Dear Governor:

About the State of Reform

Edited by D.J. Wilson

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medication management, transfer, bathing and meal preparation to seniors and people with disabilities to allow them to remain independent and live safely in their own homes and communities.

Home care is a strenuous and difficult job, and home care aides lift consumers and sometimes handle biomedical hazards, such as blood and human waste. These services are largely publicly funded through the Medicaid program and the workforce is comprised of disproportionately older and female workers.

Home care aides receive low wages, few (if any) benefits, and little job training or ongoing support. Nationally, home care aides earn an average of $9.49 per hour and nearly half of home care aides live in households earning below 200% of the federal poverty level income and receive one or more public benefits such as food stamps, Medicaid, housing, child care, and energy assistance.

While home care aides provide an invaluable service by keeping people at home and out of more costly institutions such as nursing homes and emergency rooms, they are rarely provided adequate training or support or treated as part of the medical team.

I frequently tell the story of being in Chicago a few years back and walking up a flight of stairs with a home care aide, who was about my age; a single, middle-aged mother earning just over the minimum wage and struggling with her own challenges with health, diet, and obesity. When we got to the top of the stairs she was extremely winded.

We entered her client's apartment and I sat in the kitchen with her, watching her prepare breakfast for her client. She made her bed-bound diabetic client a bowl of oatmeal with a stick of butter

Improving Care for the Poorest and Sickest Medicare Beneficiaries, the "Dual Eligibles"

The federal and state effort to transform care for the 9.2 million individuals in our country enrolled in both Medicaid and Medicare holds great potential, both in terms of human and financial stakes. Dually eligible individuals are many of our country's sickest and most vulnerable adults; their healthcare costs were about $319.5 billion in 2011.

Long-term supports and services account for sixty-nine percent of all Medicaid spending on the duals. Forty percent of the duals receive long-term care services, and about half of those receiving long-term care have a home care aide in the home on a regular basis.

These "dual eligibles" are all low income; many are elderly, but many others are young and often have physical or developmental disabilities. The heterogeneity and complexity of the "duals," highlights the need for approaches closely tied to the needs of the particular beneficiary. Although the dual eligibles constitute just 15 percent of Medicaid enrollees and 16 percent of Medicare enrollees, they account for 39 percent of all Medicaid spending and 27 percent of all Medicare spending.

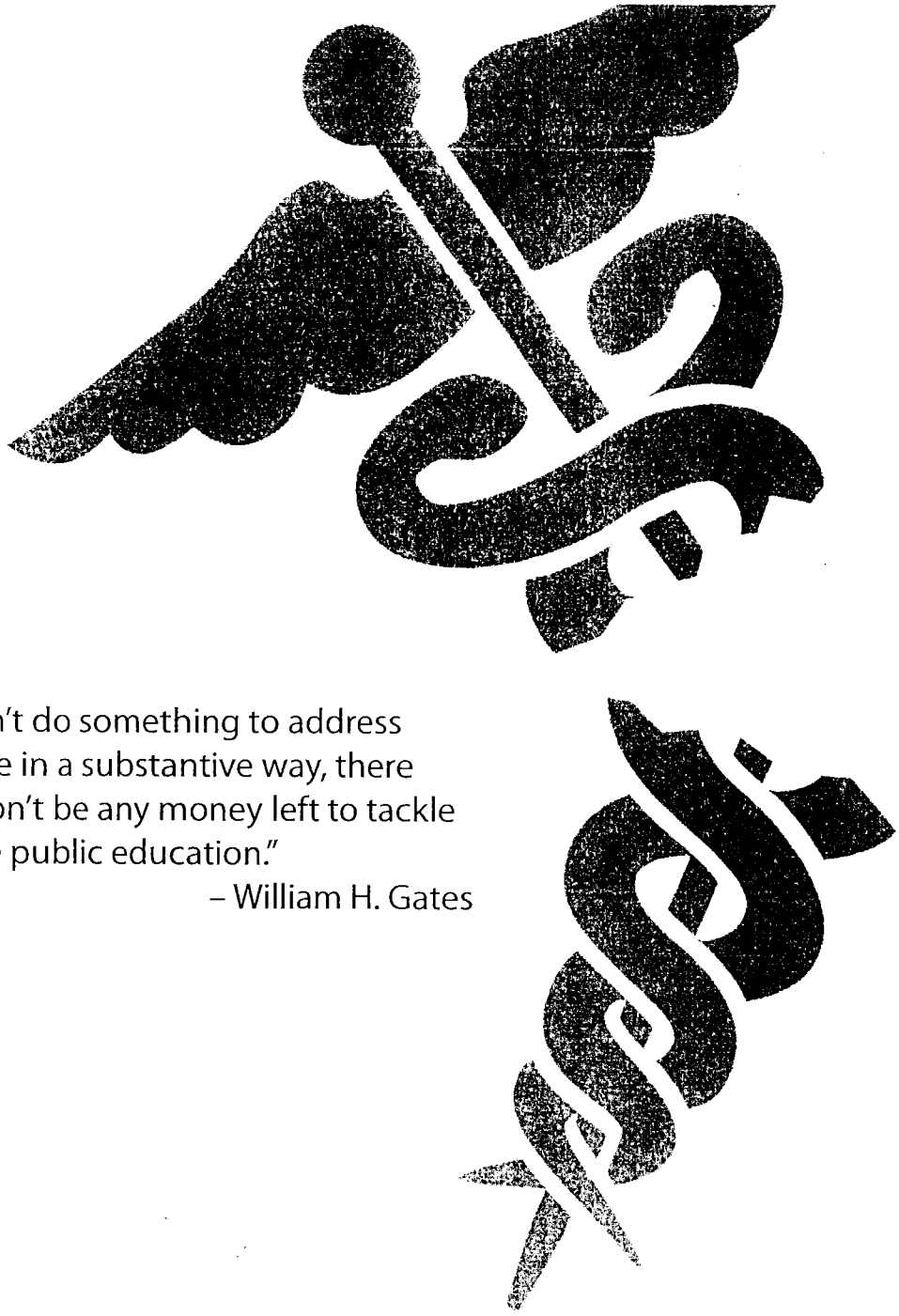
All too often, the healthcare and other support services dually eligible individuals receive are fragmented and uncoordinated. Dual eligibles represent a formidable challenge, as both states and the federal government examine what can be done to improve the quality of the care they receive and better integrate the care paid for by both Medicare and Medicaid. Achieving these goals is also viewed as an opportunity for reaping cost savings for federal and state governments.

formal role for home care aides in the new healthcare models and a clear plan for enhanced direct care worker training and responsibilities with measurable health outcome metrics.

Now is a time for innovation! The Affordable Care Act and the increase in associated federal funding, has given us all – states, community organizations, healthcare advocates and providers – an unprecedented opportunity to think creatively and intentionally about the role that home care aides and other direct care workers can play as part of a care team in coordinating care and in improving health outcomes for dually eligible individuals.

Sincerely,

David Rolf



"If we don't do something to address healthcare in a substantive way, there simply won't be any money left to tackle issues like public education."

– William H. Gates

Dear Governor: About That Healthcare Crisis

Edited by D. J. Wilson

Foreword by William H. Gates

DAVID ROLF

President
Service Employees International Union, Local 775

Dear Governor,

As the President of Washington's largest healthcare workers' union, nothing troubles me more than the sorry state of our healthcare system.

The mission of our union is to improve the lives of workers and their families, and to lead the way toward a more just and humane society.

But almost nothing could be less just or less humane than the way we fail to provide for the health and healthcare of residents of our state and our nation.

Years ago, as a young union organizer, I met a woman named Obie Bibbs, a slender home care worker in her 50's with bright eyes, a big smile, and a love of her church. Obie performed back-breaking work for her elderly clients. Her days were filled with lifting and transfer-

David Rolf is president of the SEIU Healthcare 775 NW, the largest and fastest growing local union in Washington. He is also a Vice President of SEIU International, with 2 million members in the U.S., Canada, and Puerto Rico in the fields of healthcare, public services, and property services.

ring, bowel and bladder care, feeding, bathing, medical transportation, and helping people stick to their prescriptions. She did this all so her clients could stay at home with the greatest possible amount of independence and dignity. Her compensation? Minimum wage with no benefits.

Obie signed a union card in the late 1980's, hoping that she could someday earn more than minimum wage and that she could someday see a doctor and fill a prescription. Her dream was never realized. She never got a chance to vote for union representation or a union contract. She died at age 56 of a heart attack as a result of a treatable heart ailment. Having to make the choice between eating, paying the rent, and paying for health insurance ultimately cost her life.

Somewhere today in Washington is the next Obie Bibbs, working in a nursing home or as a janitor or a retail clerk. Someone filled with energy and love, with a family and a community, whose life will soon be cut short because of our failed healthcare system.

I work for people like Obie Bibbs. So when I get up every day, I remind myself of what I've committed my life and my work to do: improve the lives of workers and their families, leading the way toward a just and humane society.

Please join me in my commitment to make our healthcare system more just and humane.

Diagnosis: Our Healthcare System is Broken

Today, our healthcare system doesn't need just minor improvements or greater financial investment; it needs a fundamental overhaul.

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the order of the day.

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We should all agree that revolutionary, not evolutionary change is the order of the day. Here's why.

Uninsurance and underinsurance aren't just moral failings of our system; they're also problems that impact each one of us, every day.

The fact that over 600,000 Washingtonians lack any health insurance coverage, and hundreds of thousands more are underinsured is an outrage, resulting in poor health and a financial catastrophe for those who lack adequate coverage. That's not where the problem stops. When the uninsured get treatment, it is often at an emergency room, and the costs get passed on to other patients and their insurance carriers. They in turn pass along the costs to employers and taxpayers in the form of higher premiums. This causes employers to raise employee premium shares or cut benefits, meaning more people lack sufficient coverage, adding them to the ranks of the uninsured or underinsured. This "reverse hydraulic of uninsurance" simultaneously raises everyone's costs and drives more people away from primary and preventive care. The uninsured aren't just someone else's problem, they're all of our problems.

A 21st Century healthcare system would cover everyone while providing a choice of doctors and health plans. Doing so would curb the rate of growth in healthcare spending as more people would have access to lower-cost primary and preventive care, avoiding costly treatment in emergency rooms.

The centerpiece of 21st Century healthcare, our employer-based system, is dying.

More and more companies can't provide affordable healthcare to their employees and simultaneously remain competitive. The large employers who do offer healthcare coverage are doing so to their own competitive disadvantage in the global marketplace, and are increasingly passing along more costs to their employees. This takes a significant bite out of wage earning potential. It's even worse for the small businesses who can't afford to offer affordable healthcare coverage to their employees; these workers remain uninsured, or are forced onto the Basic Health Plan or other public programs, or pay hundreds of dollars a month out of their own pockets. Increasingly, U.S. businesses are realizing that the employer-based system doesn't work; that's one reason why companies like AT&T, Intel, Manpower, and Wal-Mart are all advocating healthcare reform.

A 21st Century healthcare system would share costs among employers, consumers and taxpayers, through a tax base, social insurance or a healthcare connector. Efforts such as those underway in Massachusetts, or as proposed by Senator Ron Wyden (D-OR), or by former Oregon Governor John Kitzhaber help point the way to a future with universal financial participation.

We spend more dollars for less health.

Vested interests in the current healthcare system like to remind us that America "has the best healthcare in the world." That may be true for Dick Cheney, but for the rest of us it's an outright lie. The U.S. spends more per capita on healthcare than its peer countries, but with worse health outcomes by virtually any measure, as found in a 2007 McKinsey Global Institute study. While much of the waste and inefficiency comes from insurance industry profit and overhead, there is significant overspending and cost inefficiency in *every* part of our healthcare insurance and delivery system.

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A 21st Century healthcare system would no more tolerate this level of inefficiency and disregard for outcomes than any great 21st Century company would. Put simply, any activity – whether an unnecessary procedure, unnecessary paperwork, or double-digit profit-taking – that isn't specifically connected to improved health, should be systematically rooted out of our healthcare system. There should be no tolerance for the system's sacred cows, no matter how politically connected or influential.

Racial disparities in healthcare disproportionally threaten the health of minorities. Studies by the Institute of Medicine (IOM) and others have shown that African-Americans, Latinos, Native Americans and other racial and ethnic minorities receive different treatment by our healthcare system. Specifically, they have different rates of medical procedures, when compared to whites with the same rates of insurance and health conditions. The IOM found that minorities are less likely to be given appropriate cardiac medications, dialysis, or transplants, and more likely to be given inappropriate treatments (such as limb amputations) than white healthcare consumers.

A 21st Century healthcare system would target public health and educational outreach to underserved communities, provide translators in every clinical setting, recruit minority physicians, specialists, and nurses at levels proportional to the general population, and use evidence-based medicine driven by real data to eliminate disparities in treatment.

Personal behavior and lifestyle choices are hurting our health. Smoking, obesity, poor diet, lack of exercise, substance abuse, failure to seek preventative care and failure to fill prescriptions are all causes of bad health which are entirely preventable.

These behaviors can no longer be considered just instances of personal bad judgment or lifestyle choices. The demands and costs they impose on our healthcare providers and payers impact all of us in the pocketbook.

A 21st Century healthcare system would eliminate junk food from our schools and workplaces, financially incentivize behavior change, provide every consumer not just with a physician, but with a gym membership, a health assessment and a health coach to serve as ongoing resources for behavior change and healthy lifestyles.

Our healthcare system is optimized to bill for services, not produce better health outcomes.

I heard a Starbucks executive tell an informative story. While trying to uncover the reasons for a recent premium hike, Starbucks discovered that its insurance plan incentivized doctors at Virginia Mason to prescribe back surgery in many cases when routine physical therapy might have been more clinically appropriate. Why? Because the hospital and its doctors could break even or profit on back surgery at the health plan's reimbursement rate, but not on physical therapy.

Later, I was shocked to discover that SEIU's own health plan will gladly reimburse providers for hundreds of thousands of dollars of heart surgery, stroke treatment or dialysis, but that weight loss counseling to prevent heart disease, stroke, or diabetes in the first place is *excluded* from our mental health plan.

These two examples don't mean that Virginia Mason or SEIU are choosing to actively disregard the health of our patients or members. They are the result of every part of the healthcare system looking out

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for itself financially and responding to existing incentives in the market.

Meanwhile, because healthcare is a money-maker for such a huge part of the economy, every healthcare organization devotes significant resources to billing, coding, and collections, taking up precious resources which could otherwise be allocated to meeting the health and care needs of patients.

A 21st Century healthcare system should pay providers for health outcomes, not just care inputs. Patients should be rewarded for adherence to primary care appointments, prescription regimes and personal fitness and diet plans. And, every part of the healthcare system should be penalized in its rates for every dollar it spends on billing, coding, collections and overhead over a baseline set by the performance of Medicare or the VA.

More Washingtonians will need long-term care, but our long-term care system is woefully inadequate to meet their needs.

As the baby boomers age, demand for long-term care services will roughly triple over the next thirty years. [52] Our long-term care system is in no way prepared to meet this growing need. There are six key areas in a healthy long-term care system:

1. A balance of services performed in homes and communities
2. Adequate financial resources
3. Integrated chronic care management
4. Effective use of technology
5. Quality metrics
6. Workforce development

Washington's long-term care system is only on track for success in only the first point above.

By definition, a 21st Century long-term care system would meet each of these criteria with a commitment to the system's success, and to our citizenry's security as they age.

What state government could do.

So with these challenges, what's a Governor to do? Isn't this, after all, the job of the federal government to fix? Undoubtedly, system wide change must come nationally. However, historically there isn't a single example of a major federal innovation in healthcare or social services that was developed without states leading the way first. Here are 7 proposals that Washington's Governor should consider in 2009.

1. Establish universal healthcare coverage. States like Massachusetts and Vermont are already on their way to universal health insurance, and California Governor Arnold Schwarzenegger crafted a credible plan for universal coverage that was killed in the California Senate. Let's learn from these examples and send the legislature a bill to create a program built upon the innovations in these three states to cover every Washingtonian by 2012.

2. Lead the way towards a less employment-based system. Washington's universal health plan should start to share the financial burden for paying for healthcare more equally among employers, consumers, and taxpayers. Employers who now pay nothing should start to contribute through a tax or social insurance fund; employers who now cover 100% of costs should see a reduction in their health insurance burden; individuals should all have to pay on

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a sliding scale; and state government should subsidize the poor and those employed by small business through our tax base.

3. Drive out inefficiencies. As the largest purchaser *and* primary regulator of healthcare insurance in Washington, state government should use its purchasing and regulatory powers to require healthcare insurers and providers to meet ambitious targets for the reduction of paperwork, elimination of unnecessary procedures, and the practice of evidence-based medicine. The market responds to incentives, and the role of our state government as a purchaser and regulator gives it plenty of carrots to offer and sticks to wield in the healthcare marketplace.

4. Improve healthcare in minority communities. Washington should launch a program, starting in elementary schools, to recruit physicians and nurses from minority and immigrant communities, launch an aggressive health education campaign targeting healthcare providers, consumers, and community leaders in minority communities, and use its carrot-and-stick power as a purchaser and regulator to ensure that there are no quantifiable differences in the healthcare provided to minorities.

5. Lead the way toward personal behavior change. Government shouldn't micromanage the personal behavior of its citizens, but Washington can set a powerful example by introducing wellness, smoking cessation, weight loss, and exercise programs for its own employees and requiring government contractors to do the same, by getting soda and junk food out of our schools, and by requiring health coaching and wellness programs as a required benefit for all health plans marketed in Washington.

6. Require evidence-based medicine. In its own health plans and those it regulates, Washington should require healthcare providers to move to a "pay for performance" system that values evidence-based medicine and improved health outcomes, not paperwork and profit. Every provider and carrier should meet specified state standards around the practice of evidence-based medicine and paperwork reduction or face financial penalties. Reimbursement rates for state-purchased healthcare should be adjusted to provide a higher profit margin for preventative and primary care and lower profit margins for the most expensive or least medically appropriate services.

7. Find a permanent solution for long-term care financing. Of all the challenges facing our long-term care system, financing is the one that is the key to the solution of the others. According to McKinsey's 2007 report, long-term care is the only area of healthcare in which the U.S. under spends its competitor nations. The result is a largely low-quality and too often inaccessible system. By establishing a state-level social insurance model for paying for long-term care (similar to Japan's or Washington's own programs for L&I or unemployment insurance), we can become the first state to solve the long-term care financing crisis that will threaten many seniors with bankruptcy between 2015 and 2045 if we don't act to address it now.

Together, I believe that we can make incredible progress in improving the health and healthcare of Washingtonians, and we can do it now. But to get there requires bold action, the ability to call the question on many established interests and practices in healthcare, the willingness to steamroll much of Olympia's entrenched healthcare lobbyists, and above all leadership.

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Please let us know. W

Sincerely,

David Rolf

Are we, together, up to it as a state? Are you ready to lead?

Please let us know. We don't have much time left to wait.

Sincerely,

David Rolf