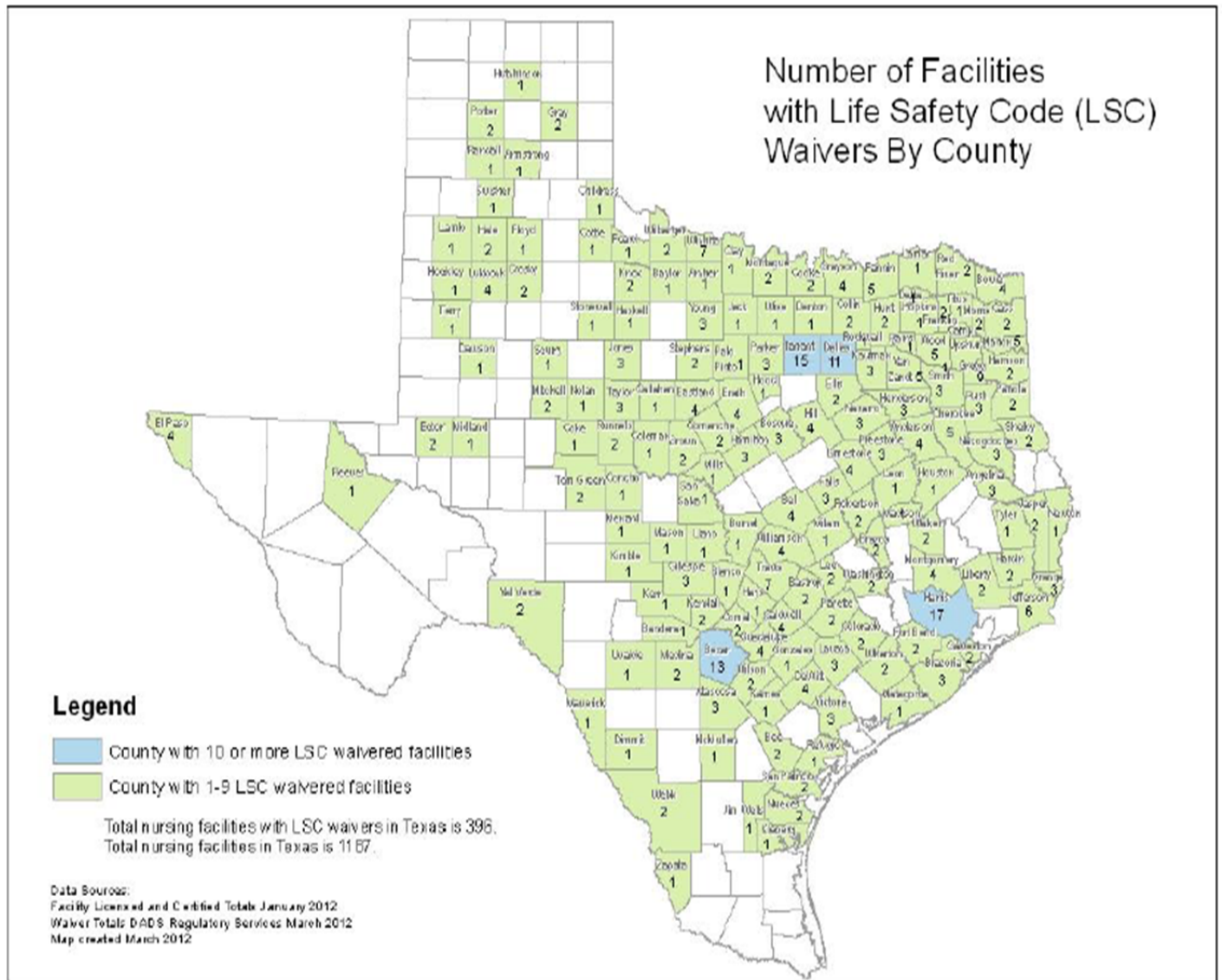
the study, 74 had at least 10 serious deficiencies. A serious deficiency can be classified as:

- Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy.
- One or more deficiencies (regardless of scope) that constitute actual harm that is not immediate jeopardy.
- One or more deficiencies that constitute immediate jeopardy to resident health and safety.

In addition to Texas' ranking of 42nd on quality of life and quality of care in long-term care settings, many of the nursing homes in Texas are currently operating under Life Safety Code (LSC) waivers approved by DADS. Under the Texas Administrative Code, Title 40, Part 1, Chapter 19, Subchapter R, Rule §19.1701, waivers of the Life Safety Code are allowed when "specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship on the facility, but only if the waiver does not adversely affect the health and safety of residents or personnel."<sup>18</sup>

Life Safety Code waivers allow nursing facilities to be out of compliance with certain physical plant and environmental regulatory requirements such as lack of proper kitchen exhaust vents, air conditioning, or low ceiling heights. As of March 2012, **396 of the 1187 (33%) Texas nursing homes were operating under a Life Safety Code waiver issued to them.** Since so many of the nursing homes in Texas were built years ago, if DADS applied rigid enforcement of compliance with Life Safety Code requirements, it would place undue burdens on the homes, which is one reason for the many LSC waivers. While the possession of a waiver does not directly correlate to low safety standards for a specific home, it does highlight a trend in quality standards in the state as a whole. It can also have an effect on the daily living environment and quality of life of nursing home residents. Figure 1.4 depicts the number of nursing facilities with Life Safety Code waivers by county.

Figure 1.4



As previously stated, the physical age and condition of a nursing home, along with its environment, can affect the day-to-day experience of residents, staff and visitors. This is not to suggest that older nursing homes are not capable of providing a quality of life for residents that is acceptable. It does, however, warrant consideration when more than 30% of the state's nursing homes operate under a waiver of the Life Safety Code.

There have been two significant evolutions in nursing home care in the past few decades to help increase the quality of life and quality of care for residents. The first involves "culture change," a term that is used to describe initiatives within nursing facilities to move from the medical

model atmosphere and replace it with a more comfortable home-like environment. Secondly, the physical characteristics, architecture and design of nursing homes has changed over the years as newer ones are built and older homes are remodeled. The design, architecture and physical characteristics of nursing facilities can provide a more home-like environment.

### **Culture Change in Nursing Homes**

Traditionally, nursing homes were designed and built according to an institutional model, much like hospitals, because the aging population required medical services that were not routinely available or accessible in the home. Nursing homes were also organized and operated in a similar fashion with a regimented and task driven schedule. Much like a hospital, the daily activities were, and continue to be, structured around the predetermined schedules of the staff. Thus, "culture change" is a way to re-imagine a nursing home by moving away from a facility organized and operated according to a medical model, and instead to a residential setting that is organized and operated in a manner that provides residents with a sense of being at home. It involves changing one's perspective of a nursing home as a place to work that is controlled by its nursing employees, and instead viewing it as a place where people are living in their home. Attempting to incorporate culture change initiatives in nursing homes will help transform the delivery of care to be more person-directed. Furthermore, culture change emphasizes community and socialization as a means for increased quality of life and quality of care.

The Department of Aging and Disability Services (DADS) has gone to great lengths to support the culture change movement in Texas nursing facilities. In November 2010, DADS established the Culture Change Initiative to promote consistent communications and collaborative activities among DADS staff and stakeholders, including residents, providers and other entities involved in the Texas nursing home industry, to foster and support real and lasting culture change. This initiative includes several components:

- DADS culture change website launch on September 1, 2011:  
<http://www.dads.state.tx.us/culturechange/>
- The hiring of Regional Regulatory Services culture change liaisons
- DADS hosted webinars and symposiums related to culture change
- An article related to person-directed/centered care published in the Regulatory Services newsletter to nursing home administrators.
- Various outreach efforts made at conferences, training events and regional provider meetings in 2011 targeted to providers, surveyors and other stakeholders.

The private nursing home sector has also taken the initiative to implement culture change in some of its facilities. Examples of culture change initiatives that some nursing homes have made include:

- Acquisition of consumer friendly equipment
- More "spa" like shower rooms
- Planning meal menus with significant resident input and including residents' "family" recipes

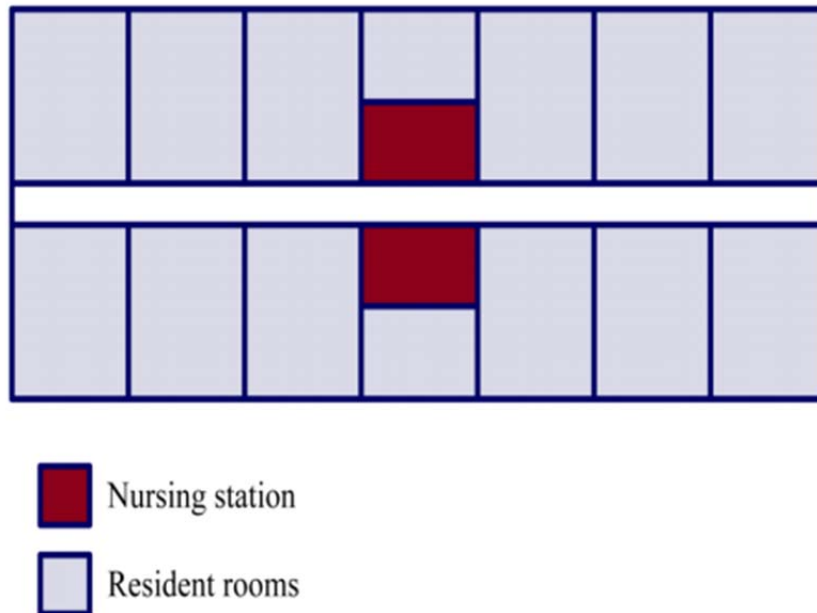
- Using nursing homes to serve as election polling sites to give residents easy voting access and help the neighborhood recognize residents as part of the community.

## Nursing Home Design Progression

### Institutional Model

Nursing home design progression began prior to the 1970s. At first, nursing homes were based on an institutional model that was based on then-existing hospital models. As noted in Figure 1.5, the bedrooms lined a singular hallway with the nursing station in the middle. In most institutional models, all rooms are double occupancy. Many of these were built in the late 1960s and early 1970s in response to the creation of Medicare and Medicaid. Many of these buildings are still in use today and suffer from much needed repairs.

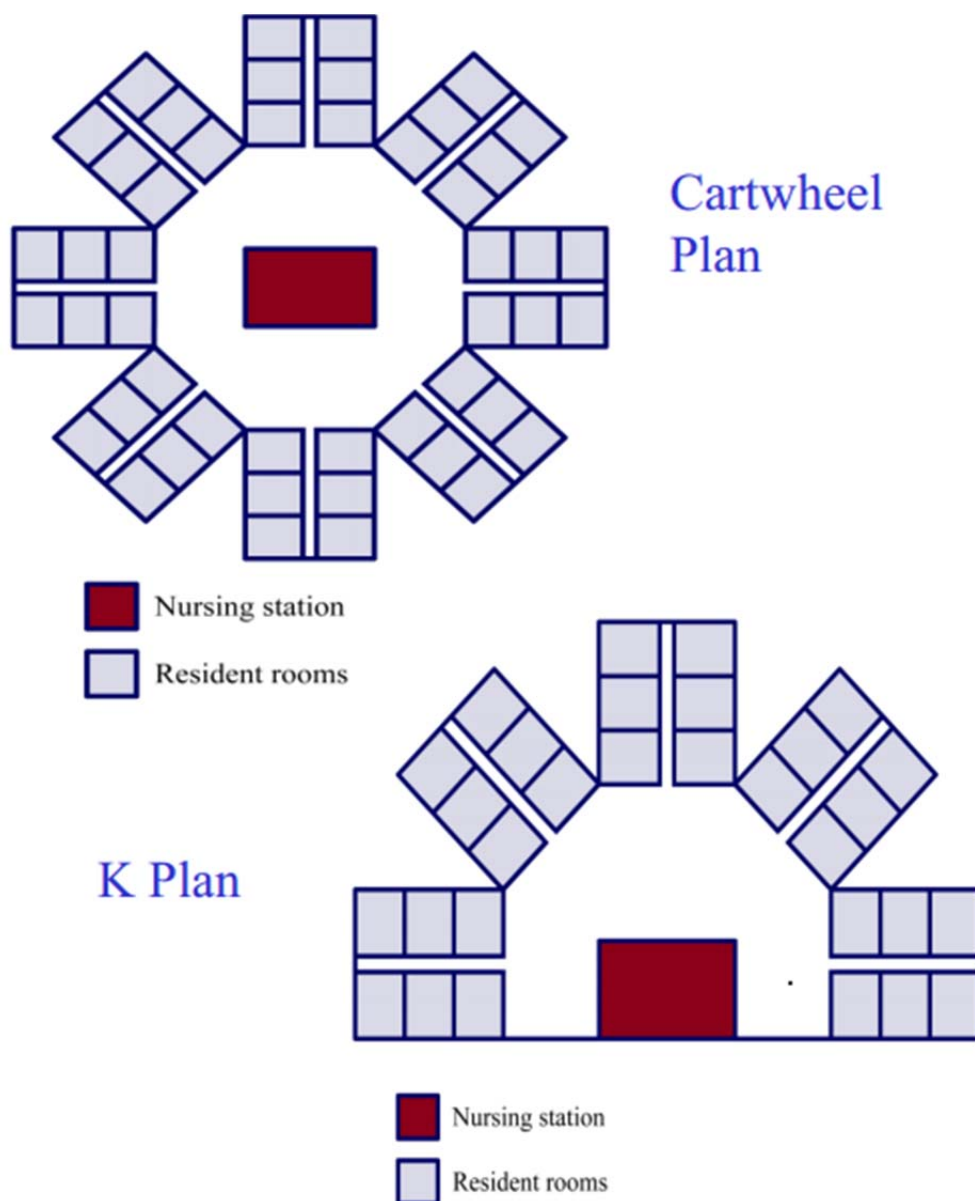
Figure 1.5



### Cartwheel or "K" Model

Other floor plans that appeared in the 1960s and continue to present day are the cartwheel and "K" models. As noted in Figure 1.6, a nursing station sits centralized in order to see down each of the hallways that spoke out from the middle. Bedrooms are aligned on both sides of the corridors and are mostly double occupancy.

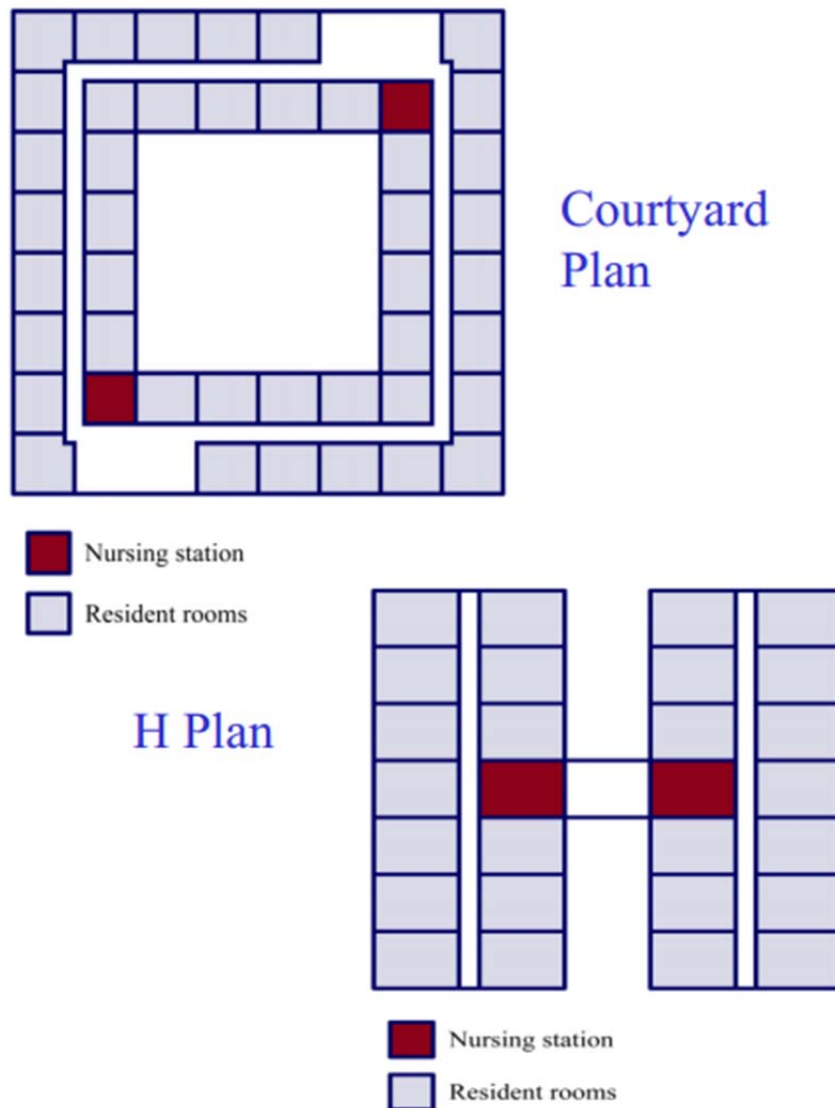
Figure 1.6



## Courtyard or "H" Model

The courtyard or "H" plans began in the 1980s and are in continued use today. As noted in Figure 1.7, this design provides more living space for residents in a centralized communal area. Nursing stations are located on adjacent corners of the courtyard. These floor plans allow for a larger number of individuals to reside in one building, thus making it hard for residents to get to know each other despite the availability of social space to do so.

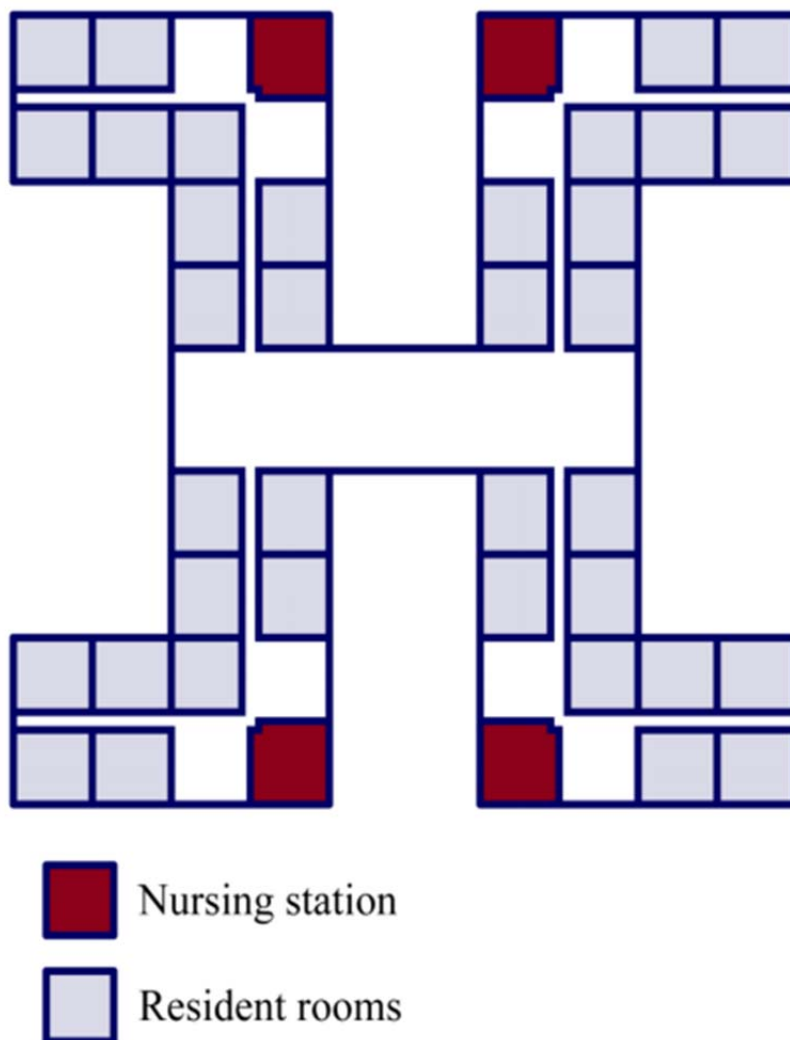
Figure 1.7



## Neighborhood Model

Neighborhood plans began in the 1990s and continue in use today. This model is characterized by "neighborhoods," or bedroom groups, to allow for resident interaction and increased staff visibility. As noted in Figure 1.8, the dining and living areas are communal in nature with bedrooms grouped around an open residential kitchen that also doubles as the nursing station. Nursing home staff often spend more time with residents outside of the provision of direct medical service, and can eat with residents at meal times.

Figure 1.8

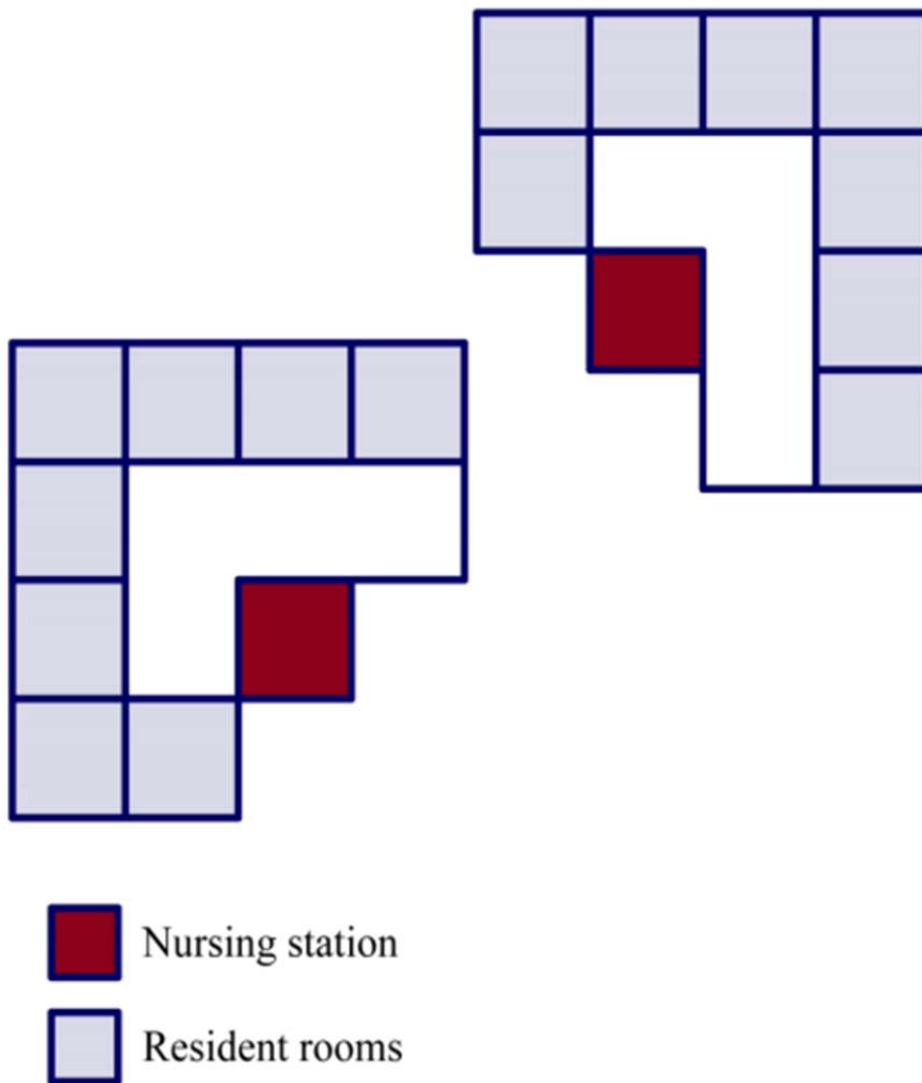




### Small Home Model

In the 2000s, the neighborhood model for nursing home evolved to a more "small house" plan. As noted in Figure 1.9, this model emphasizes small 10 to 12 single occupancy bedrooms all facing inwards to a common social area. This type of plan encourages resident interaction for dining and socialization. Since the nursing station also doubles as a kitchen, staff are inclined to participate in meals and social activities with the residents.

Figure 1.9



## **Challenges in Long-Term Care**

In Texas, only 22%, or approximately 20,178 individuals, use private pay to fund their nursing home care needs. This leaves the other 78% of individuals in nursing homes relying on Medicare or Medicaid in some capacity. The Medicaid and Medicare rates which the state and the federal governments use to pay nursing homes can be directly tied to quality of life and quality of care within those facilities. Upwards of 70% of nursing home costs are related directly to staffing.<sup>19</sup> Staff in nursing homes play one of the most important roles in ensuring residents' medical and quality of life needs are met.

Nursing facilities have recently faced a cumulative funding squeeze at both the federal (Medicare) and state (Medicaid) levels. In 2009, Texas nursing homes experienced a phased-in 10-year \$1.6 billion Medicare reduction from Congress, and another \$234 million reduction in 2012. Furthermore, the state implemented a \$58 million reduction in Medicaid nursing home funding in 2011.<sup>20</sup> This double bind has had serious implications for nursing homes throughout the state. Staffing is the largest expense of a nursing facility and is usually one of the first places administrators look to cut back on expenditures when funding is short. The result of not investing in staff is increased turnover and higher staff-to-patient ratios, each of which leads to decreased quality of life outcomes for seniors who depend on a continuity of service from their caregivers. Building maintenance and improvements of existing nursing facilities are also neglected when budgets are tight. Many of the nursing homes in Texas were built fifty years ago or more.

## **Small Home Model of Nursing Home Care**

A recent evolution in long-term care nursing homes is the small home model of care as seen in Figure 1.9. Small homes are characterized by the spirit of culture change and the centering of care around the individual as opposed to the staff. Furthermore, small home models are architecturally different from other traditional institutional nursing facility models. They are typically 10-12 room homes all surrounding a common social space. Each room is usually single occupancy. Small home models tend to have open kitchens that allow residents to participate in cooking and to socialize with staff as meals are being prepared. Staffing patterns are quite different in small home models as they are more versatile, providing direct care, housekeeping, laundry, cooking and enrichment. All-purpose staff enable meaningful relationships that add to resident's development and sense of well-being. Individuals who were declining in their health and daily activities have been known to improve and regain the ability to perform some activities of daily living once residing in a small home model. In most small home models, staff work in self-managed teams in order to reorganize continuously to meet elder's individual preferences and needs. Additional benefits of this staffing structure include better clinical outcomes, faster response to resident conditions, promotion of chronic disease management, and decrease in turnover. This is a dramatic shift in the traditional hierarchy of institutional nursing care settings.

Residents benefit greatly from this new staffing dynamic. Many quality of life and quality of care indicators are higher which, in turn, can save costs associated with hospitalizations and reduced medication usage. Examples of these indicators include reduced pressure sores, increased socialization and reacquiring functionality (bathing or feeding one's self) that had

previously been lost in other institutional settings.<sup>21</sup>

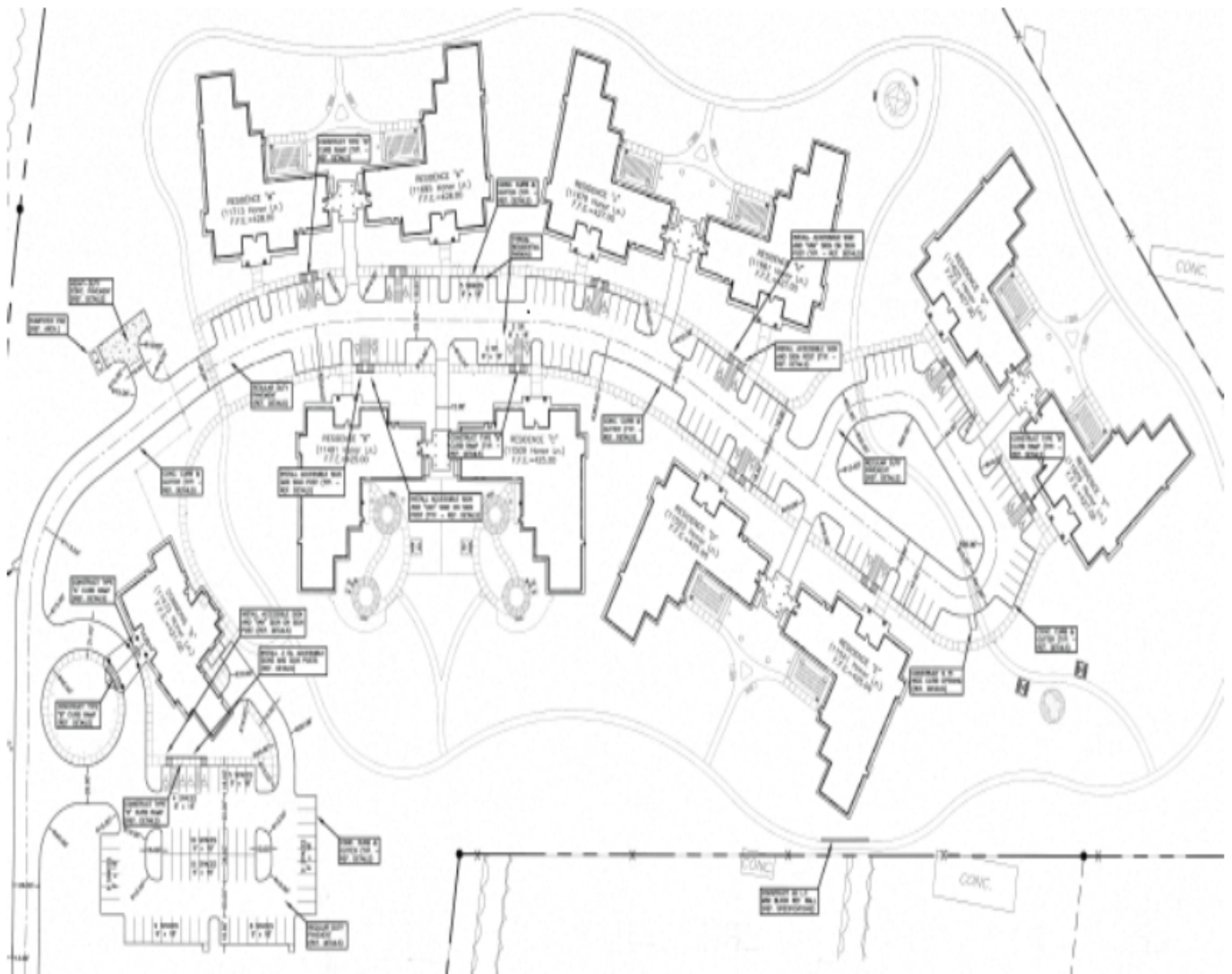
The national leader in small home model development, support and creation is NCB Capital Impact's Green House Model initiative. Green House Models exist in 21 states, with 131 homes operational, and another 150 homes in 11 additional states in the development phase. The Green House Model initiative provides academic research and consulting support to companies starting small home nursing homes. Two such homes exist today in Texas. Both facilities, owned and operated by Buckner Retirement Services, opened in 2008 in Longview and San Angelo. Both homes have experienced a 100% census along with a waiting list, and an increase in quality of life and quality of care metrics indicative of most small home models. However, Buckner has cited the need for an increased Medicaid rate that more closely covers the cost it takes to care for residents. In 2010, the cost per patient day at a Buckner small home was \$150.68 while the Medicaid reimbursement was only \$112.75. This cost differential is subsidized by the company's private pay revenues. Buckner cites a limited growth in the future due to this limited reimbursement rate that leaves donations and private financing as the only means for raising the approximately \$1.8 million needed for capital building costs.

It is important to note, once again, that small home models of nursing home care have proven to be cost-effective as evidenced by reductions in the number of both hospitalizations and acquired pressure sores. These plusses are in addition to and contribute to assuring a greater quality of life for the elders who reside in the homes. It is also important to note that the growth of small homes is limited partially due to current state regulations. For instance, each separate site nursing home is required by the Department of Aging and Disability Services (DADS) regulation to house one administrator and one director of nursing. However, with several small homes located in close proximity in the same city, this regulation has been described as burdensome and unnecessary.

Touchstone Communities in Tyler, Texas, is another example of a fully functioning small home model in the Texas. Similar to the proprietorship of Green House, Touchstone Communities has been providing the quality of life and quality of care to their community of ten small homes, on one site, for veterans since January of 2010 (Figure 1.10).

Figure 1.10

## Texas State Veterans Home Site Plan – Tyler, TX



In the same vein as Buckner Retirement Facilities, Touchstone believes specific reimbursement rates should be tied to outcomes and performance. For example, if a facility can show empirical data that it reduces costs due to hospitalizations, it should be eligible to receive a higher reimbursement rate.

## **Innovative Long-Term Care Financing Strategies**

Below are several strategies for financing of long-term care services to consider that came out of the Committee's interim hearings and ongoing research by Committee staff.

1) The Department of Aging and Disability Services (DADS) could apply for a waiver to the Center for Medicare and Medicaid Services (CMS) to begin a pilot program that supports the small home model of care through enhanced financing strategies. CMS has already indicated a funding priority for state projects that can show reduced hospitalizations. Hospitalizations of nursing home residents that come from a nursing facility are covered by Medicare – a fully federally funded program. In addition, the 100 days of nursing home care after a hospitalization is also paid for by Medicare as rehabilitative care. Any efforts on the state's part to reduce nursing home to hospital admissions is in the best interest of CMS. Not only would it reduce federal Medicare expenses associated with hospitalization, but it would also reduce the risk of poor health outcomes for residents since hospital admissions increase the risk of injury and of hospital acquired infections.

Research on the small home model of care has shown low hospitalization rates due to low resident counts, organizational structure and the holistic approach of staff. Maintaining the low staff to resident ratio along with the high quality of care should be a long-term care option for all seniors regardless of their ability to pay from private funding. Higher Medicaid reimbursement rates would be necessary if the state chooses to embrace the small home model for Medicaid clients. With an enhanced Medicaid reimbursement rate, small home models would be able to reduce the rate of hospitalizations experienced by their patients, and through a CMS waiver the state would be able to share in the associated costs savings. These costs savings would then be solely dedicated to maintaining the aforementioned reimbursement rate.

2) Another strategy that the Health and Human Services Commission is already moving forward with is the Texas Dual Eligibles Integrated Care Demonstration Project. This project is a three-party agreement among the Texas Health and Human Services Commission (HHSC), the Center for Medicare and Medicaid Services (CMS) and the STAR+PLUS Managed Care Organizations (MCO). The application, currently in review by CMS, will provide a single point of accountability for the delivery, coordination and management of primary, preventive, acute, specialty, behavioral health, and long-term services and supports (LTSS), as well as prescription medications. Quality, efficiency and cost savings are the goals of the project. Final implementation should be achieved by January 2014.

As of June 2012, HHSC has not identified the amount of savings to be incurred from the project. Once this information is gathered, stakeholders will be able to evaluate the amount of funds available for potential projects. A potential use of the savings, as outlined in HHSC's application, would be to reinvest monies in improvements and reforms to the overall LTSS system that rewards better performance and culture change.<sup>22</sup> These funds could be used to enhance nursing home Medicaid reimbursement rates to pay for performance and culture change. Currently, the savings trend that needs to be achieved through acute care savings to qualify for the enhanced rate has not been fully defined.

3) Serving individuals in the least restrictive environment promotes the dignity of the individual, increases quality of life outcomes and is often times cost efficient. In support of these goals, HHSC and DADS submitted an application in June 2012 to the Center for Medicare and Medicaid Services (CMS) to participate in the Balancing Incentive Program (BIP). Texas' application was approved on September 4, 2012, and DADS, as the lead agency for the BIP, has been holding stakeholder meetings to gain input on how to design and meet requirements of the program. The BIP is a program to help states transform, or rebalance, their long-term care systems by lowering costs through improved systems performance and efficiency, creating tools to help consumers with care planning and assessment, and improving quality measurement and oversight. The program will also help states increase access to non-institutional long-term services and supports (LTSS).<sup>23</sup> Texas has already been a leader among states in diversion from nursing homes and other institutional facilities to community-based settings with its Money Follows the Person initiative. Transforming, or rebalancing, the state's long-term care system as required by CMS, along with the ability to achieve cost savings, is made possible by a 2% enhanced Federal Match Assistance Percentage (FMAP) with the expectation that the state will increase total LTSS expenditures on community-based Medicaid services to at least 50% by 2015.

In order to achieve the above-mentioned outcomes, DADS has committed to three distinct activities of structural change, which are requirements of the BIP: 1) improving access through a "no wrong door/single entry point" system, 2) conflict-free case management, and 3) the creation of a core standardized assessment instrument.

The "no wrong door" ("single point of entry") strategy will require the state to "improve its assessment and eligibility determination processes by coordinating financial and functional eligibility systems. This will enable real time information sharing, simplify the eligibility determination process, and ensure service planning activities are coordinated. In addition, DADS will expand the number and functionality of Aging and Disability Resource Centers (ADRCs) to achieve statewide coverage."<sup>24</sup>

To achieve conflict-free case management, the state "will ensure all case management activities are conflict-free by requiring separation between entities that conduct eligibility determinations and case management and entities that provide direct services. This may be achieved by firewalls separating a provider's direct care functions from the provider's case management functions, state agency monitoring, and due process activities."<sup>25</sup> Conflict-free case management controls are necessary to eliminate conflicts of interest. Although conflicts of interest may be unconscious, a system that allows providers of services to determine eligibility, and also determine the hours and array of services needed, is a system at risk of having incentives or disincentives built into the system that may or may not promote the interests of the individual receiving the services.

Finally, DADS and HHSC will develop a screening tool that consumers can use through the HHSC Self-Service Portals, available through the website [www.YourTexasBenefits.com](http://www.YourTexasBenefits.com). Once developed, consumers will be able to go online, or contact one of the ADRCs across the state, and use the screening tool to see which services they may be eligible to receive. Of course, final eligibility determinations will be made by the state, but this will help to increase consumer

awareness and knowledge of available services. Current assessment instruments will also be modified to ensure inclusion of all required domains, and DADS and HHSC will explore the feasibility of developing a new comprehensive assessment instrument for all programs serving individuals with intellectual and developmental disabilities, in addition to those serving the aging population.<sup>26</sup> Effective implementation of these activities will go a long way towards ensuring that appropriate services are reaching aging seniors in Texas.

## TRANSPORTATION AND WORKFORCE ISSUES – April 26, 2012

April 26, 2012, Room 2E.20 (Betty King Committee Room)

The Legislative Committee on Aging met on April 26, 2012 to explore innovative strategies to address transportation needs of seniors, and to strengthen the workforce that serves the aging population.

The Committee heard invited testimony from:

- Katherine Freund, Founder and President, ITN America
- Jim Hine, CEO and President, Public Policy Solutions
- Jon Weizenbaum, Deputy Commissioner, Department of Aging and Disability Services
- Anita Bradberry, Executive Director, Texas Association for Home Care and Hospice
- Dr. Cheryl Grenweldge, Professor and Co-Director, PATHS: Texas A&M University
- Eric Roberts, Coordinator, PATHS: Texas A&M University
- Dr. Carmel Dyer, Professor and Director, Division of Geriatric and Palliative Medicine at The University of Texas Medical School at Houston

The Committee received public testimony from:

- Amanda Fredrikson, Manager of Advocacy, AARP
- Nancy Crowther, Personal Attendant Coalition of Texas (submitted written testimony)
- Texas Medical Association (submitted written testimony)

*Audio/Video recordings, minutes, witness lists and presentations for the above-referenced hearings may be found online at:*

<http://www.senate.state.tx.us/75r/senate/commit/c802/c802.htm>



## Elements Driving the Need for Senior Transportation

According to the U.S. Census Bureau, in 2010 there were 3.7 million Texans who were over the age of 60, with nearly 2 million of those over the age of 70. Given those numbers, almost 15 percent of the 25 million Texans were over 60 years of age, and more than 7 percent were 70 years of age or older in 2010. The U.S. Census Bureau estimates that the proportion of Texans at least 60 years old will increase to 20 percent by the year 2030, and by the year 2040, there will be almost 10 million Texans over the age of 60, tripling the 2010 number.<sup>27</sup> The majority (80%) of older Texans live in urban areas, and nearly 20 percent live in rural areas. As the aging population grows, so will the need for health care, long-term care, and other services as well as an increasing need for volunteer and community engagement activities. Figure 1 shows the population growth of Texas residents age 60 and older from 2000 to 2010, and projected growth into 2040. Figure 2 shows the percentage of Texas population ages 50 and older from 2000 to 2040.

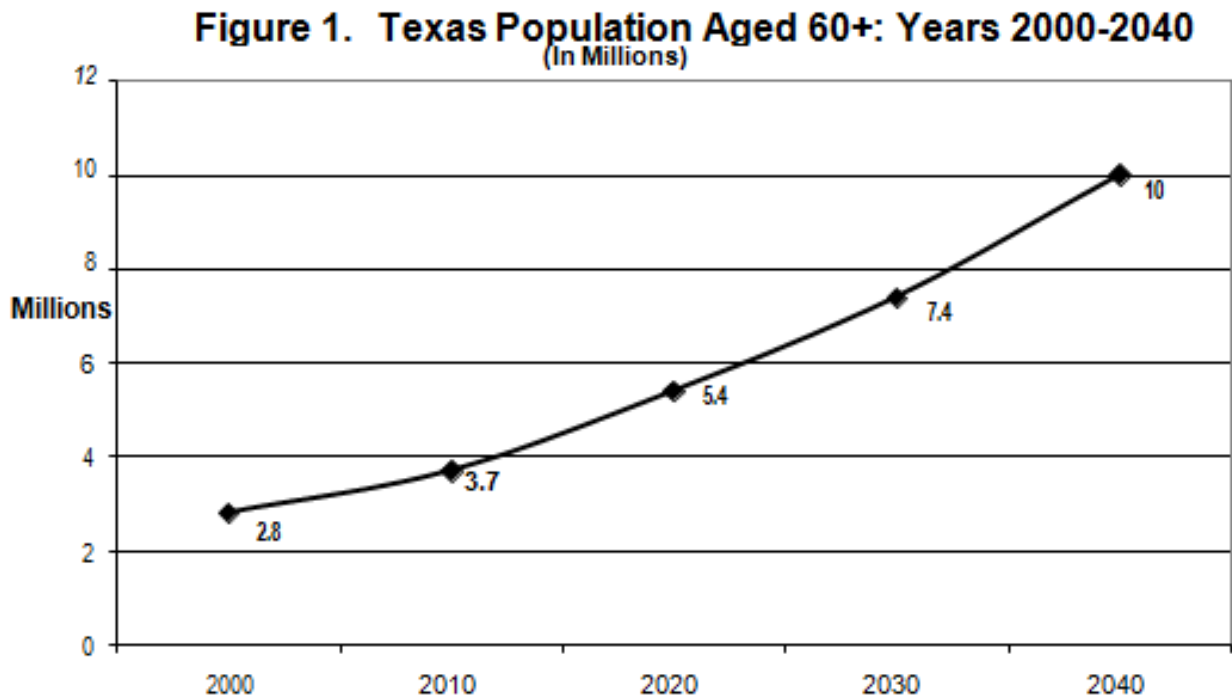
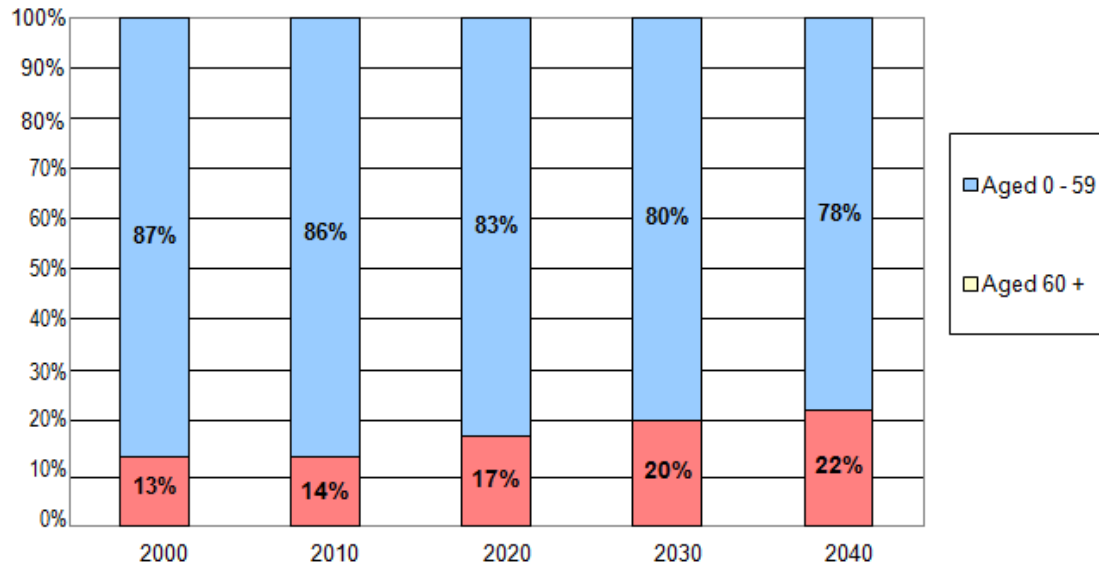


Figure 2.

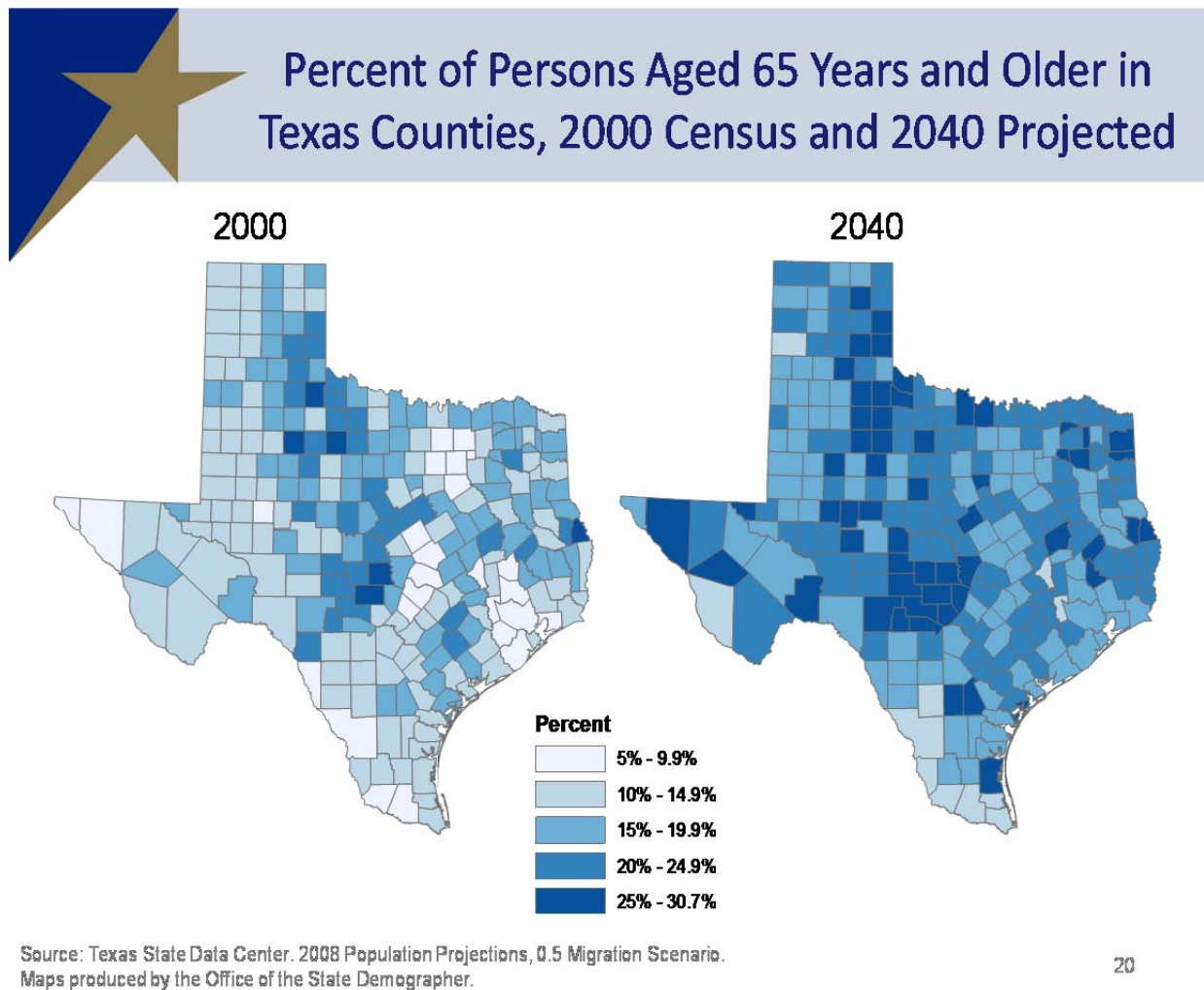
**Figure 2. Texans Aged 60+ As A Percent of the Total Population: Years 2000-2040**



Source: Texas State Data Center at the University of Texas at San Antonio. Projections Based on 2000-2007 Migration Scenario.

There are 254 counties in Texas with 177 of those in rural areas of the state. Texas is one of a handful of states with "frontier" counties that average fewer than seven people per square mile. There are 64 frontier counties in Texas. While the state has the largest rural population in the nation, urban areas of the state are experiencing a higher rate of population growth than in rural areas, and the population in rural and small town areas is getting older. The proportion of residents 65 years or older is growing at a faster rate than the total population of rural areas. Figure 3 shows the distribution of people 65 years of age and older by counties.

Figure 3<sup>28</sup>



A number of factors contribute to the quality of life of the aging population. Mobility, a person's ability to travel, to have the freedom, independence and convenience to be able to move from one location to another, is one of those factors.<sup>29</sup> Since the aging population tends to be healthier

and living longer today than in the past, seniors are more likely to be engaged in community activities throughout their lives. In order to sustain an active life and remain independent, it is likely that seniors will need mobility assistance at some point.<sup>30</sup> Transportation and the freedom to move from one place to another is critical to maintaining connections to the community.

Nationally, by 2030, one in every 5 Americans will be over the age of 65, and one in four drivers will be 65 or older by 2025.<sup>31</sup> As individuals age, their ability to drive may become hampered by their physical health, medical conditions, or other age-related conditions. According to AARP, older adults currently make about 90 percent of their trips by automobile. The Insurance Institute for Highway Safety reports that fragility is the largest contributor to older persons' increased risk of dying from an automobile wreck when compared to someone younger than 60 years of age.<sup>32</sup> There are those in the aging population who don't drive, and others who eventually will have to stop driving, due to safety concerns.

There are few alternatives for those seniors who do not drive. Many will have to rely on family or friends for rides to medical appointments, shopping, hair salon and social outings, but not everyone will be able to depend on those around them for mobility assistance. The Aging Texas Well Indicators Survey Overview Report of 2009 (TWISOR, 2009) indicated that a "lack of transportation can have an impact on overall quality of life. According to the Surface Transportation Policy Project, as cited in the TWISOR, nationwide, older non-drivers make 15 percent fewer doctor visits, 59 percent fewer trips for shopping and dining, and 65 percent fewer trips for social family and religious activities."<sup>33</sup>

Again, alternative transportation options for the aging population are limited. The public transit system is one option, but its accessibility depends on a variety of factors. For example, one must consider how close the bus lines are to where the individual lives, and if the individual has health issues that prevent walking or standing for periods of time. The days and hours of operation of the public transit system is also a factor in determining accessibility, as well as whether there is door-to-door service, a fixed route or flexible route service, and reasonable fares for senior citizens.

Currently in Texas, Medicaid recipients are eligible to use the Medical Transportation Program (MTP) for rides to and from medical appointments and pharmacies. The MTP, administered by the Texas Health and Human Services Commission (HHSC), will reimburse family members or friends, with prior approval as a provider, for transporting a Medicaid recipient. In the past, drivers would be able to receive payment in advance of the trip, but recent changes in the program require reimbursement after proof of the transport is received at HHSC. Many times, seniors or their family members may not have enough money to cover gas expenses for the trip; the state's policy of payment prior to the trip was helpful to those households. Per the new policies, HHSC now informs individuals requesting a ride of other means of transportation, and refers them to use those services if available. This could involve riding a bus, local community transit door-to-door service, or cab services. If public transit is available but not accessible to the individual, verification from his or her doctor is required before HHSC submits the trip to one of its MTP contractors. Once approved for transport through the MTP, HHSC electronically submits the trip request to its MTP contractor in the area to schedule transport.

In 2009, the Texas Legislature directed HHSC, through a rider in the General Appropriations Act, to develop and implement a pilot program using a full-risk broker model of transportation for the Medicaid population. A full-risk broker model is one that pays the broker (the company the state contracts with) a set rate of reimbursement mutually agreed to in advance through a contract. Under this model, the broker is the point of contact for clients, and the broker approves and schedules trips rather than state employees. The company is paid a per member/per month rate, and the broker/company accepts the risk. If members require more trips than the broker anticipated or estimated, the broker is responsible for the transports even if it means a loss of profits. In addition, the contract requires the full-risk broker to pay back monies to the state if profits exceed a certain percentage. This provision is built into the contract to prevent the brokers from denying trips in order to increase profits, since full-risk brokers are paid a set per member/per month rate regardless of how many trips are made. This pilot program is operating in the Dallas-Ft. Worth and Houston areas. There have been mixed reviews of the pilot from consumers, advocates and health care professionals.

The MTP model currently operating in areas not participating in the pilot does not require the transport company to accept the risk. Under this model, brokers schedule appointments and directly provide transportation if they own vehicles and driving is part of the service they provide. Some brokers under this model schedule trips but do not own vehicles. In those situations, the broker subcontracts with transportation providers. Under the existing model, brokers are reimbursed for each trip per a negotiated rate under its contract with the state, and approval and denial of trips is performed by state employees and not by the contractors.

The federal government provides a 50% match of the state's costs to administer the contracts with transportation brokers who own vehicles and directly transport clients. There is a higher rate of 60% federal and 40% state for administrative costs for contracts with brokers who do not own vehicles and do not directly transport clients.

With the various models of transportation currently available to Medicaid clients, and with the recent statewide rollout of Texas' Medicaid managed care program that serves many of the aging population, HHSC is evaluating how best to meet transportation needs of this vulnerable population. HHSC is holding public meetings to receive input from stakeholders, consumers and providers. The state is faced with decisions of whether to continue the various models or to choose one model. If a decision is made to use only one model statewide, a decision about which model is best will need to be made. This is a policy decision that will likely be discussed in the upcoming legislative session.

As noted previously in this report, the aging population in rural areas of the state is growing at a faster rate than the overall population in those same areas. According to the U.S. Census Bureau, the percentage of aging Texans living rurally has increased by 14% in the past decade and will significantly increase by 2040. In testimony to the Legislative Committee on Aging in 2010, Texas' State Demographer reported that approximately 273,000 persons age 65 and older living in urbanized areas experience transit gaps in 2010, suggesting that seniors living in non-rural areas experience shortages in transportation resources as well.<sup>34</sup> Older Texans living in rural areas may experience isolation from the greater community as they age. Their network of friends and support may also be aging and their level of social activities is often limited. The issues that come with living in rural communities, such as limited access to health services,

shopping and social activities, can be exacerbated when the aging lose the ability to drive. This can lead to greater feelings of isolation, increasing the risk of depression and, in turn, increased medical costs.

Even with the MTP for Medicaid recipients, there is no government funded and operated program to transport the aging to grocery stores, social outings, or other types of trips. Also, seniors who are not receiving benefits through Medicaid are not eligible for transportation services through the MTP at all, and are left to local community resources, if they are available.

The Texas Department of Transportation (TxDOT) receives federal funding that is distributed to local entities, rural and urban, for public transit systems improvements of accessibility and mobility targeted specifically to the aging population and individuals with disabilities. One such program administered through TxDOT is the Federal Transportation Administration's (FTA) Elderly Individuals and Individuals with Disabilities Program (also known as the 5310 program). Established transit districts can apply for these funds. Even with this funding available, aging Texans must rely on other resources to stay mobile within their communities. According to the Aging Texas Well Indicators Survey Report of 2009, 18% of non-driving respondents who rely on alternative methods of transportation (such as public transit or rides from family members) stated they were not able to secure transportation in a timely manner.<sup>35</sup> Due to budgeting constraints, non-profits and volunteer based services will become more and more important to the mobility of seniors. There are also Regional Coordinated Transportation Planning Organizations for every region of the state that develop regional transportation plans that are required to include consideration of transportation services and accessibility for certain vulnerable populations, such as the aging. Regional Transportation Authorities may submit applications to the FTA for available funding of approved projects.

The Legislative Committee on Aging attempted to identify and assess available transportation services to meet the needs of the aging population and found that the current system is composed of a patchwork of services and that there is no consistent statewide system and infrastructure in place to ensure the elderly have access to transportation services in their communities as they age.

In its interim hearings leading up to the 2011 legislative session, and in its interim report to the 82nd Legislature, the Committee on Aging explored TxDOT's programs and funding to increase access to transportation for seniors. During those hearings, the Committee also heard testimony from AARP about an approach to community planning, called Complete Streets. The principle of Complete Streets is to promote the construction and improvement of streets and surrounding built environments to enable safe access for all users, including pedestrians, bicyclists, motorists and transit riders of all ages. Complete Streets promote independence and help decrease isolation and potential health decline by supporting additional transit options to help seniors meet their basic transportation needs. Several Texas cities are embracing the Complete Streets concept, including Dallas and San Antonio. During the last legislative session (82nd, 2011), legislation was introduced that would have required TxDOT to establish and adopt a Complete Streets policy, and to ensure that transportation planning, design and construction, as well as reconstruction and improvements to streets, highways and other projects under the Department's jurisdiction, comply with the policy. The legislation did not pass.

## **Other Points of Access for Information on Senior Transportation**

There are 28 Area Agencies on Aging (AAAs) in Texas that provide information, referral and assistance specific to an individual's geographic location. Individuals can find contact information about their closest AAA at <http://www.dads.state.tx.us/contact/aaa.cfm>, which is accessed through the DADS website and is another resource to learn about available transportation services in their area. The AAAs are quasi-governmental entities, and through contracts with DADS, provide information and services to individuals age 60 and older, and to some individuals under 60 who are enrolled in Medicare. These services include information, referral and assistance; benefits counseling and legal assistance; care coordination; caregiver support services; in home support services and nutrition services. AAA services are targeted to individuals with the greatest economic and social needs, including low-income minorities, older adults living in rural areas, individuals with Alzheimer's disease and related disorders, and older adults at risk of entering a nursing home.

Another information and referral resource regarding transportation as well as other services is the 2-1-1 Texas Information and Referral Network (TIRN). The TIRN is a network of 25 regional Area Information Centers that work to provide information about health and human services resources in close proximity of a caller's location. This resource is available to anyone who calls, and is another place seniors can go to learn about transportation resources in their area. HHSC contracts with local entities to provide the Information and Referral services in the 25 regional areas. The 2-1-1 system can also be accessed online at [www.211texas.org](http://www.211texas.org).

Texas also has 14 Aging and Disability Resource Centers (ADRC) that can link transportation resources with seniors needing rides. Information and referral services provided by the ADRCs are not limited to transportation. They are intended to provide a "single point of entry" or a "no-wrong door" system of information and referral to simplify the process of individuals accessing Long-Term Services and Supports (LTSS). ADRCs allow individuals or their family members to contact one physical location to receive the information and referrals rather than the more traditional way of contacting several different agencies, at different locations or phone numbers, to receive information about all available services and programs.

## **Innovative Transportation Mechanisms**

On April 26, 2012, the Legislative Committee on Aging heard invited testimony from Katherine Freund, President and Executive Director of the Independent Transportation Network, as well as from Jim Hine, CEO and President of Public Policy Solutions. Both individuals presented the Committee with mechanisms to consider as ways for improving and enhancing access to transportation for the aging population in Texas.

### *ITN, Dignified Transportation For Seniors*

The Independent Transportation Network (ITN) is the first and only national non-profit transportation network for the aging population in America. It is based on a principle that all seniors should have access to transportation when they want it.

The ITN was established in 1990 in Portland, Maine. The premise was that a lack of transportation resources for the aging population was a social problem that could be solved by making use of public and private partnerships. ITN is a social enterprise model, and is proving to be a sustainable model of transportation for the aging population. This model utilizes technology and volunteers to provide a unique service dedicated to the needs of aging consumers. Its purpose is not to replace subsidized transportation, but to complement public transport by alleviating some of the demand. ITNAmerica is "a non-profit, market approach to a pressing social need."<sup>36</sup>

From 1990 to 2002, ITN received grant funding for research and development projects from the Federal Transportation Administration, the Transportation Research Board and AARP. From 2003 to 2005, ITN developed and presented a business plan and in 2005 began its national plan implementation rollout. Currently, there are 23 ITN affiliates in 20 states that have transportation programs serving seniors. Meanwhile, ITN continues to conduct research on ways to further develop its model both nationally and internationally. As part of its research and development activities, ITN has conducted a 50-state analysis of state laws to identify barriers to developing financially sustainable, grassroots supported models of transportation for seniors.

ITN is an affiliated national system under which local municipalities, counties or states can become ITN affiliates. There are currently affiliates in Maine, Iowa, Illinois, California, Nevada, Kentucky, Connecticut, Missouri, Ohio, Wisconsin, Massachusetts, Kansas, Florida and South Carolina, in addition to others being developed in Rhode Island, Colorado, Michigan and New Jersey. Affiliates are linked to a national community through technology, branding, technical assistance, and newsletters as well as annual meetings of all affiliates. ITN provides affiliates use of its software program that provides a portal, website and email management system. Affiliates also get to use the brand of ITN to help with marketing, communications and public relations. ITN provides support and technical assistance with finance and human resources, fundraising, quality control, research and public policy. ITN offers its annual meeting of affiliates along with peer group calls and national campaign support.

Under the ITN business model, sustainability of an affiliate program should be attainable in five years. Initially, seed or start-up funding is necessary. These funds could come from a variety of sources such as grants, major private gifts and up to 50% of public funds. In her testimony to the Committee, Ms. Freund indicated that "less is more" when it comes to using public monies. The ITN model is not intended to be funded through the use of public funds. Rather, the program is based on a diversified base of voluntary community support.

Under the model, seniors who want to participate in the transportation program sign up as members and pay membership dues. The driving is provided by volunteers who are certified and use their own vehicles or may use donated automobiles. Affiliates appeal to corporate sponsors, raise money through annual events such as "walk for rides" to raise awareness of the program and engage the business and general community. Research has indicated that individuals will contribute to community-wide efforts that they believe will help to address identified social problems affecting their community. The ITN affiliate model is based on that premise.

ITN affiliates use a core business model that includes setting up Personal Transportation Accounts (PTA) for its members. The use of PTAs allows members to "trade" their automobile



in return for credit in their own PTA. For example, seniors who own a vehicle, but are no longer able to drive, may donate their car to the program to be used by volunteer drivers for transporting members. In exchange, the person donating the vehicle gets a certain amount of credits, or hours, to go toward trips they need or might want to take. Rides are provided 24 hours a day, 7 days a week under this model, allowing seniors access to transportation when they want it. This model preserves the dignity and independence of individuals as they age. The program is sustained through fares from those who use the service, and from voluntary local community support without the use of taxpayer dollars.

In a survey of all ITN affiliates providing rides between July 2010 and June 2011, the average age of riders was 79.76 years of age, average length of rides was 4.97 miles, average duration of rides was 19 minutes, average fare for the rider was \$10.89, and rides were scheduled on the same day 5.16% of the time. The purposes of rides were for medical needs, consumer activities such as shopping, religious outings, social outings, recreation and volunteering, and employment and education. Five years of ITN affiliate data was collected and analyzed to determine how ITN customers used the transportation services. (See Figure 4)<sup>37</sup>

In 2010, a Customer Satisfaction Survey was mailed to all ITN customers nationally with the following results:

98% would recommend ITN to a friend,

96% reported their overall experience was excellent or very good,

98% were very satisfied with the staff,

98% were very satisfied with the quality of the service, and

48% have an annual income of less than \$25,000, and 2% found the service to be too expensive<sup>38</sup>

Figure 4



## How Do ITN Customers use the Service?

(5 years of data, 1/04-12/08) (n=1,557 customers; 58,736 rides)

- 83% use ITN for medical needs
- 46% consumer needs (banking, general, grocery, hair, mall, pharmacy)
- 24% social needs (community affairs, funeral, nursing home/hospital visit, family/friends visit)
- 21% general purposes (hourly, personal, unknown)
- 19% recreation (dining, exercise, gaming, museum, show)
- 16% worship
- 8% inter-modal connections (airport, bus, train, ferry)
- 7% education (library, class, cultural)
- 6% employment (paid, volunteer)
- 6% professional services (finance, legal, veterinarian)

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In her testimony to the Committee, Ms. Freund indicated that state laws or local ordinances may inhibit or discourage volunteering to provide rides or driving. She pointed out several policy changes that other states have made to remove barriers to volunteering, and to encourage and increase the use of volunteers to provide transportation services to the aging population. It was her recommendation that the Committee consider similar changes in Texas.

California and Maine have laws in place that protect volunteer drivers against certain liabilities under their automobile insurance policies by providing immunity to penalties from insurance companies. Currently in Texas, insurance companies are not prohibited from charging increased rates on personal auto insurance policies solely because the driver uses the vehicle to provide rides. When individuals do volunteer, they face the risk of paying higher insurance premiums or

cancellation of insurance policies due to their participation as volunteer drivers. Texas currently has a Good Samaritan law that protects volunteers from civil liabilities, but such protections are not in place for volunteers who operate motor vehicles as part of their volunteer work. This may act as a barrier to sustaining a pool of volunteers willing to provide transportation to the aging population.

The State of Delaware has a law that provides exemptions to automobile vehicle registration fees of vehicles owned by certain non-profit organizations if the vehicles are used in charitable or public welfare work. This is a good approach if non-profit organizations own vehicles that can be used by volunteer drivers, but many organizations do not own vehicles for volunteers to drive. To further encourage volunteers to become drivers, exempting vehicle registration fees of volunteers' automobiles might be worthy of consideration. The pool of volunteers providing transportation to seniors may continue doing so for longer periods with this or other incentives in place.

According to Ms. Freund, several states have found that livery laws are barriers to individuals volunteering to drive. Colorado and California have passed legislation to eliminate such barriers. California's law, California Insurance Code § 11580.25, requires that no insured motor vehicle shall be classified as a common carrier, livery, or for-hire vehicle solely for the reason that the named insured is performing volunteer services for a nonprofit charitable organization consisting of providing transportation services to individuals who are senior citizens or individuals who have special transportation needs because of physical or mental conditions and supported in whole or in part by funding from private or public agencies.

Colorado's approach was to make a strong policy statement recognizing the importance of promoting improved transportation for the elderly, persons with disabilities, and for residents of rural areas and small towns. The policy is to support improved transportation for those populations through an expanded and coordinated transportation network, and to legally define and recognize "people service transportation" and "volunteer transportation" as separate but contributing components of the transportation system. In keeping with Colorado's state policy to remove barriers to low-cost "people service transportation" and "volunteer transportation," transportation systems that meet the criteria of people service or volunteer transportation are not classified as public utilities or as any form of carrier subject to regulation by the transportation commission, and are instead regulated by the appropriate entities that regulate and administer people service and volunteer transportation.

#### *Volunteer Advocate Program for the Elderly*

Mr. Jim Hine, President of Public Policy Solutions, provided information to the Committee about another model to consider in addressing transportation needs of the aging population. He presented testimony concerning the concept and framework of a program that was established in Texas, but has not yet been fully implemented due to a lack of funding. In 2009, the 81st Texas Legislature, through passage of House Bill 4154, required HHSC and DADS to work together to establish a volunteer advocate program for the elderly. Although funding was not appropriated to fully implement the program, the Volunteer Advocate Program Advisory Committee (Advisory Committee) was established, and DADS worked with HHSC to convene meetings and follow through with requirements of the legislation.

The initial meeting of the Advisory Committee was May 18, 2010, and subsequent meetings were held on a monthly basis through November 2010. The work of the Advisory Committee focused on formulating a design for the program, training curriculum for volunteers, and developing a draft request for proposals to be used if funding to fully implement the program becomes available.

The Volunteer Advocate Program for the Elderly was modeled after the Court Appointed Special Advocates (CASA) program. CASA trains and provides children in the Child Protective Services system who have been removed from their homes due to abuse or neglect with court-appointed volunteers who provide support and advocate on behalf of the child. Under the CASA program, volunteers are required to go through extensive training and must make a commitment to the children assigned to them. The Volunteer Advocate Program for the Elderly would provide volunteer advocates, but volunteers would not be appointed by the courts.

According to a December 1, 2010 report on the Volunteer Advocate Program for the Elderly, "the program would not duplicate services, but fill in the gaps and add value to services currently received."<sup>39</sup> The program would serve older individuals and their caregivers regardless of their income. The role of the advocates would be to inform individuals of available resources and programs in addition to providing numerous direct services. Such services could include home visitation, transportation to medical appointments, arranging medical care, and providing education to family caregivers on medication management activities. "One key guiding principle would be to facilitate informed choice and the personal preferences of the individual in a way that provides the best care for that individual and enhances their safety, dignity and respect."<sup>40</sup>

In his testimony, Mr. Hine acknowledged that a lack of funding has been a barrier to the program's full implementation. He suggested the Legislative Committee on Aging consider using the Volunteer Advocate Program for the Elderly as a framework to implement and fund a pilot program, in an effort to enhance transportation and mobility needs of seniors who live in the areas participating in the pilot. Even though the Volunteer Advocate Program for the Elderly is intended to provide more than transportation services, the concept and framework is a model that can be used by any willing nonprofit or governmental entity to form a public/private partnership to increase access to transportation.

## **Caregiving and the Direct Care Workforce**

### *Elements Driving the Demand of a Caregiving Network*

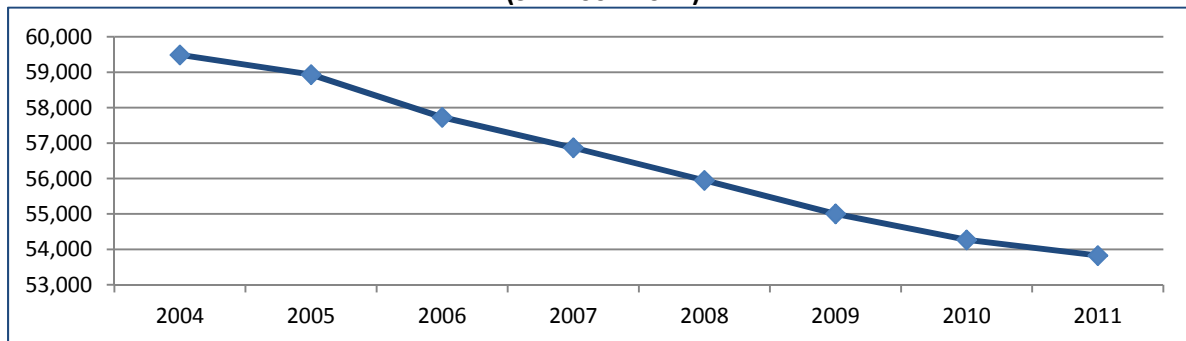
As reported earlier in this report, the number of Texans over the age of 60 is on the rise. In 2010, there were 3.7 million Texans over the age of 60, with nearly 2 million of those 70 years of age or older. The U.S. Census Bureau estimates that the proportion of Texans at least 60 years old will increase to 20 percent by the year 2030, and by the year 2040, there will be almost 10 million Texans over the age of 60, tripling the 2010 number. It is estimated there will be 530,000 Texas residents 85 and older in 2030, with that number almost doubling by 2040 to 944,000.<sup>41</sup> The Legislative Committee on Aging was created in response to concerns that there needed to be a legislative committee focused solely on the demands of a state experiencing significant growth of its aging population.

Over the last decade, Texas has seen a trend of more individuals staying in their homes in the community as they age rather than entering nursing homes or other institutional settings to receive necessary services. Nursing home admissions in Texas have been on the decline even though the senior population has been growing (See Figure 5 below).<sup>42</sup>

Figure 5.<sup>43</sup>

### Medicaid-funded Texas Nursing Home Residents are on the Decline

(SFY 2004-2011)



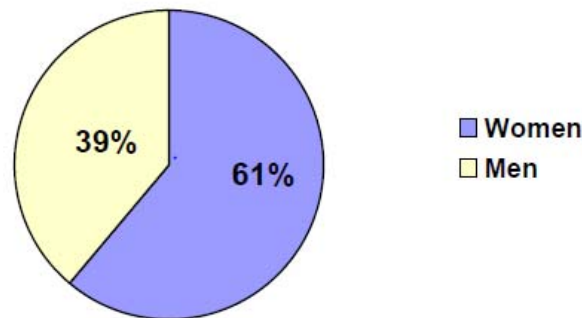
Source – *Fiscal Size-Up 2010-11*, Legislative Budget Board, December 2009.

The trend of declining nursing home admissions can be attributed to several factors, one of which is individual preference to continue living in one's home or in a home-like setting in the community while receiving services. Another factor is that Texas has several programs that allow seniors the option of receiving necessary services in the setting of their choice rather than having to move into a nursing facility to receive services. The Primary Home Care (PHC) program, the Community Attendant Services (CAS) program, and the Community-based Alternative (CBA) Waiver program are three such cost-effective programs that serve seniors in Texas. If seniors can access care in the community, it saves the state money since the cost of community care is significantly less than the cost of care in nursing homes. In fact, the average monthly cost to serve someone in a nursing facility in Texas is \$2,982 (Fiscal Year 2012). The average monthly cost of the CBA program is \$1,320 while the average monthly cost of the PHC or the CAS programs is \$833.<sup>44</sup>

An important component of Texans being able to stay in the community longer as they age is having an adequate and accessible workforce to assist seniors, and provide the services that are necessary as they age in place. The rapidly aging population and the growing popular preference to age in the home have already begun to strain available resources for caregiving services. The prevalence of disability in the aging population will also influence the need for more in-home assistance. The U.S. Census Bureau, in its American Community Survey for 2010, indicated that 51% of Texans aged 75-84 had a disability in 2010. For individuals who were 85 and older, that percentage increased to 76%.<sup>45</sup> The availability of individuals providing in-home care will be integral to the aged and disabled population that prefers to age in the community.

Many older Texans have family members who are able to care for them and provide necessary assistance, but everyone is not fortunate enough to have family or friends who can care for them as needed. Even when family and friends are able to assist and provide care, they need relief at times. Another important factor increasing the need for caregivers is the changing workforce with respect to gender. The overwhelming majority of caregivers, formal or informal, are women.<sup>46</sup> (See Figure 2) Over the past few decades, though, more women have joined the workforce, altering the structure of the nuclear family and leaving fewer women at home or with the flexibility to stay home and care for loved ones.

**Figure 2: Gender of Caregivers**



Base: 1,247 caregivers in the U.S.

Source: Caregiving in the U.S., National Alliance for Caregiving and AARP, 2004.

Given the current and expected growth in the aging population, it is incumbent upon the state to take necessary steps to ensure an adequate supply of quality trained direct care workers. Otherwise, as Texans age, they will be denied the choice of receiving assistance and services in their homes, and will instead have to receive services in a more costly setting. Those costs will eventually fall on the state as individuals spend their incomes and assets down quickly while receiving care in nursing homes or hospitals, leaving Medicaid responsible to pay for their care.

### **Defining Caregiving**

Both formal and informal caregivers are the backbone of home and community-based services. Caregiving helps to fill the need for preventative measures in day-to-day living by assisting with activities that would otherwise pose a safety risk for aging individuals. It is difficult to imagine aging in place without supports to help with certain Activities of Daily Living (ADL) in the home. ADLs are tasks normally accomplished in everyday living, such as bathing, grooming, light housekeeping, toileting, feeding, grocery shopping and laundry. Caregivers interact with the individuals they provide care to on a personal level and therefore have unique insight and understanding of the lives and needs of those they care for. The regular contact and interaction with caregivers also serves to meet some of the social needs of the aging.

#### *Informal Caregivers*

It is important to make the distinction between formal and informal caregivers, although both will be necessary to meet the needs of Texas' aging population. Informal caregivers are usually unpaid social supports, such as family members, friends or neighbors. In a 2010 study conducted

by the Centers for Disease Control and Prevention, a survey of Texas adults indicated about three million Texas adults provided care or assistance on a regular basis to a friend or family member who was older or had a long-term illness or disability in the month preceding the survey. The survey also showed that most of those individuals receiving care by a family member or friend were related to the caregiver.<sup>47</sup> Individuals who provide care for relatives or friends provide an important service not only for those they assist, but also for the community and the state as a whole. It is estimated that informal caregivers in Texas save the state \$3.2 billion to \$12.6 billion a year by providing care that would otherwise need to be provided in institutions or by health care professionals and paid for by Medicaid.<sup>48</sup> The contribution of informal caregivers is not isolated to Texas. According to a 2011 report by the AARP Public Policy Institute, about 42.1 million family caregivers in the United States provided care to an adult who needed assistance with Activities of Daily Living (ADL) at any given point in time in 2009, and 61.6 million provided care some time during 2009.<sup>49</sup> According to the report, the estimated economic value of their unpaid contributions was about \$450 billion in 2009. This figure is based on 42.1 million caregivers age 18 or older providing an average of 18.4 hours of care per week to recipients age 18 or older, at an average value of \$11.16 per hour.<sup>50</sup> If informal caregivers were no longer available, the economic cost to the U.S. health care system and long-term services and supports (LTSS) systems would increase astronomically.

Providing informal care does not come without costs to caregivers and their families. The typical caregiver is a 46-year old woman who works outside of the home and provides 20 hours a week of unpaid caregiving in addition to her regular job. In Texas, there are 3.4 million unpaid caregivers at any time.<sup>51</sup> Providing informal care to someone, above and beyond the typical duties of one's own day-to-day life, can have an enormous impact on the health of caregivers. The demands of being a caregiver can vary from simply providing rides to appointments or shopping, to the more strenuous and demanding tasks of feeding, changing diapers, toileting assistance and other tasks that require constant attention and assistance. Informal caregivers do not get paid for providing care to their family members. This can create financial hardship as well as cause emotional stress and be physically taxing.

In its "Stress in America" 2011 survey, the American Psychological Association found that family caregivers are more likely to feel overwhelmed, do a poor or fair job of managing their own health, experience increased stress levels, feel stressed about their own personal health concerns, and get sick at least five times a year.<sup>52</sup>

Recognizing the importance of informal caregiving to the state's ability to meet the needs of an increasingly older population, policymakers must consider ways of not only maintaining the existing network of informal caregiving, but of ensuring necessary supports are in place to assure that family and friends will continue to step up as informal caregivers. As stated earlier, not only does informal caregiving provide an important role to those individuals receiving the care, but it saves federal and state dollars by providing care without financial compensation. If informal caregivers were not available, the national and state health-care systems resources would be further strained and, probably overwhelmed.

The Committee heard testimony about a program in Texas that is designed to provide respite for informal caregivers, and this was presented as one option for providing supports to unpaid caregivers. Respite allows someone to come into the home and temporarily relieve primary

caregivers of their duties. The Texas Lifespan Respite Care Program was established by the 81st Texas Legislature through passage of House Bill 802. The legislation funded a direct service component to expand the availability of respite services for caregivers of individuals of any age with any chronic health condition or disability, not specific to the aging population. Respite services under this program are only available to caregivers who are not eligible for respite services through other programs. This was designed as a way of addressing an unmet need of certain informal caregivers. In addition, Texas received a grant from the U.S. Administration on Aging that allowed for the creation of the Texas Respite Coordination Center to compile and update the Texas Inventory of Respite Services, and provide outreach and training tools for caregivers. Currently, DADS contracts with six community partners to implement the direct services component of the Texas Lifespan Respite Care Program. The contractors are responsible for developing volunteer and emergency respite resources to provide needed relief for those caregivers.

In addition to the Respite Program, DADS developed a program to provide tools and resources for all caregivers. The Take Time Texas program, accessed on the internet at [www.taketimetexas.org](http://www.taketimetexas.org), was developed to address the identified need for caregivers to have a place to access education, support and respite resources. The Texas Inventory of Respite Services can be accessed from this website, in addition to other tips and tools for caregivers and educational materials about health and disease-specific topics. There were discussions between the Committee and the then Deputy Commissioner of DADS, Jon Weizenbaum, who presented testimony on the importance of educating the general public about these important resources. Concerns were raised by at least one Committee member that most people are unaware that these resources are available, and the Department was encouraged to enhance its public education and outreach efforts.

It is not uncommon for informal caregivers to neglect their own physical, emotional and mental health while focusing on providing care to family members. The availability of respite services is one way of providing those caregivers with time to be mindful of their own health and self-care needs. Respite care is provided when another individual steps in to temporarily take the primary caregiver's place for a certain length of time, ranging from a few hours to a few days.

#### *Formal Caregivers*

Direct service workers who provide hands-on long-term services and supports are generally referred to as formal caregivers. The formal caregiving workforce is composed of professionals and paraprofessionals who are paid for their work and the services they provide. Some are self-employed, but the majority are hired and compensated by home health agencies or other types of agencies that provide home health and personal attendant services to individuals requiring assistance in order to stay in their homes. These workers play a critical role in the lives of older Americans and Americans who have disabilities, and without their assistance many individuals would be admitted to nursing homes sooner.

Wages paid to the formal caregiving workforce are ranked among the nation's lowest. Workers generally do not receive any health insurance or sick or vacation benefits, experience high injury rates, and are not always assured predictable working hours. In fact, the Committee heard testimony from Anita Bradberry, Executive Director of the Texas Association for Home Care & Hospice, that the majority of attendants work part-time so would not qualify for benefits



available to full-time employees. According to Ms. Bradberry, many workers desire to work part-time as it provides flexible working hours that allow them to work around the demands of their own families. However, in public testimony provided to the Committee, it was noted that formal caregivers many times must work for more than one employer in order to make enough money to cover their daily living expenses. Given the low-wages paid for this type of work, receiving pay from multiple employers does not provide benefits or even the assurance of a certain monthly income.

In an April 2012 survey of State Home Care Associations, Texas was classified as having the lowest rate of pay among all states for Medicaid Personal Care Services. Kentucky was identified as paying the highest rate for those services at \$30 an hour while Texas pays \$10.81 an hour. This is the amount that is paid to the employer, and is not paid directly to the caregiver providing the services. While \$30 an hour may seem high, consider that the second lowest rate paid for Medicaid Personal Care Services is shared by four other states and was between \$12.91 an hour to \$13.80 an hour. That places Texas' rate of reimbursement for such services at \$2.10 an hour lower than the second lowest response in the survey. The average reimbursement rate among all states is \$14 to \$19 an hour.<sup>53</sup> To make the point that the Texas Legislature should consider revising its Medicaid reimbursement rates for in-home and community-based services provided by the direct service workforce, Ms. Bradberry pointed out that the rates for the same services vary depending on the program the individual receiving services is enrolled in. This inequity in pay can discourage service providers from participating in programs with lower reimbursement rates, further limiting access to care for individuals receiving services in those programs.

Three categories of formal caregivers discussed in this report are:

- Nursing Assistants, usually referred to as Certified Nursing Assistants (CNAs). CNAs typically work in formal long-term care settings such as nursing homes or assisted living facilities, but are also employed by community agencies and provide in-home services. They provide direct, hands-on assistance with Activities of Daily Living (ADLs), e.g., toileting, bathing, dressing, and eating, and perform certain clinical tasks such as range-of-motion exercises, blood pressure checks, and medication administration as allowed by state law.
- Home Health Aides (HHAs) work strictly in community-based and in-home settings. They also assist with ADLs while helping with other tasks such as shopping, housekeeping, cooking, using the telephone and managing money. This assistance enhances the ability of individuals to remain in their homes or community settings.
- Personal and Home Care Aides are generally referred to as Personal Care Attendants. These formal caregivers work in a consumer's home or in group home settings, and provide services to the aging population, individuals with physical disabilities and individuals who have intellectual and developmental disabilities. Personal care attendants provide the same services offered by home health aides, but may also provide transportation assistance in addition to employment assistance and support.<sup>54</sup>

While these category descriptions are specific to their titles, they are all considered part of the state's formal caregiving workforce and are referred to as the direct service workforce.

In his testimony to the Committee, Commissioner Weizenbaum reported that in 2009, the median hourly wage in Texas was \$7.50 for personal care aides, \$8.21 for home health aides, and \$10.21 for nursing aides.<sup>55</sup>

Job turnover rates are high among the formal caregiving workforce. National turnover rates are estimated to be 40% to 75% annually, with the direct cost of turnover at least \$2,500 per new hire.<sup>56</sup> The state does not track direct service workforce turnover rates, but they likely follow national trends and may be greater due to low wages and lack of benefits in Texas. Factors contributing to high turnover rates mentioned in this report include low wages and the lack of benefits such as sick and vacation time. These act as barriers to increasing the state's pool of formal caregivers.

While this part of the report has focused on formal caregivers serving the Medicaid population, it is important to note that there are private-pay agencies that employ direct service workers, in addition to home health services that are covered by Medicare. The private pay-agencies are paid by individuals receiving the services or through their private insurance coverage. Home health services paid for by Medicare or private pay generally pay their direct service workers \$2 to \$4 higher than the minimum wage of \$7.25, which most Texas Medicaid supported agencies pay their direct care workers. The variances in pay are contributing factors to an unstable direct service workforce.

Given the substantial increase in the demand for direct service workers in Texas over the next decade, policymakers need to consider the importance of both the formal and informal caregiving networks, and recognize that both are necessary components of caring for older Texans. The state must further demonstrate its support of the direct service workforce while providing supports to retain and maintain an informal caregiving network. Otherwise, it is unlikely Texas will be able to meet the demands of the increasing numbers of aging in the most cost-efficient and effective manner.

One strategy for increasing the direct service workforce was presented to the Committee by Dr. Cheryl Grenweldge and Eric Robert of the Center on Disability and Development at Texas A&M University. They provided information about the Postsecondary Access and Training Human Services (PATHS) program developed by the Center that offers training to students in order to become Direct Support Professionals. PATHS was developed out of an identified need to have a well-trained workforce to support older Texans and people with disabilities. The program was designed with the hopes of increasing the direct support workforce while also providing employment opportunities for individuals with intellectual disabilities. In 2010, the Texas Department of Assistive and Rehabilitative Services partnered with the Center at A&M and provided funding to develop the program. Individuals who were identified as having a disability themselves, and who were interested in becoming part of the direct service workforce, were chosen to become students in the first class.

The program uses a defined curriculum that includes classroom instruction and instruction from field experts. The program uses mentors, as well as student advisors and tutors, and requires

completion of a demonstrated competency practicum. Students are paid for their work in the practicum, which requires at least 15 hours of work each week, and are paid more than the minimum wage during their practicum. At the time of the presentation to the Committee, the Center had practicum agreements with five statewide providers of Home and Community-Based Services and one Home Health Care Agency.

The first class of 10 students began as a pilot program at Texas A&M University in the Fall semester of 2011. Of that class, nine students passed the first semester and were placed in paid practicum sites, and eight of those students were on track to pass the practicum and graduate with a certificate as a trained Direct Service Professional. Four of the students were hired to work at their practicum sites after graduation.

At the time of the presentation to the Committee, national accreditation of the program was being sought from the National Alliance for Direct Support Professionals. Furthermore, additional partnerships with providers are being developed to offer training and practicum sites for students and employment opportunities for graduates.

The Texas Council for Developmental Disabilities and the Texas A&M University Center on Disability and Development have partnered to provide funding of the Bridge to Career in Human Services Project. This project will serve as a "net" of support for PATHS students who have more significant disabilities, and will provide housing on campus and other supports for students in the PATHS program. The addition of the Bridge to Career in Human Services Project will provide the necessary supports to help ensure that more individuals with disabilities graduate from the post secondary certificate program and become gainfully employed as direct service professionals.

## **Geriatric Medical Training**

### *Elements Driving the Need for Geriatric Training*

Carmel Bitondo Dyer, M.D., Professor and Director of the Geriatric and Palliative Medicine Division as well as the Interim Chief of Staff of the LBJ Hospital and Associate Dean of Harris County Programs at the University of Texas Medical School in Houston, was invited to provide testimony to the Committee on the need for geriatric training of medical professionals.

In her testimony, Dr. Dyer cited the New England Journal of Medicine, November 24, 2011, report that nationally there were 100,000 emergency hospitalizations a year for adverse drug events in older Americans. The majority of the patients were over the age of 80, and one-third of the hospitalizations were for the use of anticoagulants, costing hundreds of millions of dollars.<sup>57</sup>

She also cited reports indicating that, due to the lack of training of medical professionals specific to geriatrics, many older patients are misdiagnosed. It is "estimated that 10% to 15% of older patients with depression are misdiagnosed as having dementia. Major depressive illness was found to be an independent risk factor for mortality, increasing the likelihood of death by 59% in the first year after diagnosis."<sup>58</sup> In addition, hospitalizations of individuals 65 years of age or older increase their risk of developing other health complications such as loss of strength due to being bedridden, pressure sores, faster than usual bone loss, and a greater risk of death if surgery

is performed. Performing comprehensive geriatric assessments of older adults admitted to hospitals would prolong life, improve individual functioning and reduce the likelihood of institutionalization at no increased costs to hospitals.<sup>59</sup>

Given the increasing number of baby boomers who are turning 65 years of age every day and that they are the highest users of emergency centers, account for 26% of all medical office visits, 35% of all hospital stays and 34% of prescriptions, in conjunction with reports of current and projected health care workforce shortages among states, there is a critical need for more physicians and medical professionals to be trained in geriatrics and the care of older adults. Not only does this impact the actual care provided to older adults and their quality of life, but it also affects the costs of caring for the aging population.

Dr. Dyer provided information from the American Medical Association and the Association of American Medical Colleges showing that nationally, from 1993 through 2009, the amount of geriatric medicine fellowships and programs has been relatively flat despite an increase in the number of available first year positions in geriatric medicine. This has created gaps in adequate care of the aging population. According to Dr. Dyer, the need for geriatric training is not limited to increasing the number of geriatricians. There is also a need for medical professionals in geriatric psychiatry, geriatric nursing, gerontological social work and physical and occupational therapy, and geriatric dentistry. This is important with respect to improving health outcomes, reducing health care costs and improving quality of life for people who are aging.

To address the gap of care of the aging population, Dr. Dyer offered suggestions for legislators and medical educators. Those suggestions involve 1) redesigning models of care and broadening provider and patient roles to achieve greater flexibility, 2) increasing recruitment and retention of geriatric specialists and caregivers, and 3) enhancing competence of all individuals in the delivery of geriatric care.

Potential strategies proposed included:

- Integrating geriatric medicine training in medical school coursework
- Enhancing loan forgiveness programs
- Providing "double points" for continuing medical education units that are specific to geriatrics
- Enhancing Graduate Medical Education payments to hospitals that train more geriatricians
- Providing incentives to boards of medical specialties
- Investing in education by tying a certain amount of funding from the state's 1115 Medicaid Transformation Waiver to education and training of geriatrics practitioners.<sup>60</sup>

In an effort to further stress the importance of, and need for, requiring education and training specific to geriatrics and the care of older individuals, Committee member Betty Streckfuss, a Registered Nurse, shared with the Committee an account of her recent personal experience as a patient in a hospital emergency room. As she described the treatment and care she received, it was clearly not up to the standards she had been taught during her training -- standards that she provided for years as an RN. She indicated that trauma is difficult in itself for seniors, and

seeking care in a hospital emergency center leaves individuals with a loss of control. Proper concern and attention to the unique needs of seniors is important to preserve a sense of identity and individual dignity. For reasons made evident in her testimony, Ms. Streckfuss believes geriatrics should be included as a requirement of continuing medical education for physicians.

The Texas Medical Association (TMA) submitted written testimony to the Committee on current issues physicians face while serving elderly patients. The testimony indicated how funding cuts to the Medicare and Medicaid programs affect the ability of physicians to appropriately care for seniors. Due to funding cuts to these programs, since 2007, in Texas, "around 150 physicians per year have ended their involvement with the Medicare program."<sup>61</sup> Nationwide, one in four seniors has difficulty finding a primary care physician, and in Texas, the number of doctors who accept Medicare patients has decreased significantly over the last decade.<sup>62</sup>

Geriatrics is a labor intensive specialty for caregivers, physicians and other medical professionals and their support staff. TMA's testimony pointed out that Medicare does not pay enhanced rates or reimburse for additional time and education required to treat the aging population. In addition, recent changes in state funding of dual eligibles, i.e, low-income seniors who receive health coverage through Medicare but who also qualify for Medicaid coverage, have left physicians and other health professionals responsible for providing more care for less payment. In Texas, there are more than 320,000 individuals considered to be dually eligible for both programs. TMA stresses that the impact of inadequate reimbursement is most evident in the number of physicians available to care for the aging.<sup>63</sup>

In addressing concerns about the lack of adequate geriatric education and training requirements in medical schools, TMA stated that all medical schools in Texas include some geriatric instruction for students. The Liaison Committee on Medical Education (LCME), the nationally recognized accrediting authority for medical education programs leading to allopathic medical degrees, lists courses in geriatrics as part of its multidisciplinary requirement of educational opportunities. Additionally, TMA reports that medical schools have updated their curricula over the last decade to include geriatric issues as a focus of subjects. There are physician shortages in many specialty areas in Texas, including primary care. TMA regards a specialty serving the aging population as just one of the many areas of physician needs in Texas.

TMA indicated that one way to produce more physicians who are specifically trained to serve the needs of the aging population is for the state to take steps to maintain stable support of graduate medical education and medical students. Providing adequate funding for Graduate Medical Education slots in medical school programs is most important since this lays the foundation for increasing the number of residents and physicians practicing in the state. That is a key in ensuring that there is an adequate supply of physicians in Texas to meet the demand. TMA points out that the Legislature almost eliminated the state's Physician Education Loan Repayment Program in its last budget cycle. The program offered loan repayment for Geriatrics and other primary care physicians who practiced medicine in underserved areas of the state. This is one example of incentives that were provided to ensure more equal distribution of physician services across the state. According to TMA, the decision to cut funding to the program has closed the door to some of the state's most vulnerable communities.

In an effort to cut costs and balance the state budget, lawmakers also eliminated the state's primary care preceptorship program. This program was designed to encourage medical students to choose primary care as their area of practice by exposing them to community practice early in their medical education. This program required relatively little funding from the state, but was eliminated in the 82nd Legislative Session. Through the preceptorship program, physicians in the community were recruited to offer voluntary experiences to medical students who were in their first two years of training. These types of opportunities are otherwise not offered to students in their early semesters of medical school, and allow students to observe and "shadow" physicians in real clinical settings.

While TMA recognizes and respects concerns raised about a lack of geriatric-specific providers, it does not believe that state mandates requiring education in geriatrics for all medical students and physicians is the best approach to increasing the number of physicians specially trained to serve the needs of an aging population.

## RECOMMENDATIONS

### Long-Term Care

**1. The Committee recommends the creation of a pilot program providing an enhanced Medicaid rate for small home model nursing homes.**

In an ongoing effort to promote culture change within Texas nursing homes, it is recommended that the Department of Aging and Disability Services (DADS) create a pilot program to provide an enhanced Medicaid rate for small home model nursing homes. This would require the Texas Health and Human Services Commission (HHSC) to seek approval of a federal waiver from the Center for Medicare and Medicaid Services (CMS). The Center for Medicare and Medicaid Innovation has identified reducing hospitalizations from nursing homes as a funding priority. Currently, the Center is reviewing applications from organizations across the nation that will use appropriated funds for projects to reduce hospitalizations and thus save federal Medicare dollars.

Research regarding the small home model of care has shown reduced hospitalization rates, unlike the more traditional medical model of nursing homes. The outcome of reduced hospitalization rates is due, in part, to the inherent strengths of this model, which include low resident count, organizational structure and the holistic approach of staff. However, in order to maintain the quality of care and continue to reduce the amount of hospitalizations associated with the small home model, a higher Medicaid reimbursement rate is necessary. By partnering with the CMS, DADS could increase the Medicaid reimbursement rate provided to small home model nursing homes by using the Medicare savings incurred from reduced hospitalizations. Those nursing homes would incur the financial risk of such a reimbursement rate if they could not show the anticipated outcomes.

**2. The Committee recommends amending the existing licensing statute to allow certain multiple related nursing homes integrated in the community to continue to operate under the same license.**

Currently, in reference to the governing body of a nursing home, the Texas Administrative Code states:

“(a) The facility must have a governing body, or designated persons functioning as a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. The governing body must have periodically updated written policies and procedures that are

formally adopted and dated, specifying and governing all services. The policies and procedures must be available to all of the facility's governing body's members, staff, residents, family or legal representatives of residents, and the public. The governing body must:

- (1) designate a person to exercise the administrator's authority when the facility does not have an administrator. The facility must secure a licensed nursing home administrator within 30 days; and
- (2) ensure that a person designated as being in authority notifies the Texas Department of Human Services immediately when the facility does not have an administrator.

(b) The facility must operate under the supervision of a nursing facility administrator who is:

- (1) licensed by the Texas Board of Nursing Facility Administrators;
- (2) responsible for management of the facility; and
- (3) required to work at least 40 hours per week on administrative duties.

(c) The administrator must be accountable to the governing body for overall management of the nursing facility.”

Tex. Admin. Code tit. 40, § 19.1902<sup>64</sup>

In summary, each independently state licensed nursing home is currently required to have both a lead Administrator and a Director of Nursing. Traditionally, these positions are necessary when caring for upwards of 150 residents in a typical institutional setting. However, this regulatory requirement becomes a burden as the small home, community integrated model becomes more popular. Instead of one Administrator and one Director of Nursing for 150 residents, under the current regulations a small home model is required to have one of each for each 10 resident small home. This is not only unnecessary, but provides a financial obstacle and a disincentive to the growth of the small home model movement.

To remove this barrier, the Committee recommends that the Texas Administrative Code be amended to allow for multiple related nursing homes on contiguous lots to remain under the same license. This would permit a single nursing home operator to hire a single Director of Nursing and Administrator for a series of small home models within the community while keeping the administrator-to-resident ratio low.

The Committee supports the work that DADS is currently conducting to identify and eliminate barriers to "culture change" within Texas' nursing home care. Currently, DADS contributes substantially to promoting the culture change movement in Texas nursing homes. Culture change is defined as ways in which a nursing home can move away from the traditional medical model and provide residents with a sense of being at home. By doing so, delivery of care becomes more person-directed. DADS has included



culture change on its website at <http://www.dads.state.tx.us/culturechange>, has hired culture change liaisons, hosted various webinars and symposiums on culture change and produced articles to educate nursing home administrators about available resources on culture change.

The Committee recognizes the importance of this ongoing work and supports further efforts to identify and eliminate barriers to culture change within Texas' nursing homes.

**3. The Committee recommends increasing the base Medicaid reimbursement rate for nursing home care.**

In Texas, 78% percent of all nursing home residents are dependent on Medicaid or Medicare funding for their care. Any cuts or increases to the reimbursement rate of either of these programs have a direct impact on the quality of care for these individuals. In 2011, the Texas Legislature enacted a \$58 million reduction in state Medicaid nursing home funding after Texas was already ranked 49<sup>th</sup> among states with the lowest reimbursement rates in the country. In 2010, Texas' Medicaid reimbursement rate for nursing homes was \$126.29 a day. The state's reimbursement rate remains nearly \$50 a day lower than the national average. It is also important to note that the average cost of caring for a nursing home patient is much lower in Texas than in other states. For instance, the cost differential between the Medicaid rate and the expense of caring for an individual is \$9.84.<sup>65</sup> While many states with much higher reimbursement rates have greater cost differentials, this differential still places a burden on Texas nursing homes. In light of continued funding cuts and increases in the costs of providing care, coupled with the cost differential, the Committee recommends that the base rate be increased to maximize the number of facilities willing to accept and care for Medicaid patients. Furthermore, increasing reimbursement rates will also have a positive effect on nursing home quality of care, staff turnover, and maintenance and rehabilitation of old, out-of-date buildings, and would lead to a decrease in Medicaid and Medicare funded nursing home closures.

**4. The Committee recommends that a portion of the savings from the Texas Dual Eligibles Integrated Care Demonstration Project be used to create an enhanced add-on rate for nursing homes that can demonstrate evidence of achieving specified acute care savings above a defined savings trend through reduced avoidable hospitalizations.**

The Texas Dual Eligibles Integrated Care Demonstration Project is a three-party agreement among the Texas Health and Human Services Commission (HHSC), the

Center for Medicare and Medicaid Services (CMS) and STAR+PLUS Managed Care Organizations (MCO). It is a partnership between the federal government, the state and Medicaid managed care health plans. The state's application for the project, currently in review by CMS, is designed to provide greater transparency and accountability for the delivery, coordination and management of primary, preventive, acute, specialty and behavioral health services, long-term services and supports (LTSS) and prescription medications. Improved quality of care, efficiency and cost savings are the goals of the project. Final implementation should be achieved by January 2014.

As of June 2012, HHSC had not identified the amount of savings to be achieved from the project. Once this information is available, stakeholders will be able to better evaluate the amount of funds available to be used on other possible projects. A potential use of the savings as outlined in HHSC's application would be to reinvest monies in improvements and reforms to the overall LTSS system across the state that rewards better performance and culture change.<sup>66</sup> The Committee further recommends that a portion of these funds be used to enhance nursing home Medicaid reimbursement rates to help pay for performance and culture change. The savings trend that needs to be achieved through acute care savings in order for nursing homes to qualify for the enhanced rate would need to be fully defined.

**5. The Committee recommends supporting the Health and Human Services Commission and the Department of Aging and Disability Services in their application to the Center for Medicare and Medicaid Service's Balancing Incentive Program and implementation of the program.**

Serving individuals in the least restrictive environment promotes the dignity of the individual, increases quality of life outcomes and is oftentimes cost efficient. In support of these goals, HHSC and DADS applied to the Center for Medicare and Medicaid Services (CMS) for a Balancing Incentive Program waiver that would allow the state to increase access to non-institutional long-term services and supports (LTSS) beginning on October 1, 2011. Texas' application was approved and the state has begun work to lower costs by improving systems performance and efficiency, creating tools to help consumers with care planning and assessment, improving quality measurement and oversight, and providing new ways to serve more people in home-based settings over the next four years (October 2011 – September 2015). This is made possible by a 2% enhanced Federal Match Assistance Percentage (FMAP) with the expectation that the state will increase total LTSS expenditures on non-institutionally-based LTSS to 50% by 2015.<sup>67</sup>

In order to achieve these outcomes, DADS is committed to moving forward with three distinct activities of structural change: 1) improving access through a "no wrong

door/single entry point” approach through the state’s Aging and Disability Resource Centers (ADRC), 2) implementing conflict-free case management, and 3) creating a core standardized assessment instrument. Since each of these activities is oriented toward empowering aging Texans and providing them with resources they need, the Committee supports the ongoing implementation of the Balancing Incentive Program.<sup>68</sup>

**6. The Committee recommends the Department of Aging and Disability Services demonstrate stricter enforcement of existing licensing regulations of nursing homes that have a pattern of serious deficiencies.**

The Department of Aging and Disability Services (DADS) is responsible for enforcing nursing home regulations. Nursing homes can be cited for deficiencies on their annual investigation or when a complaint is made on a specific home. A State Auditor’s Office (SAO) report<sup>69</sup> in April 2011 found that DADS rarely terminates contracts of nursing homes that have a pattern of serious deficiencies. According to the report, between September 1, 2007, and February 24, 2011, the Department identified three or more repeated serious deficiencies at 452 nursing homes within a 24-month period. Seventy-four of those homes had at least 10 deficiencies. The Committee is concerned about repeated patterns of serious deficiencies since nursing homes care for some of the state’s most vulnerable individuals. However, many of the nursing homes that DADS contracts with are dually certified, and accept both Medicare and Medicaid patients. Even though DADS is the state regulatory authority over nursing homes, a contract is a shared responsibility between the state (DADS) and the federal government (Center for Medicare and Medicaid Services). DADS does not have complete authority or control over the contracts. In fact, DADS received direction from CMS in 2001 that prohibits the state from applying the “three strike rule” against dually certified nursing homes. The three strike rule means there were three serious deficiencies within a 24 month period and DADS imposed Category 2 or 3 remedies. DADS does, however, have complete control over licensing of nursing homes operating in the state. Current licensing laws and rules are in place that would allow DADS to revoke a nursing home license. The Committee knows that there are many good nursing homes providing quality care. There are some, however, that continue to demonstrate a pattern of serious deficiencies, and they need to know that such behavior will no longer be tolerated. In order to ensure that all nursing home residents in the state are safe and receive high quality care, the Committee recommends that DADS strictly enforce binding arbitration, and in some cases employ its rarely used authority to revoke the licenses of those nursing homes that continually violate regulations.

## Caregiving

- 7. The Committee recommends supporting the Department of Aging and Disability Services' (DADS) ongoing efforts of outreach and education regarding available respite services and resources. In order to ensure that all Texans are aware of the resources, the Committee recommends that DADS extend its outreach efforts to community centers, health-care providers, schools and churches to the extent possible within existing resources.**

Texas depends on the work of informal caregiving to meet the demands of a growing population of aging individuals. These informal caregivers are likely to be relatives or friends who provide unpaid care and save the state an estimated \$3.2 billion to \$12.6 billion in Medicaid institutional spending annually. However, voluntarily caring for an individual takes its toll on caregivers and their families. The American Psychological Association's (APA) "Stress in America" survey in 2011 found that caregivers are more likely to report feeling overwhelmed, doing a poor job managing healthy behaviors, and experiencing increased stress levels in addition to getting sick five times a year or more. Respite services provide a temporary relief to caregivers from their duties. Respite services are offered through numerous state and federally funded programs including the Medicaid 1915(c) waiver programs administered by DADS, the STAR+PLUS managed care plans, and the Older Americans Act services administered by the Area Agencies on Aging (AAA). Furthermore, DADS participates in a wide range of activities to promote respite services for the caregivers of aging Texans.

For instance, the Texas Lifespan Respite Care Program was established in 2009 to expand the availability of information regarding respite services for caregivers. The federal Administration on Aging (AoA) also funded the creation of the Texas Respite Coordination Center (TRCC) to compile and update the Texas Inventory of Respite Services, create media and best practice toolkits for respite providers, and hold a series of respite care stakeholder forums throughout the state. This information and more can be found at [www.taketimetexas.org](http://www.taketimetexas.org), which was developed in response to caregiver need for streamlined access to education, support and respite resources.

The Committee commends DADS for the respite work it has accomplished. Countless caregivers have benefited from the resources provided. However, the need for enhanced efforts regarding outreach to all Texans cannot be overstated. The Committee recommends that further education and outreach be conducted, within DADS' existing resources, especially in rural areas and including, but not limited to, community centers, health-care providers, schools and churches.

**8. The Committee recommends that the Legislature explore ways to increase the base pay rate that direct service workers are paid for providing personal care services to low-income seniors and clients receiving Medicaid services.**

A direct service worker, also known as an attendant, is a formal paid caregiver who cares for individuals with disabilities or those who cannot care for themselves due to old age. Activities for which a direct service worker is responsible include personal care, dressing, toileting, bathing, household chores and errands necessary for a person to live independently in the community. Direct service workers are usually employed by a publicly-funded community in-home attendant services program. The pairing of a direct service worker with a person living in the community makes for an attractive and less expensive alternative to a more costly nursing home or other state supported institution. The Committee believes that ensuring a healthy, well trained and robust direct care service workforce will save money in the long term and increase the quality of life of the clients served by enabling them to remain independent and in their homes.

The Committee recommends that the base pay rate that Medicaid reimburses attendant programs in fee-for-service Medicaid and STAR+PLUS managed care be increased in order to strengthen the workforce as a whole. Retaining quality trained direct service workers has been identified as a difficult problem. The greatest contributing factor in high turnover rates has been the inadequate pay direct service workers receive. In fact, in 2008, Texas had the lowest rate of pay among these types of workers. According to an April 2012 survey of State Home Care Associations, Texas is still the lowest of all states in the minimum rate paid for Medicaid Personal Care Services. Furthermore, in the Primary Home Care/Community Attendant Services/Family Care non-priority category, the state reimbursement for services is only \$8.34 per hour.<sup>70</sup> Despite this, however, most workers providing services in the PHC/CAS/FC programs are paid the minimum wage of \$7.25 per hour. The Committee recommends that the state Medicaid rate be increased to at least the \$9.22 per hour rate, and to \$10.64 for priority PHC/CAS/FC and the Community Based Alternatives program. Other issues that should be addressed to increase the direct service workforce include travel, training, electronic visit verification, benefits and the lack of available full-time positions.

**9. The Committee recommends that the Department of Aging and Disability Services develop a networking and mentoring system for direct service workers. The Department should look for ways to develop a system through the use of existing resources, to the greatest extent possible.**

In a 2007 national survey of State Initiatives on the Long-Term Care Direct-Care Workforce, direct service worker vacancies was considered to be a serious workforce

issue in most states.<sup>71</sup> As the aging population in Texas begins to spike in the decades to come, this issue must be addressed. While the demand for caregivers is reduced due to the expanded use of informal caregivers, usually family or friends who volunteer their time to care for loved ones, the state cannot solely depend on a supply of unpaid caregivers. Many informal caregivers are women, and more women have joined the paid workforce and no longer have the time to provide care for their relatives. Additionally, the population of informal caregivers is getting older, and over time will no longer be available to care for others. The average informal caregiver is a 46 year old woman who also works at least 20 hours a week in a paid job, in addition to caring for a relative. It is the position of the Committee that the state needs to take necessary steps to build upon, and provide supports for, both the informal and formal caregiving networks. Both are necessary for the state to meet the demands of Texas' graying population.

In order to ensure that all seniors are able to receive quality care in long-term services, efforts must be made to bolster the direct service workforce. Without substantive state support, the “care gap” between the availability of direct service workers and our aging population will worsen. In addition to a previous recommendation that DADS extend its outreach and educational efforts to reach more Texans, especially those who may be part of the informal caregiving network, the Committee recommends that DADS develop a mentoring system for paid direct service workers.

In the 2008 *Stakeholder Recommendations to Improve Recruitment, Retention, and the Perceived Status of Paraprofessional Direct Service Workers in Texas* report, as part of the Texas Direct Service Workforce Initiative of the Texas Health and Human Services Commission, stakeholders voiced the need to create networking and mentor opportunities for direct service workers.<sup>72</sup> By creating a mentoring system, direct service workers would be provided an opportunity to learn from each other, which in turn would help to improve the quality of care consumers receive. Furthermore, access to mentors would increase workers' confidence in their skill and increase the likelihood that workers would stay on the job, increasing retention rates. A networking system for direct service workers would also help workers feel less isolated increasing job satisfaction and retention. Confident and satisfied workers are also more likely to recruit others to become direct service workers.

## Transportation

**10. The Committee recommends legislation requiring the Texas Department of Transportation to convene a Work Group to study the development of a Complete Streets policy for Texas. The Work Group would be required to submit a final report with recommended Complete Street guidelines to the 84th Texas Legislature.**

The Committee heard testimony about two programs that could be used as potential models for a statewide transportation system increasing access to transportation for seniors. The Committee supports the use of committed and trained volunteers who are educated about issues related to the aging. While the Committee believes both are viable models of providing rides for seniors while making use of willing volunteers, the Committee supports the use of public/private partnerships developed at the local community levels. This would be one way of fostering community participation, and possibly generating pools of volunteers willing to drive seniors in their communities. Organizations with experience recruiting, training and sustaining volunteers who are interested could seek funding through foundations, grants, gifts, or any local community funding to form public/private partnerships. The models presented to the Committee, i.e., the Independent Transportation Network (ITN) and the Volunteer Advocate Program for the Elderly, are two ways of expanding and further enhancing the existing infrastructure to ensure Texas seniors have access to transportation and are able to move around freely in their communities.

The Committee believes that policymakers and lawmakers need to prepare for a future of an aging population with serious mobility needs, and consider mobility and transportation access from a more holistic perspective. With this in mind, state transportation planning must take population projections of a graying Texas into consideration. A state policy requiring transportation and development plans to include a variety of modes of transportation and mobility, including walking, would go a long way towards building an infrastructure to accommodate the growth of an aging and mobile population. Not only would this provide the infrastructure for seniors to be able to stay active and mobile longer, it would also contribute to addressing the issue of reducing obesity rates in younger generations. The experiences of other states demonstrated that designing developments and projects which provide easy access to move from one place to another, outside of driving, encourages younger generations to walk, ride bicycles and stay more active.

### Geriatric Training

#### **11. The Committee recommends that the Legislature restore funding to the Physician Education Loan Repayment Program to 2010-2011 biennium levels.**

While Texas has experienced success in attracting new physicians to the workforce, the numbers are not keeping pace with increased demand and growing populations. Texans are living longer, and as people age they require more physician services. Texas has about 43,000 physicians providing care for approximately 24 million people. The state

ranks 45th among all states in the number of physicians per population. This is especially true in the geriatric specialty area. The nation, as a whole, is seeing poor representation of physicians trained in geriatrics due to a lack of geriatric graduate medical education, high costs associated with extra years of training, and relatively low pay. Nationally, there are only around 7,100 geriatricians, and that number is declining. Nationwide, there are only about 1,600 geriatric psychiatrists, while less than 1% of nurses and pharmacists and less than 4% of social workers specialize in geriatrics. Given the projections of an increasingly older nation over the coming decades, those numbers alone should be of concern to policymakers.

While the Committee believes the state needs to provide funding and supports to increase the provider base of primary care physicians, this recommendation focuses on meeting the needs of the aging population, since that is the focus of the Committee. An Institute of Medicine report, *Retooling for an Aging America: Building the Health Care Workforce*, recommends incentives to increase the number of geriatric specialists, including higher pay, loan repayment and scholarships. Thus, the Committee recommends that the Legislature restore funding to the Physician Education Loan Repayment Program (PELRP) to 2010-2011 biennium levels. The PELRP provides loan repayment funds to physicians who agree to practice in a Health Professional Shortage Area (HPSA) for at least four years. Participating physicians must provide health-care services to recipients enrolled in Medicaid. The 2012-2013 state budget shortfall presented extraordinary challenges to the state. Funding for the Physician Education Loan Repayment Program was reduced from \$22 million for the 2010-2011 biennium to \$5.6 million for the 2012-2013 budget period. For this reason, no new participants are being accepted into the program for the next two years.<sup>73</sup> If this valuable and successful program continues to be underfunded, physician shortages in vulnerable rural, border and inner-city communities will increase, and students will be discouraged from entering into less lucrative specialty fields such as geriatrics.

**12. The Committee recommends restoring funding of preceptorship programs at the 2002 – 2003 biennium levels, and creating a specific General Geriatric Preceptorship Program similar to the General Pediatric Preceptorship Program, which was created in 1995.**

Texas continues to produce too few general practitioners and general geriatricians to keep up with its growing population. Of Texas' 254 counties, 129 are considered health professional shortage areas (HRSA), with a total of 5.8 million people living in those areas. Texas has attempted to increase access to those underserved areas by providing medical students with opportunities to explore primary care settings as a potential career



path early in their education. Otherwise known as a preceptorship, students work closely with doctors to understand the exact scope of work that the field can offer. Three programs currently exist to fulfill this goal – the General Internal Medicine Statewide Preceptorship Program, the Texas Statewide Family Medicine Preceptorship Program, and the General Pediatric Preceptorship Program. Each of these is funded through the Texas Higher Education Coordinating Board and has provided 6,000 students with four week internships since 1995. These programs have proven to increase the rates of doctors entering these respective fields and to keep more students and doctors in Texas.

Preceptorship programs have also proven to be a cost-effective way of increasing states' physician workforces in the specific areas of investment. The relatively little \$1 million a year goes a long way to addressing the physician shortfall in Texas. However, since 2003, funding for these programs has been cut several times – first, in 2004 by half, another 10% in the 2008-2009 biennium, a 5% cut in the 2010-2011 biennium, and finally, complete elimination in the 2012-2013 budget.<sup>74</sup> The program has proven to be a wise investment of state dollars, and provides a great return to Texas and its residents.

It is the recommendation of the Committee that the preceptorship programs be restored to their 2002-2003 biennium funding levels. Furthermore, the Committee recommends that an additional General Geriatric Preceptorship Program be established to address the needs of the growing aging population in Texas.

**13. The Committee recommends that relevant professional boards of examiners, including but not limited to the Medical, Nursing and Social Work boards, explore the option of offering double credit hours for geriatric continuing education.**

Ongoing education of all health-care professionals who work with the aging population is essential in providing high quality care. This is especially relevant with respect to primary care since professionals may not have had access to specialized geriatric training. Seniors are not simply older adults. They require a unique array of services and care. Many preventative services can be administered to prevent the aging population from seeking services in more costly emergency rooms. Diagnosing geriatric patients requires extra knowledge and training. For instance, 10-15% of older patients with depression are misdiagnosed as having dementia. Depression increases the likelihood of death in aging patients by 59% in the first year after diagnosis. Furthermore, correct and appropriate health care for the aging population depends on the expertise of not only geriatricians, but primary care physicians as well. As an example, one third of the 1.8 million Medicare recipients in Texas who were at least 65 years or older had surgery in the year before their death. Many of the procedures failed to improve the patient's quality of life, and involved health-care costs that could have been avoided. If geriatric patients are not

cared for appropriately in their primary care settings, the quality of their outcomes when admitted to a hospital decreases dramatically. In addition, nurses and social work case managers who are able to identify signs of poor health before symptoms worsen improve the quality of life and health outcomes of geriatric patients and minimize the potential of greater cost burdens.<sup>75</sup>

In order to provide the best quality of care possible to aging Texans, the Committee recommends that relevant professional boards of examiners, including but not limited to the Medical, Nursing and Social Work boards, explore the option of offering double credit hours for geriatric continuing education. This recommendation is meant to offer an incentive to professionals to train in best practices for geriatric clients, while not overburdening the requirements already placed upon the professions.

**14. The Committee recommends that the 1115 Texas Healthcare Transformation and Quality Improvement Waiver include, as an option, geriatric medical training projects on its Delivery System Reform Incentive Payments (DSRIP) funding menu.**

The Texas Health and Human Services Commission (HHSC) has received federal approval of a Medicaid 1115 Texas Healthcare Transformation and Quality Improvement waiver. Among other things, the waiver will provide incentive payments for health care improvements in the newly created Regional Healthcare Partnerships (RHP) across the state. These payments, also known as Delivery System Reform Incentive Payment (DSRIP) funds, allow hospitals, local mental health authorities (LMHA) and other community providers to enhance consumer access to health care, increase the quality of care and the cost-effectiveness of care provided, and improve health outcomes of patients and families served. With guidance from stakeholders, HHSC is in the process of finalizing a menu of possible projects for which entities within the RHPs may use their intergovernmental transfer funds.

As an ongoing effort to increase access of quality care to the aging population, the Committee recommends that geriatric medical training projects be included as an option on the DSRIP funding menu. As the spirit of this waiver is directed toward local control of projects, this recommendation would simply allow geriatric medical training projects as an option and in no way would require RHPs to participate in this type of program.

## Letter from Committee Members Sen. Joan Huffman and Rep. Susan L. King

December 20, 2012

The Honorable Elliott Naishtat  
Chairman  
Joint Committee on Aging  
CAP GW.16, Capitol  
Austin, TX 78768

Dear Mr. Chairman,

It has been our pleasure to serve as members of the Joint Committee on Aging this past interim. It is clear from the testimony and findings of the committee that substantial and pragmatic policies must be formulated to meet the future needs of a diverse and aging population in Texas.

While we offer our signatures to this report, it is with reservations. One essential aspect of the recommendations that did not receive thorough investigation or research was the fiscal impact of the proposals. In general, we are supportive of the overall concepts and direction of the report's recommendations which are substantive, innovative and forwarding thinking.

However, the actual cost and impact of each proposal on the state budget and taxpayer needs to be further studied and vetted in order for us to provide our wholehearted support for each of the recommendations. Moving forward, the committee may want to consider having the recommendations in the report reviewed by the Legislative Budget Board and all relevant state agencies and report back to the members of the committee on the potential fiscal impact of the recommendations. Further, the recommendations may be better served and enhanced by prioritizing them by need, impact and consequence.

We extend our gratitude to the members and staff of the committee for their efforts and dedication to the charges of the committee. Our offices remain committed to these charges and to implementing those recommendations that are both innovative and fiscally responsible. On a personal note, we specifically appreciate the service of this committee by public member, Betty Streckfuss and the late Homer Lear.

Sincerely,



Susan L. King  
State Representative  
House District 71



Joan Huffman  
State Senator  
Senator District 17

## ENDNOTES

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