

Hartford Faculty Scholars Program

Administered by The Gerontological Society of America



GERIATRIC SOCIAL WORK INITIATIVE

Meeting Notes

Policy Leadership Institute

Grant Hyatt Washington, Washington, DC

October 21-23, 2009

Preface

This document supplements the resource portfolio given to Institute participants in the opening session. These notes and pictures provide an expanded view of the 2009 Leadership Institute, focusing on the opening night activities and the discussions between scholars and presenters.

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Wednesday, October 21, 2009

**Reception and dinner at the Monocle Restaurant
Capitol Hill, Washington, DC**



*An
Evening at
The Monocle
on
Capitol Hill*



Before dinner, **Barbara Berkman**, Program Director of the Hartford Faculty Scholars Program in Social Work at GSA, and **Pamela Dudzik**, Program Associate, Building Academic Geriatric Nursing Capacity (BAGNC) Scholars Award Program, welcomed scholars and other guests to the reception.



Attendees included:

Hartford Scholars

- Richard Beaulaurier, Florida International University
- Banghwa Lee Casado, University of Maryland
- Rita Jing-Ann Chou, University of South Carolina
- Angela Curl, University of Missouri
- Marilyn Luptak, University of Utah
- Sudershan Pasupuleti, University of Toledo
- Louise Quijano, Colorado State University
- Victoria Rizzo, Columbia University
- Kim Stansbury, Eastern Washington University
- Scott Wilks, Louisiana State University
- Hilaire Thompson, University of Washington
- Janet Van Cleve, University of Pennsylvania
- Nancy L. Chu, University of Oklahoma

Other Guests

- Bob Blancato, Keynote Speaker, Matz Blancato & Associates
- Bob Harootyan, aging researcher (and Linda's husband)
- Toni P. Miles, Fellow, U. S. Senate Finance Committee (Wise-Nelson Chair, Clinical Geriatrics Research and Professor, Family and Geriatric Medicine, University of Louisville)
- A. T. Stair, husband of Barbara Berkman



GSA Staff and Institute Consulting Staff

- James Appleby, Executive Director
- Sara Halperin, Hartford Program Administrative Assistant
- Linda Krogh Harootyan, Deputy Director
- Brian Lindberg, Citizens Coalition for Quality Health Care
- Julia Meashey, Hartford Program Manager
- Doris Reeves-Lipscomb, Groups-That-Work LLC

Introduced by friend and colleague Brian Lindberg, Bob Blancato, veteran House Aging Committee Staff Director, Executive Director of the White House Conference on Aging in 1995, Director of the national Elder Justice Coalition, among many other earned and designated titles, and beloved and respected by many aging advocates, came to tell us what is really going on in Washington.



“Washington Update”
Robert B. Blancato, Consultant
Matz Blancato & Associates

Welcome to the un-event-ful city of Washington, DC. We are now 274 days out of the change we all voted for in November. Think about that: 274 days of unbelievable activity. Change went from a campaign message to a governing philosophy. Just look at the bills that have been introduced, and titles of bills, to see what’s happened: Climate change, health care reform, regulatory reform. We have changed in one year’s time from fatigued to excited, from inertia to initiative.

And there’s been a change in what Congress is working on. If you just looked at today’s hearing schedule up the road in the House and Senate today, what would you find? You would see:

- Monitoring the response to H1N1 that we could spend a whole day on out here.
- The consumer protection agency of regulatory reform and the need to regulate that whole area.
- Iraq re-deployment, remember the Iraq war? Now we are talking about how to disengage from that war.
- The 2010 census, critically important to a lot of aging programs.

- Another big change, the Patriot Act Reauthorization. Boy, have we changed our approach to that thing? Is that a good change?

The biggest change that you have seen from a year ago is the expanded role of government. Government is again trying to help people instead of maybe being against people.

Here is the biggest change that has happened, and it just happened last week. Remember the balloon boy? If balloon boy had happened during the Bush administration, Cheney would have ordered it shot down. (silence and “boo”) You’re supposed to laugh! I worked a long time on that joke. (“You need to work a little harder” heckled Bob Harootyan.)

So, Pres. Obama, what does he do for the trifecta? He won the presidency, the Nobel Prize, what does he do now? Maybe health care reform? Maybe, we’ll see. But let’s go back for a minute and see what he walked into a year ago. By the way, I am going to do a poll right now. How many of you want to hear the 45 minute version of this speech? How about a 15 minute version? Brian pegged it right. If I have been here for nine years, and I have, and I have seen all kinds of groups here, my guess is that this one is feistier and will participate in questions and answers more than any other. I will go through my remarks as quickly as I can so we can turn to your comments as we go along. Or, you could do it the old Bronx way where I come from...which is stick your hand up whenever you want to say that something is right or wrong . . . (Do you raise your hand in the Bronx?). You raise one finger in the Bronx; I think that’s what happens.

*What does
President
Obama do
for a trifecta?*

Bob Blancato

But think about this, President Obama walked into an incredibly difficult environment because of the economic mess that he inherited. Five to six million jobs lost, two trillion dollars lost in retirement savings in the course of a year. Twelve million people lost their home equity in the past year because of the recession. Entire industries collapsing right and left. There had to be a response and he had to move on it quickly. And that became the first stimulus bill that passed early in this session of Congress. It was about saving Medicaid and giving \$87 billion in new dollars to make sure that the enhanced enrollments of people in the states could be accommodated. New money for the Older Americans Act, nutrition programs, and older worker programs. New money for the food stamps program for the record numbers of people enrolling in that program. Shovel-ready road projects but guess what else was shovel-ready? A lot of stuff went on in your field: research projects, scientific projects. If you were shovel-ready, you could pick up money. How many people picked up stimulus money in your departments? (About to...) If you were ready to go, you came forward. And now another billion dollars in prevention and wellness, a very important investment that we have been lacking the last couple of years.

Seven months later, the results are starting to come in on the stimulus plan: 250,000 new jobs in just education that came out of this bill. 11,000 new health care centers opened up at the community level. 700,000 cars were sold through Cash for Clunkers; anybody do Cash for Clunkers in this room? Still driving the old one? Ten billion in funds for capital for small businesses which are very important to the economy. Food stamps were increased; the monthly benefit went up \$80 a month as a result of the stimulus bill, which was the first meaningful increase in a lot of years. Seniors and veterans received a \$250 cash payment early this year and you have got a lot of expanded grants and so on.

One of the big topics now in Washington is “Do you do a second stimulus package?” Conversation on this is moving forward in probably three areas. One, seniors could receive another \$250 cash payment for a number of reasons including the lack of a Social Security cost of living increase this year. Unemployment benefits will be extended through the end of the year because unemployment remains very high and concerns a lot of people. And the homeowner tax credit which is beginning to take shape, which is beginning to help the industry, will most likely be extended by Congress as part of the stimulus. Beyond that, anything else that gets extended is anything that led to job creation and any program that performed well during the first stimulus. If you delivered well what you were supposed to do, chances are you will see a second stimulus come your way.

Also this year, S-CHIP for children’s health insurance was extended and expanded for 4 million new children to be covered. A program that Linda, Brian, Greg O’Neill, James and I have been involved with, the Serve America Act, was passed. It will triple our capacity to do national and community service in this country. It took a real commitment of this President to take this bill that had been languishing for years and pass it into law.

Now think about all the other issues that have not been addressed that are on the docket: climate change, regulatory reform, tax changes, trade, Afghanistan, Guantanamo or NIMBY as we call it (Not In My Back Yard). But what’s really front and center right now?

It’s health care reform, the 900 lb. gorilla, and people like Toni will tell you, that’s just the weight of the bills! I don’t have a lot of time to talk about everything about health care reform. Nor would you listen. I’m the son of an anesthesiologist. My late Dad was a great anesthesiologist, a department chairman in NY City. I promised him that I would never try to emulate him when I gave a speech.

But in health care reform, if I could touch on these things, I will: Why health care reform now? What is the status? What should be in the bill and what’s in the bill? And a little punditry about what we think is going to happen at the end of the day.

Why we need health care reform is a no-brainer in this conversation. If we are trying to bring economic security back to families in this country and to the country, then we have to pass

health care reform. Health care spending has been at an unsustainable rate for some years and will continue to be in the future. Sixty-two percent of bankruptcies in this country are tied to medical bills which is a fifty percent increase in just the past six years. 14,000 people lose insurance every day in this country. Forty-six million people don't have health insurance. Twenty percent of those who are between 18 and 64 have no health insurance. The Business Roundtable now estimates that if we do nothing, in ten years time, the average cost per employee for health insurance will be \$29,000. The Harvard Medical School said that the lack of health insurance may be contributing to as many as 45,000 deaths a year in this country. These are real numbers and there are plenty more out there. But these are the ones I put out there.

The status of health care reform: it is a day-by-day proposition. What do we actually know? There are five bills produced by four committees. There is a merger going on between 3 House bills and 2 Senate bills. An ongoing deliberative process, heavy on deliberative, meaning *slow*, all aimed at getting to a vote in the House and Senate on health care reform.

But just when you think you are making progress, something pops up as an issue. Today's issue: Doc Fix. This is an effort to fix the formula under which doctors are reimbursed by Medicare. Every year, you run up against this thing whereby you are going to get cut by 4 or 5 percent, and they put a one year fix on the deal and promise to come back to it the next year. This time they want to make a permanent fix, a \$247 billion dollar fix, and take it out of health care reform and vote on it separately. Guess what? Today, they learned that the votes are not there in the Senate to do that. To pay for it has to be determined before they can go forward and pass the bill.

Also, new on the conversation topics for today is the new headline on Medicare for all, the new Part E, *Medicare for Everyone*. This is all about how to repackage a public option idea and put it under the context of Medicare. Let's assume for a moment that a bill passes in each house. More than likely, there will be two different bills. And then they have to go to conference committee to work out the differences. That is the bill that would go to the President. Up to

*There is no
policy without
politics.*

Bob Blancato

now, this has been a very transparent process, almost painstakingly transparent. Painfully, you could see everything. Now as it starts to get more serious and closer to the end, it becomes more secretive. A few people are making a lot of the decisions. The things done at the end of the process are probably the most important decisions to be made. Remember one more thing which I am sure you will hear tomorrow from the advocacy side is: there is no policy without politics. If there is ever a case of that being true, it is in health care reform.

What should be in this bill if everything were perfect? I'll quote Yogi Berra, the great philosopher from New York: *if the world were perfect, how would you know anyway?* If we're dealing with a perfect health care bill, what would it have in it? It would move us toward

universal coverage. It would adopt the four Obama goals: lower costs; guaranteed choice; guaranteed access to high quality, affordable health care; and not add to the deficit. If the President had not set these goals, we would not be where we are today. They are still in play; they are still providing the leadership to move the Congress toward health care reform.

What must be in the bill? There must be an option to private insurance. There must be competition introduced into this arena. Is it a public option? Maybe. Is it a nonprofit, consumer-owned coop? Maybe. They are all considered alternatives to private insurance. The bill must be deficit neutral or even contribute to reducing the deficit. The bill must contain employer and individual mandates with subsidies for people who cannot afford to suddenly take out health insurance as part of their budgets. There must be meaningful workforce investments in health care reform. There must be long term care services and supports because this is the only opportunity for a while to reform health care. If we don't include long term services and supports, we will have missed a big opportunity. There must be malpractice reform in health care reform. There must be a focus on prevention and wellness, care coordination, paying for good value instead of just quantity of care. There must be strong consumer protections on the insurance side to eliminate pre-existing conditions and caps. And there must be some expansion of Medicaid because the near poor have been slammed more by the recession than a lot of other groups. And the near poor are growing at a rapid rate in this country.

So what do we have in this bill? I'll preface my remarks by saying they could be obsolete by the time I finish them because things are happening so quickly up the street.

Do we have universal coverage? Kinda. Depending on whose version you are looking at, we could have between 92-94% coverage of Americans from the 83% of coverage that we have now.

*... my remarks
could be obsolete by
the time I finish
them ...*

Bob Blancato

Public option? Four of the five bills have it. The Finance Committee bill has the consumer coops.

Individual mandate for health insurance? All five bills have it as well as subsidies to help people with that.

Employer business mandate? Four of the five bills have that.

Deficit neutral or better? It varies among the bills but they are all trying to get there.

Medicare savings is in all the bills but they differ to some degree.

Prevention and wellness are in almost all the bills.

Workforce is in all the bills with the most common thing being the creation of a health workforce commission that could finally look at workforce needs and propose solutions for the future.

Medicaid expansion is in the bills but it is a fight for whether the feds pay for it all or whether states are asked to pick up some of the costs.

Long term services and supports are in a lot of the bills but they are different.

But let's go back for a minute...if it weren't for a lot of decent advocacy by aging and disability groups, we wouldn't be this far with having long term care in the bill. The CLASS (Community Living Assistance Supports and Services) Act being one important component, the voluntary social insurance plan that was championed by the late Sen. Kennedy, the Community First choice in the Finance bill where you would provide higher Medicaid rates to states that embark on strong new plans to provide home and community based services with nursing home diversion.

You've got a ten year extension of the money follows the person program in the Finance Committee bill; a five year extension of the Aging Disability Resource Centers in the Finance bill. Care coordination is featured in all these bills to aid in quality performance, patient centered direction, and interdisciplinary teams including social workers, transitional care to reduce readmissions, and a Center for Innovation in CMS. All of these things could wind up in the final health care bill around long term care. And there may be something to vote on called 20-20 championed by Sen. Cantwell of Washington state which would direct new money into the aging network from the Medicare trust funds to expand their capacity to do patient centered information services, evidence based disease management programs, and nursing home diversion activities.

Brian and I are very proud that so far, we do have elder justice provisions in one of the Senate bills and one of the House bills. The thing that is in both bills is that it would expand the pilot projects in seven states to allow them to impose criminal background checks on people seeking employment in nursing homes and long term care facilities. When those results came back, and over 9,000 people were turned away from employment because of what they found in the background check, Sen. Kohl said "We should make that national." And the House and Senate bill have included a national background check bill. The Elder Justice Act, the main bill we have been focused on, is included in the Senate Finance Committee bill which would be the most comprehensive elder abuse prevention that we have ever done in this country. It would dedicate money for adult protective services, new training for long term care ombudsmen, improved staffing by having tax credits for retaining qualified staff in nursing homes and community based long term care, federal coordination and so on. Another feature in both bills is nursing home transparency. It's about time we understand who owns nursing homes in this

country and getting additional staffing data and rules on facility closures because who gets most penalized on facility closures? The residents. We need to build rights into that, so they are not displaced as they are. Of course, we would like demonstration projects on culture change in nursing homes, too.

So these are things in the bills now. So you might say to yourself, “Why aren’t we done yet? Where are the disagreements?” Oh, my goodness. They are out there. Sen. Grassley once said “We’re eighty percent there.” But you know what? Twenty percent is still a long time away from the finish in any race if you haven’t trained for the whole run.

I guess the question is: is this bill about cost or coverage? It is a fundamental question that hasn’t been resolved completely yet. The public option gets all the attention. That’s the front and center issue. It wasn’t in the Finance Committee bill which many people felt was an important development because many people believe that the Finance Committee bill will ultimately define health care reform.

What comes up for a vote in the Senate if it comes up for a vote in the Senate? Is it a full blown public option, a Medicare Part E or some other thing? Is it a state option where states could opt in or opt out for a public option type arrangement depending on their needs and circumstances? Or could they do a trigger where you wait a period of time—one year, two years—and hope for reforms to happen in private industry? If they don’t, you come back and apply a public option. Guess what? Nobody has the answer to that.

It was an important development to happen today when the Congressional Budget Office (CBO) at the request of the Speaker of the House came back with an initial score on a robust public option and it came out less than 900 billion dollars. That’s viewed as a positive development. On the individual mandate, how much of a subsidy should be provided? Subsidies will constitute half the cost of a health care bill at the end of the day so you have to address that issue up front. Same thing with business. And as far as the cost is concerned, we are all struggling for a magic number. The president said it has to come in under 900 billion dollars. There are a lot of bills that come in under 900 billion in costs over ten years, with some as low as 500 or 600 billion dollars over ten years.

But the question goes back to the Doc fix. It will take \$247 billion no matter how you fix it. Where is that going to play into the deal?

How do you pay for this?

Bob Blancato

And the issue about Medicare reductions, I don’t care what anybody says, and I’m an advocate for seniors, a lot of people in this room are as well, seniors don’t get it yet. They see \$500 billion in reductions. Yes, from fighting fraud and waste. Yes, by cutting subsidies to the Medicare Advantage program. They don’t sense another problem behind it. It’s going to lead to some cuts somewhere. And they are resisting.

And meanwhile the Medicare Advantage groups have been able to bring their troops out to say “We get great benefits, we should not have them cut.” There is a big fight here. These levels are not going to sustain themselves at the end of the day. Do you tax the higher-cost Cadillac plans? Possibly. Do you want to put new fees on medical devices and the pharmaceutical industry? I want to tell you one funny story I read about, this is a Washington term to describe something like this—*funny*—but actually the Senate Finance Committee discovered they could pick up an additional \$40 billion in savings in the bill because in the bill, when they were first drafting it, the fees that the industry, medical devices and pharmaceuticals, were going to pay, were going to be tax deductible. Can you imagine this? By making them non-tax deductible, they picked up another \$40 billion in savings.

For those of you who don’t believe that making laws is like making sausage, you had better look again. There are a lot of ugly things that go on in passing laws in this country.

Let’s go onto punditry. What’s going to happen? This is the easy part of the speech. Because you know, who knows? I don’t have a crystal ball. I can get up and say that something is going to happen. How is it going to happen? I don’t know. What’s it going to look like? I don’t know. When is it going to happen? I don’t know. One thing I do know is that a lot of congressional staff are not making plans for Christmas because they think they will be here trying to get this thing done before Christmas is over.

Is the public option going to pass? I think so but I think there will be more people unhappy with it than happy with it. Because what we have gone from is the *perfect* health care proposal which is what the President came out that was introduced in bills to what is *possible* in health care reform to what’s *passable* in health care reform. That is a big leap from the *perfect* to the *passable*. That is where we are now. The question that everybody has to ask right now is how much political capital has the President used to get health care reform done? What is the impact on future relations between the President and Congress? And here is another question that we should think about. There are a lot of advocates who are a bit disenfranchised and disenchanted with what’s going on with the administration and what is happening in health care reform. Does that translate into their not being good advocates for other priority issues for the President? I don’t know.

I am tempted to stop here and ask if you have questions.

Nancy: I have heard the comment that this is not really health care reform. It’s been said that it’s health insurance reform rather than how we use health care. Is this true and how do you feel about it?

Bob: They have made the subtle distinction in how to talk about it from health care reform to health insurance reform. It will go back to the question of what ends up being merged when

this legislative process goes beyond where it is right now. You have a variety of different choices in the bills being discussed. They have to be melded together and go before the full House and the full Senate for votes. If the process is open to amendment to improve the focus of the bill, then maybe you'll see a different bill at the end of that process. But right now, what I think you are seeing is a scaling back process from where we were to where we need to go in order to achieve some kind of health or insurance reform legislation. The insurance industry, some members in Congress, and the Administration may be at the worst level of relations at any time in this discussion. They are going to pass legislation now on their anti-trust status for insurance companies to throw into the fire. It's hard to say what the bill is going to look like at the end of the day. But most of us are thinking it will be a scaled down version that is ultimately different from what we have, but is it enough to match the fervor for health care reform at the beginning of the year?. It is tough to answer that question.

Vicki: I teach health policy. I am a pessimist. My concern is you have the perfect, the possible, and the passable. It is great to insure 40 million more people. But it's not health care reform. I feel like it's health insurance that passing Medicare Part D me, this can't just be health

I don't want another Medicare Part D. That was a disaster.

Vicki Rizzo

reform. A lot of people said was better than nothing. To insurance reform.

What I teach my students is health insurance piece. That

we are focusing on the may not be what's in the

reform. But I have to tell you that it is my major concern. And the costs to states. My best friend is a county manager; the burden on states and inequity in state subsidies is troublesome. I'm from New York State which has the Cadillac Medicaid program. And on the subsidy program, they're not the ones getting the money. It's the people in states that already say "We're not providing it" who will get the subsidies because their states are not providing health care coverage. So there are these inequities—we are going to cover more people but at what costs?

Bob: I am going to yield to my colleague for a comment.

Toni: You can not put Medicaid and the insurance reform piece into the same pot. They are different populations. Health insurance reform is something we really need. We really, really need that. For those of you who don't know, I've been working on the Senate Finance Committee since January for 267 days. Here is how I understand it.

The health insurance piece is so that people who buy their insurance through the Exchange will get a good deal. This is middle class insurance. The Medicaid issue is another issue. This sells health reform to the middle class.

Vicki: But my question is: are we going to get sold down the river like Medicare Part D? What I am saying is that the same thing could happen. It's about politics, right; you can't take the politics out of it.

Toni: What I see in the bill...the reason you have rate reforms, the 1-5 ratios, right now we don't have them. How many middle aged women do we have in this room? You don't have to raise your hand. You cannot go out and buy insurance today as a middle aged woman. You can be healthy and still not be able to buy insurance. You cannot buy insurance in the market with diabetes. In order to participate in the health insurance exchange, which is where people want to do the individual market shopping, the rules are in place. No more lifetime caps. Because we don't have transparency now, and pre-existing conditions keep people from getting health insurance, is why we have all these bankruptcies. In between the perfect and the possible, if we get health insurance reform out of this, we will all be in better shape, those of us who work for a living.

The people who are uninsured, a portion of those people will be able to get insurance through the exchange with a subsidy. How many of those are we don't know.

James: We are not getting at it. We are really talking about health insurance reform. Health care—the quality that the patient receives—does not seem to be anywhere in the equation. I am just trying to figure out where the care part of it is—we keep talking about the financing of it. How we pay for all this is one thing, but no one is talking about the care the patient receives and making sure it is high quality?

Health care quality does not seem to be anywhere in the equation.

James Appleby

Bob: We are up here mumbling...there is a range of features that if allowed to go forward whether it is for care coordination, bundling of payments, medical home demonstrations or pilots for testing new models and methods of health care delivery, are all intended to address the question of better health care. You've got the top tier issues that get the headlines and conversations but the stuff that's underneath that's been negotiated just as hard, and just as deeply as the top tier issues, are just getting lost in the shuffle but matter just as much. That's why people who are advocating have to read the whole bill, the whole description of things because you will draw different conclusions if you look underneath all the different pieces of it, to go deeper into the weeds.

My hunch is that you will not have to fight at the end of the day for these features. I think you will wind up with strong care coordination features, medical homes, bundling payments and things of that nature as negotiations move forward to a better health care system. The fight is going to be about the top tier issues: the competition of the insurance industry, the cost of the bill, mandates—business and individual, and what you do with Medicare. Medicare issues is a fierce fight to be resolved. If you look at the numbers where you started, such as \$500 billion,

offsets are down to \$200 billion, you need something to make up the difference. A real good examination will suggest that there is more to this than meets the eye from the standpoint of better health care.

Toni: James, the things that you asked about, the quality of care issues, that's part of Medicare reform. Medicare is the main driver of how we do things. If Medicare asks for it to be done a certain way, everyone else falls into line. That's addressed in Medicare and it is thought that everybody else will follow along.

Marilyn: In terms of these issues, there is an issue of long term care not being present within health care reform. How can it be health care reform without addressing that issue? I tried to read the fine print but haven't read the bills in the last two weeks. Where does it fit? What does that mean? It's not Medicare.

Bob: This bill goes deeper than just Medicare. Everything is half empty, half full depending on your perspective. I think the problem that long term care services supports had coming into the conversation, the fight initially was how you deal with the uninsured, rather than the underinsured. A lot of people characterize long term care issues in that context and you have to battle out the two approaches.

But meantime, a lot of groups and coalitions were promoting the notion that you could accomplish some degree of long term care reform by advancing home and community based services and supports over traditional Medicaid institutional care services. The CLASS Act is a more complicated proposition; state options about expanding and enhancing the federal Medicaid match by doing more with home and community based care; little pieces, expanding ADRCs (Aging and Disability Resource Centers), things of that nature. What people were looking for was some big comprehensive long term care reform within the framework of health care reform, but neither of those is going to happen. It is not going to be big health care reform or big long term care reform. So what you try to do is figure out what did you get in that you can move from, and build from, going forward. There are probably a lot of disappointed people right now on long term care in the whole context but there's more in there than you might think. Brian, you have been working with this, what do you think?

Brian: I think if you look at the health care system, and right away, this was on the table from beginning, they know the cost of long term care. They know the current system relies on impoverishment. People become impoverished and then become eligible for Medicaid. Then the state and federal government pay for their long term care. They know they are already doing that and the costs of doing that are astronomical. When they are trying to provide basic health insurance to every American, they decided that they can't possibly do more in the long term care area and give everyone the right to long term care. They decided to punt on that

The CLASS Act is a major step forward.

Brian Lindberg

and let the Medicaid system handle that to a great extent.

The CLASS Act is like, I hate to say this, it is like Medicare Part D. AARP and other groups pushed for Part D under Medicare to get drug coverage. They didn't like it. It was a Republican Congress. They couldn't get what they wanted. They bit the bullet and decided to support it and down the road said, "We will try to fix it." And that is exactly what they are trying to do now. They are trying to fill the doughnut hole. They've gotten the pharmaceutical industry to commit to a certain amount of money. Depending on the bill you are looking at, we are trying to close the doughnut hole in the House and Senate.

And they are trying to do the same thing in long-term care with the CLASS Act. It was a Kennedy bill. It is the only thing left that will look like something he did. Plus right now because we would all pay premiums for it for ten years, and most people would not become eligible for it until they had invested five years in paying for it, it actually brings in \$55 billion dollars over a ten year period, which is extremely important right now because who will eliminate that program from the discussions, when it reduces the deficit by \$55 billion. It is a foot in the door. It is a national long term care health insurance program. It's voluntary. Employers don't have to offer it. It's not perfect. But it's a foot in the door. Bob has mentioned things about changing the service delivery system so that coordinated care and other community based services are more likely to be provided. That's the best we could do this time because we don't even cover every kid in this country so how could we possibly take the major leap and cover long term care, even though it is part of the daily thought process for all of us in the room, it just wasn't the highest priority.

Bob: Something else I would add...there hasn't been the synchronization of message between the aging and disability communities when it comes to long term care. There was an opportunity that should have been realized and may result in a policy casualty that we did not get as far as we would want.

Rich: This will show my ignorance. I've always been a fan of the public option. I believe in universal coverage. I have lived abroad where they have it. I think that health care should be off the backs of business. But we have a war in Afghanistan that is likely to get more expensive. The smart money is that it is likely to be more expensive rather than less expensive in the coming months and years. We have over a trillion dollar deficit. We have a financial crisis that was driven by bad debt. And since I make payments in euros, I know that we are at a low point in the dollar. One of the things that means to me is I tend to see a recovery in the dollar when there is foreign confidence in our markets. Despite what's been happening with the Dow, we are at an all time low vis a vis the euro. Here is what I worry about . . . this looks expensive to me. I have to go talk with Mario Diaz-Balart, the most conservative person in Congress. How do I talk to him about what is affordable? I'm worried that the whole package could lead to a collapse.

Toni: No, no, doing nothing will lead us to a new collapse.

Bob: That's fundamentally part of the answer to the question. If you let the unsustainable health care expenditure process go unchecked for more years, you will be looking at a far worse situation. The perception problem is that when the public outside the beltway looks at the \$787 billion stimulus package, they are looking at the FY 09 appropriations package, they are looking at the commitment for the war, and x and y, other things in the bailouts, the question becomes: How can we afford to spend this again, an additional expenditure for health care reform? The only thing you can counter with is to go back to projecting ahead what it would cost us if we did nothing going forward. Recognize that we may have to scale back . . .

Rich: Isn't there something better than the "we're damned if we do, damned if we don't" argument?

Bob: If there is, it hasn't been articulated all that well.

Toni: Really, one thing I have learned to do being at Senate Finance is to look at money. I used to think that money was an evil thing. It's not. It's a tool like anything else. If we walked away from everything we did today, and just kept going as we are, we are going to have our institutions collapse. We have doctors leaving the system prematurely. We live in an aging society. That aging drives the whole conversation.

Vicki: It does but Medicare is not a main part of the conversation. You are going to cover people; 80% of our long term care dollars come from Medicaid and it's for older people. And states are collapsing. And that's not part of the conversation.

Bob: I know what you decided to do; you are having a town hall meeting tonight.

Vicki: We have a tsunami of old people coming. And the sickest of them are on Medicaid, spending dollars.

Bob: I don't want to lose Rich's question. Everything you are doing tonight is a warm up to your advocacy work that you will do while you are here. And you need to go in with answers to some of these things. And if you don't have the answer, maybe the flip side of the question is to ask your congressman why he is taking the position he is and what direction does he think we should be going in and find out from him his way of thinking where the opposition may be.

Rich: And if he says the answer is just to cut more Medicaid? *"There are too many people eligible for Medicaid..."*

Bob: The ones who give you fraud, waste, and abuse solutions to everything are the ones thinking the least about the issues.

Rich: I am not talking about fraud and waste; he'll just say to cut the program.

Toni: The other thing that you have to understand is that the funding streams for health care are fractured. You are absolutely right; the states are dead in the water. So Medicaid is dead in the water. Part of medical education has the same problem. The other part of the bill that I worked on is graduate medical education. Undergraduate medical education is a state function. Graduate medical education is a federal function. It's that state/federal dynamic. If you have some insight to that, call me.

Hilaire: In response to that, we haven't provided some of the answers because from the cost effectiveness perspective, we haven't done the job. Part of the onus is on us as researchers providing answers that people need. We can provide the primary prevention argument that reduces costs.

Rich: But it's not enough and not fast enough.

Hilaire: We know intuitively that if you treat early, it will reduce costs.

Toni: No, it doesn't. You can't make that argument on a cost basis. You can't!

Hilaire: You can't because we don't have the evidence to support it.

Toni: No, no, the evidence will tell you that the longer a person lives, the more they cost the system. You can't make that argument on a cost basis. It is a moral appeal. But back to your question...

Hilaire: That's because the qualities are completely problematic, a really flawed system to be evaluating. That is another whole issue.

Toni: Back to his question, some of those people making the cost argument are not bargaining in good faith. That is what I saw at the table with the gang of six. I will name names because I am six days away from the end of this fellowship...Enzi was not bargaining in good faith. He had no intention of ever supporting anything. He was not interested in coming to an agreement. You have to decide if the person who represents you is in the game or not. Mitch McConnell is my senator; what does that tell you?

Bob H: One of the things that you mentioned is that this is really about health insurance reform. You mentioned the public option that is in most of the proposed bills. The latest polls show that a majority of the public now supports the public option. Given all of that, do you want to do a crystal ball about the impact of that and the impact for us?

Bob B: At the end of the day, it is a vote issue. It is going to be like Medicare Part D. Medicare Part D, as many of you remember, passed by one vote in the longest vote ever held in the House of Representatives' history. And the reason that the vote took that long, is because they were out bargaining for what "it's going to take to get your vote."

They are trying to do this earlier this time around. They are trying to figure out what is going to keep you on my side and voting for a final passage of a bill. And if enough sentiment is out there that a public option of some kind, robust, meager, in-between, whatever, they are trying to find the place that will produce the most votes for victory on health care reform this year. It will be a question of how vigilant advocates are for pushing the public option. How many can they bring on if they scale it back to make it palatable for them to support it?

It's really about votes more than it is about the merits. You could not sit there and say you can automatically pass something unless you make tradeoffs along the way. That's where we are.

The one thing that I cannot do, in fairness to you, is talk about the other things on my paper; things like Social Security reform, workforce issues, transportation issues, housing issues, Older Americans Act issues . . . but what I can do is introduce something brand new to the Hartford Scholars program, something that's never been done before this year, we are going to switch gears entirely and you are going through a pop quiz. There's no prize necessarily with this . . . you simply raise your hand when you think you hear the right answer to the question.

1. What builds strong bodies 12 ways? Flintstone vitamins, the Buttmaster, spaghetti, **Wonder Bread**.

Next time follow the instructions. Raise your hand when you hear the correct answer.

2. Before Robin Williams, Peter Pan was played by whom? Clark Gable, **Mary Martin**, Doris Day, Errol Flynn, Jim Carey, or Jay Leno

3. Bob Dylan advises never to trust anyone? Over 40, wearing a uniform, carrying a briefcase, someone you don't know who says "trust me," or **over 30?**

4. Hey kids, what time is it? It's time for Yogi Bear. It's time to do your homework. It's bedtime. It's time for Romper Room. The Mighty Mouse Hour. Or **Howdy-Doody time?**

After dinner speakers can't just talk about serious topics. They need to talk about goofy things, too. So this is your last question for the night.

5. What do M and M's do? Make your tummy happy; melt in your mouth, not in your pocket; make you fat; melt your heart; or **melt in your mouth, not in your hands**. Yay!

All right. That's all I have to say. Good luck. Thank you all very much. Have a good time at the Institute.

Thursday, October 22, 2009
Grand Hyatt Washington

9:00 AM ***Introductions and Meeting Overview***



Brian W. Lindberg, Executive Director
Consumer Coalition for Quality Health Care

Brian welcomed the scholars and reviewed the agenda topics and speakers for the day.



Doris Reeves-Lipscomb, President
Groups-That-Work LLC

Doris explained the process for the day: presentations; discussion with experts; and scholars reflecting on how their new insights might shape their thinking and behavior back home.

9:30 AM ***Keynote Speaker: “Why Academics Need to Integrate Public Policy into Otherwise Full Lives”***

Brian introduced Judy Feder, the keynote speaker, praising her for decades of work as a critical thinker, mover and shaker in national health policy development, Medicare, and Medicaid issues, and her candidacy for Congress in 2006 and 2008 in Northern Virginia.



Judy Feder, Professor
Georgetown University Public Policy Institute

I am happy to be here with you today. We often joke about the 18 minute gap in Washington. What I would like to do for you in the time we have together is try to connect for you what is often frustrating for researchers. I am in political science so that makes my research more connected to politics than you may sometimes feel yours is. But I am a researcher at heart and know how researchers look at the political world, “What is wrong with them and how can this possibly be going on?” I want you to have some understanding of how what you do that is evidence-based

and analytic and seems very far removed from death panels, and other claims made on the progressive side, how it matters in the policy debate.

When you think about policy analysis and going to shape policy—as analysts, we think of it probably in a linear fashion—we think about doing research on a problem; what the problem is that we are trying to address; what analytic options we might have to intervene to make it better; the instruments of policy and how we would use them; and then coming together and going into a political environment and being debated; and I’m sure we think about being messed with; and hopefully putting out something good and somewhat related to where you started, at the end of the day.

First, I want to bring to your attention, that when political analysts look at the policy process, they recognize that it is not remotely linear. There are always problems whatever we might be working on, such as health care reform. Did we just discover that we have a problem with health care? The problem is always there, the key question is: “What brings it to the top of the agenda?” Indeed, the solutions are always there. Sometimes the solutions are there looking for problems, although not so much on the health care side. You do see some of it such as someone who’s been on Energy and Environment, they see jobs out there because the economy is a major issue. We do this in health care, and in long term care, too, that is: looking for support for direct care workers. So we grab it saying, “Hey, have I got a problem for you to solve or a solution that you can tie to your unemployment problem, energy problem, etc.”

*Policy is not
remotely linear.*
Judy Feder

And politics, the political aspect is always there, sometimes grabbing some of these problems and solutions because there is a political candidate or a President who is most able to set the agenda, who regards it as an important issue for his administration, or before that, for his election. But, also, he regards it as something that needs doing. So you have to recognize that all these things are going on all the time. Your work contributes to every aspect of it, to identification of problems, to identification of options, in an interesting fashion to political battles around what happens.

So let me say a few words about each area to get you thinking about how what you do fits into this mix. First of all, on the problem . . . I said, on the issue of uninsured or health care costs or long term care needs or unmet caregiver issues—these issues have been here a long, long time. When we do research that highlights problems in terms of people getting access to services they need, it rarely puts an issue on map. What is much more likely to put an issue on the map in health care and long-term care for older people is a crisis. I’m going back now for more than 20 years on the development of safety standards for nursing homes. Someone falls or gets scalded in the bathtub in a nursing home or is caught in a nursing home fire, as horrifying as that is, it does much more to move safety standards forward much more, unfortunately, than anything that we might do in research on the quality of care. So I don’t

want to exaggerate what research does. But research is always there keeping the issue important in policy makers' minds, giving them evidence. You may think they are only grabbing it for rhetorical purposes. But it is a learning process, they are also able to educate with it, and you see it in the press. Even in the last year, we have seen more attention to older people's concerns and long term care even though it hasn't been a front burner issue.

It is your and our research on what kinds of problems people are facing, such as difficulties getting access to care in their homes which is where people want to live, the problems of the health care system in terms of focusing more on high tech, high cost services instead of focusing on chronic disease management, and not paying enough attention to management of care, that matters. Those are the types of issues that if and when we have done research on them, policy makers grab them. I want you to remember that even if a crisis is likely to move an issue, doing research on what you perceive as the problem matters a great deal for having it available when the moment is right.

... doing research on what you perceive as the problem matters a great deal for having it available when the moment is right.

Judy Feder

When we look at options, the same thing is true. When I think about policy options, I think about identifying the ways in which to intervene, and policy-government instruments to address a particular problem. I just mentioned the chronic care management as an issue which actually has become ripe in the policy debate because policy makers have grabbed it as a hook to control health care costs. The research tells us that we have a way to go to make it effective and that it really can deliver better

quality care at lower costs. The fact that it is out there as a possibility has led policy makers during their campaigns to use a new mantra: "What are we going to do to address health care costs? We are going to deliver better primary care, better chronic disease management." It's all part of a mantra. So having the options, we need to know what works and what doesn't.

We have had some recent setbacks on this issue in research analysis when CMS comes out with evaluations of very narrowly targeted demos and finds that they didn't do squat for improving care and controlling costs. It is not a help to our movement to improve this situation. Analysis is a good thing, you need to know what works and doesn't. Sometimes in the political arena, when you think there is surely something here that we can do, to have research come out with the emphasis on the negative rather than positive is a real problem. In the chronic care management evaluation or medical homes or whatever I'm triggering for some of you, the goal of advocates who are using analysis is to point out: "Now wait a minute, even if the particular demonstrations as a whole were not successful, where were the successes? Where were the failures? What elements of good primary care and chronic care management had some impact in the demonstrations, what can we pull out to highlight and emphasize for the future?" You see the research feeding into the options in positive and negative ways. That's research. As you think about the kind of research you do and drawing conclusions from it, you always want

to think about the implications of your results, and how you can present your results and a way to use your results, even if they are negative, to contribute to next steps that might lead to a more positive direction.

In the big picture, I want to point out something that might be obvious—the way analysis matters in the political process as we are now on health care reform, is that when we look at institutional analytic arms, the Congressional Budget Office (CBO) plays an enormous role in evaluating, and either facilitating or standing in the way of legislation. The CBO is charged with assessing the budget costs of a particular initiative and assessing whether particular legislation, if we are in an era of fiscal responsibility (we've gone in and out of laws and rules that require legislation to be paid for), and I will confess as a politician and a strong advocate of health reform, I believe in bringing down the deficit, but if we could have deficit-spent our way into health care reform, I would have taken it in a heartbeat. But we are responsible Democrats and we are paying for this legislation. So CBO becomes the arbiter of what works and what doesn't. Their analysis is not always right and may be disputed, and often is, by whoever is a loser in their analysis. There is much evidence that they are very conservative. Sometimes, depending on what is on the table, that is a good or bad thing. And they have been wrong many times. Nevertheless, they are the arbiters. When they do an analysis of costs and revenues and whether things are working, it sets the tone for the debate. All of what they do is grounded in analysis. When we do things on the long term care side, like look at whether home and community based care will save money, and the advocacy for that from the early days—back to the early 80s—was that home and community based services are much less expensive on a per person basis than a nursing home placement. It was put forward as a way to save money by not putting people in nursing homes. Unfortunately, the evidence did not support that. It is cheaper on a per person basis, and it enables you to serve many more people which I would argue is a very good thing. But if savings is a sales point, you will have a hard time with that. The CBO is likely on any given occasion to point that out. It is a lesson in research. It's much easier to kill something than to move it forward.

Question: Do they do a cost-benefit analysis on it?

Judy: No, they don't do a cost-benefit analysis, they do a cost analysis. Think of it this way . . .

Question: How can they talk about savings?

Judy: The argument is sometimes made that if we expand home and community based services for people under Medicaid, the services will substitute for nursing home care, and that there will be savings if we use nursing home care less often and serve the same number of people with cheaper alternatives. What the evidence more often tells us is that if we will expand the number of people being served at home and through community based services, and there is some evidence that if we simultaneously squeeze down on whom we are serving in nursing homes, we can possibly save money, or at least not spend more. That's the kind of analysis

CBO does. They are drawing on research in the community. They don't do original research. So it means that research is very important to getting this done. In the political process again, don't get too excited about the value of research. CBO has to guess or do its very best.

An example of this is a line from the health care debate 15-16 years ago. As Robert Reischauer — the CBO head in the early nineties — put it after a member of Congress wished to know if the CBO's estimates about Clinton's health care reform plan were "in the ballpark," Reischauer said "Congressman, I believe that we are in the town the ballpark is in." Cost estimating involves assumptions of behavior as does the issue of substituting other care for nursing homes. They are estimates because they really don't know what is going to happen. They are using models to estimate changes in behavior. But Congress needs an exact—what they call a point—estimate of costs. Estimates of dollars play an enormous role. I can't think of any major issue whether it's health care reform or something else, that money is not a driving factor in our ability to move forward, whether we are trying to save it or trying to spend it, it is a tremendous challenge.

I will come back to where analysis and preoccupation with money are actually moving us forward on a long term care issue in a very surprising way. It is the movement of the CLASS Act. It is a long term care program that actually is in the health care reform legislation that is moving forward. Its potential for enactment—I've been a fan but very skeptical about its chances—it all has to do with analysis and money. Before I do, I want to talk about the third use of research.

The third reason for research may be the toughest for researchers to get and I think is most important for you to pay attention to as you do your research. Well, maybe, it isn't the most important, but it's the one you are least likely to pay attention to, so I wish to highlight it for you. Research is a weapon in a political debate. When elected officials and advocacy groups are fighting about an advocacy issue and have chosen to come down on a particular side, they are going to take whatever is out there that they can use to make their case. This is not about shaping their arguments.

*Research is a
weapon in a
political
debate.*

Judy Feder

At the same time that you do quality research, there is a boat load of schlock out there that passes as research. It is done to make the case. As an honest woman, I will tell you that I remain at times, a serious, totally analytic, hard core researcher, but those times are fewer and farther between than they used to be. Now when I am with anything I would label research, I would call it advocacy research because I am looking for evidence to support something. I am not going to put it in a schlock category but it is driven by having chosen my answer. This is not the way we think of research so I wanted to put this on the table.

The use of research as a weapon, I want you to think about, but the death panels did not use research as a weapon. That was pure rhetoric. But something that feeds into death panels,

where the research doesn't get good enough is you have heard arguments about how much money we put into care during the last year of life, it becomes a case for some, even good guys, that we need to do something about that. But the argument can then go to pull the plug and money issues, and that is what feeds the bad guys to say, "Oh, they are talking about death panels" when people are really talking about counseling on end-of-life decisions. It is a misuse of research and of evidence.

The argument that we spend as much as we do in the last year of life for individuals is used to say that we are spending too much in the last 2-3 months of life, wasting resources by delivering too much care to people that we know are going to die. What's wrong with that is the evidence is based on looking backwards to see those who have died and how much was spent in the last year of their lives. When you look forward, and this is done periodically using Medicare data, at very sick people, at the high cost cases, you find about one half of them live, one half of them die. Going in, you don't know that the money you are spending will secure someone's health; you are spending money because they are sick. We would like to know prospectively the prognoses and outcomes better. Half the time amazingly, you will succeed in making someone better. But just a data point about how much we spend in the last year of life is used in different ways and I would say, very destructively in some arguments, even though what we want to focus on is better targeting, better knowledge, and better planning.

It is a cautionary tale to know that when you do straightforward research, it will be used in peculiar ways. I would urge you to be very sensitive and attentive to how the research will be used. Whether you use it or not, someone else is going to. And they may still misuse your research. That you can't help. As you write and analyze and speak, be thoughtful about how it might be used, and caveat to guide its effective use.

Let me end with a research/policy/politics story about the CLASS Act, that if we carry this off, it will be an amazing story to tell. The CLASS act design comes out of years of effort to provide more resources to keep people in the community for long term care, to move away from a long term care system that is not insurance based, but relies for the most part on families and friends for care and on Medicaid when our resources are exhausted. Medicaid dollars are much more likely to be spent on nursing homes than on home and community based care. We have a heavily oriented nursing home system and it isn't insurance based, because you have to exhaust all your resources to be Medicaid-eligible.

We tried for years to expand home and community based services, and have been successful to a significant extent. There is a lot more Medicaid spending on home and community based care than there used to be, partly motivated by law suits, and motivated by a desire to better serve people. But not insurance. Private long term care insurance has been sold, yes, but it has been called a fledgling industry for the 30 years of its existence. All you have to do is look at the private health insurance market outside of employment, to see how many people don't

have health insurance to know that this is not a ticket to the future. That's where we have been.

In the last couple years, disabled and aging communities came together around a proposal for people to voluntarily have deducted from their payroll, a contribution to a fund that should they become disabled, they could receive a cash benefit on a daily basis, ideally to help sustain themselves at home. The program is designed so that you have to work five years to contribute and become eligible. You have to tell your employer, if your employer chooses to do this for you, that you want to participate, dollars will be taken out of your paycheck unless you tell them not to, because this is evidence based again, more people are likely to participate if they have to opt-out rather than decide to opt-in. There has been research in the pension area that shows this. It starts with the working age population but over time if this goes forward, this will serve as insurance for people of all ages with disabilities.

The advocacy community has been very much behind this along with other provisions to expand community based care and to emphasize people with functional impairments as well as chronic diseases in the effort to coordinate care and refocus delivery systems on primary care and chronic care management. This CLASS Act is an entitlement program for individuals. Amazing! So what happens? They do an analysis, Sen. Kennedy championed this, he has this incredible staffer . . . and that is another lesson in using plain old advocacy or research to advance policy. In the field, this is someone we would call a policy entrepreneur, someone who grabs something and runs with it. And Sen. Kennedy had this staffer, Connie Garner, who has done that and has been working for two-three years to build a coalition to get support for this legislation. I think Sen. Kennedy became an ever bigger fan as he suffered from his brain tumor because Connie was reminding him all the time how important it was to have support and assistance and people helping him and his family. And so, the Senate included this legislation in the Health, Education, Labor and Pension Committee in its version of health care reform. It is not in the Senate Finance bill. Amazingly on the House side, where it has a much more generous treatment of health care reform but has not done as much on long term care because they are saving every dime to put into subsidies for health insurance, one of the committees, Energy and Commerce, picked up the CLASS act, and it is in that version. I don't know if it is in the combined bill that is coming forward but there is a likelihood that it will be there. Now Congressional Budget Office does an analysis. They find, not surprisingly, that if people contribute for 5 years before they become eligible, and without any spending, that in the ten year budget window, which is how CBO does an analysis, son of a gun. It adds 50-75 billion dollars on the plus side of the ledger. In the early analysis, as you go 20 to 30 years out, they question whether it will provide enough money. Again, we have seen where analysis works, and analysts are modifying this bill so that under current estimates, this program is viewed to be in the ball park, solvent for years to come.

There are many in the Congress, Democrats as well as Republicans, who view another entitlement program as the curse of whomever. They worry about the cost of commitments

we have already made, whether this one is funded or not. Sen. Conrad, head of the Budget Committee and a Democrat, is a fiscal hawk raising unnecessary questions about what is a very good program, and nicely funded. I'm not saying that it will automatically happen but what's likely to make it happen is not only the good work that was done on why this program is of value and helpful to people, it's not only that no one made tremendous claims about cost savings although there is some savings in that these new dollars will offset spending in Medicaid, so that's all good. It is not only because it's based on a policy design that people worked on, or that advocates for the elderly and those with disabilities, often competing for limited resources, came together. But I would tell you, most importantly because we need money to pay for health reform. That is the primary obstacle to getting a piece of health reform legislation passed. If we have 75 billion to contribute over a 10 year period to financing health care reform while putting in place another program, that becomes the ticket to success.

So it is not a story of research matters or that research can trump politics in the end. But if you can bring everything together—research, advocacy, analysis in place, and you get lucky and can save money in a period, and if a political window of opportunity arises, you have a real shot at success.

It's rare that I have a positive story to end my talk because other pieces of my story are too often negative. You have to watch how your research may be used. You have to think about it as you do it and write it and communicate it, you have to maximize that it will be used well. You need to recognize that politics will trump more often than not whatever you care about, what you do as researchers, make sure that evidence about a problem, about an option that can work, about really analyzing an impact as opposed to the schlock that is ammunition, make sure that what you do, to put it a little grandly, is ensure that the truth is at least at the table, when we are discussing where policy needs to go, and where politics is taking us.

Let me leave it there . . . I am happy to answer questions and engage with you.

Question: How does one time research to impact policy?

Judy: That is a challenge to time one's personal agenda to the issues that are before the policy makers. You have to look at the issues landscape over time. You will never be too late although you may miss the first opportunity to inform policy development with your research results.

Have ongoing discussions with policy makers because that will enable you to have access and influence when it matters—they will know whom to turn to.

Question: If the primary fear is costs, but projections show the money will be there, what does the fear become?

Judy: They are concerned about creating new entitlements with new claimants and more money needed to serve them. It also becomes a posturing opportunity to undermine the policy by bringing up costs even when they might not be an issue.

Question: With the cost of CLASS Act provisions, and all that happened with banking bailouts and bonuses for banking executives who helped us get to this mess we are, is there (rightfully) an uncertain future for how health care reform dollars will be used? What can we do to protect the monies to be used for the intended purpose?

Judy: Social Security and Medicare are not like a Bernie Madoff scam. It is an intergenerational compact that allows government to take in money and redistribute it immediately to those who are eligible for the benefits. We do need money to shore up Medicare and Medicaid. And in health care reform with its subsidies to help low income people, it will be a challenge to keep it protected. The need for re-election affects the motives and actions of all elected officials.

Projecting a sustainable growth rate for DRGs goes back to 1989. Politicians are not always listening to sound recommendations and sometimes they sacrifice views or stances that do not protect districts and constituents. But there is no good alternative to politics. Commissions have a limited impact and can not stay removed from politics indefinitely either.

I agree that we need more grassroots advocacy to support issues and help politicians make better choices. We need to elect the best representatives we can and recognize that the decisions they make now will play out in November 2010. People are worried about keeping their jobs, their kids, and are not paying attention to everything right now.

10:30 ***“Framing Your Issue: A Work Session to Choose and Protect Your Story”***



Thomas G. Goodwin, President
Thomas Goodwin Communications

Tom’s presentation and copies of his rewritten “at home” messages on scholars’ research abstracts were distributed at the Institute.

1:45 PM ***“Testifying on Behalf of Your Work: A Demonstration”***



Rita Jing-Ann Chou, Hartford Faculty Scholar
College of Social Work, University of South Carolina

Dr. Chou distributed her testimony to the scholars just prior to her remarks.

Debriefing

Rita’s reactions

- Didn’t have time to anticipate all the questions and issues
- Great learning experience nonetheless

Brian’s feedback

- It was the best prepared statement ever.
- She had good eye contact by looking up periodically
- Use of data was good—on borderline of too much? What do you think?
- Need really strong last paragraph to summarize testimony and to also go to if time to testify is reduced.

Other Points

- Going off on tangents can cost you! No ad libbing.
- Request for raising eligibility and # of participants—should you offer a cost estimate? Answer: Yes, you should have the cost amounts.
- Rita spoke clearly and concisely—it was easy to follow
- It is good to know members’ bills and their stance on issues to praise them if you can
- If there is a question for data and you are not sure, what should you do? Answer: “I don’t know” or “I can get the information to you in writing” is the preferred response.
- Is it good to include a homey vignette? Answer: Yes, take one minute to tell a story for them to remember.
- Avoid terms such as “probably”
- Brian—I start with long testimony, highlighting the best parts but submit the long record for publishing/sharing.
- Rita did a good job bridging back home after senators’ questions
- She also did a nice job linking SCSEP to the economy; could there be links to health reform, too?

“Advice on Communicating with Staff and Members of Congress”

2:15 PM **Kathryn G. Kietzman**, Health and Aging
Policy Fellow
Office of Senator Debbie Stabenow (D-MI)



Katherine Hayes, Vice President, Health Policy
Jennings Policy Strategies, Inc.

Kathryn G. Kietzman

Thank you very much for the introduction. It is a pleasure to be here. I have been privileged to work in the office of Sen. Debbie Stabenow for the past nine months or so, coming right out of my doctoral program. I am in a fellowship program called the Health and Aging Policy Fellows Program. This is a new program—a multidisciplinary group of scholars—geriatricians, nurses, social workers, and psychologists, and we have had an opportunity to immerse ourselves in the policy world here. Coming right out of graduate school and doctoral work, it has been very interesting to get on the other side of the information business, so to speak.

I am pleased to be here. For those who don't know, Sen. Stabenow was trained as a social worker and that was one of the pulls that led me to her office. It has been a great choice for me. She also serves on the Finance Committee. So this year with health care reform on the front burner, it has been a very interesting and rewarding experience. As Brian mentioned, I have been working on a variety of health care issues, with particular focus on mental health, aging issues, of course, and integration of physical and mental health care systems, in addition to anything under the sun that has to do with health care. I have been visited by hundreds of folks representing different components of the health system—providers, consumers, hospital CEOs, and so forth. The antidote to the dissertation experience is to go to Capital Hill to get the breadth as opposed to the depth.

So in terms of my experience and understanding what you have already been talking about, this is just another form of communication exchange. The communication of information is going to be in a different form when you go to a member's office. You will be meeting with staffers, who on average, are in their late twenties, maybe early thirties. They tend to be on the

younger side. Bringing in information on the aging population, part of what you can bring to the table is education about what that means, and helping staffers make the connection to their world and the member they represent. As nurses and social workers, you already obviously have the training and communication skills on how to engage folks, how to facilitate conversation, so that it is already an advantage when you go in. Now you may have ten minutes, or fifteen, or thirty minutes to meet with a staff member and to convey your interests.

One of the first things that is really important is to go in with a clear sense of your own purpose. If you are going in to champion a particular bill, or to introduce yourself and make yourself available to the staff as a resource, it is important to let that be known upfront. It might change the dynamic if you go into say “Here I am . . . I am an expert in this field . . . I am a scholar . . . I would like to be able to help on these issues.” You may be received in a different way than if you go in with a really strong, specific, narrow agenda. So I would like you to think about the relationship that you build with staff either on the short term agenda or the longer term perspective. If you know this is your one visit during the year and you have one specific issue to bring to their attention, your interest is going to be different than if you want to build a long-term relationship that you see cultivating over a period of time. That might redirect how you approach the meeting with staff.

I would like to talk about your actual meeting with the staff. Of course, you have to come in with the three “Ts,” that is—tips—with the “Ts” on the other end. I would like to talk about brevity, clarity, and credibility. Those are the three “Ts” with the “t” on the end. I am sure you have talked a lot about the high premium placed on being concise and to the point. It is something that you have heard before. It is really true; you don’t know how much time you have to get your point across. So just taking your research skills and distilling the points that you want to get across to a very accessible level is very important. It is not that the staffers are not smart. They are very smart. They have so much information that they have to manage, that making your message very clear and concise is going to serve you better, and it will be received better by the staff member.

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Kathryn Kietzman

There are so many issues and so little time, going in and understanding who the member is, is also very important. What committees they serve on, what legislation they have supported, what they have opposed, what they have introduced, and so forth; the more informed you are, the more credibility you are going to establish with the staff. And being really clear about the purpose of your visit, what it is that brought you there, why the issue is significant, getting down to the essence of the problem, and its scope.

One thing that I had heard, but not realized in a very direct way is how important geography is. I have been working for the Senator from Michigan. I grew up in New York. I have lived many years in California. I had to learn a lot about Michigan. Knowing how you can translate your

information to make it state, regionally, or district specific if you are visiting a House representative is very, very critical. This is part of the information that the staff is looking for because this is what the member is going to need. They need to know not only how the information affects people across the country but how it affects their constituents. So having that information readily available is going to help move your message forward.

As clear as you need to be about the issue and the scope of the problem, you also have to be very clear what your recommendation is for action, if that is what you are going in to propose or recommend a course of action. You have to keep it simple. There is a limited amount of time that you will have. It's sort of like a class. You have three major points you want to get across. You introduce your points; you revisit them during the lecture; at the end you revisit them again. It might seem very repetitive but it is important. Sometimes I sit and meet with folks, back to back, for three-four hours, for 15-20 minutes at a time. It is a lot of information to receive.

I think it is also important not to assume what the person on the receiving end knows and doesn't know. You spell that out for them. It is another way to advance your message. If they ask questions, and you don't have the facts to respond, this is the opportunity to say that you will get back to them. In sending them information in follow-up, you establish some ongoing communication.

The credibility "T" is like any relationship; it is a matter of establishing trust. They need to know that you are going to give them good information. That is what it boils down to when decisions are made on the Hill. Information is going to be taken from a reliable source, but it takes time to show that you are that reliable source. I think part of that is the whole give and take of the exchange. You are coming in to introduce yourself, letting them know who you are, what your areas of expertise are, and how you can be helpful to them. Once you have established that trust and credibility, they will call on you, if you can provide them with information specific to the state or region, or to the issue broadly. Being available and responsive following the visit is very key if you want to build an ongoing relationship. If they call on you to clarify something or to provide them with statistics, getting back to them quickly will also gain their trust. Then you can expect that they will call on you again and again. And if you don't know, if it's not your area of expertise, but you have a colleague you can refer them to, that's another way to expand the scholarly network they can draw on. These are all pieces of the "T."

The paradox is that the other T, T, T is that Things Take Time. What is interesting to me is that as much as there is a premium on things moving fast on the Hill, there is something indefinable about how things actually move. Something will take off in an instant that you did not expect to move. Being prepared as a scholar who wants to contribute to an issue or legislative initiative is really key. Once that vehicle gets moving, you might have to move really quickly. On the other hand, you might be waiting for some time before your issue comes to the surface and

that's really all about the window of opportunity. You really can't predict when it's going to be there. But you want to be prepared when it does present itself.

Making your story compelling is really something that will get someone's attention. Having a very specific statistic that people will respond to or putting a face on the issues is really important. If you can find a way to bring your data, and have others bring forward similar data in a different way in the form of a constituent or a person who has experienced the issue you are researching, I think of it as a form of triangulating. You've got your expertise that you're presenting, a person who comes in with a live story of what the issue is, and then have the national organization or advocacy group weigh in, it is really through this multi-layering of interests that things start to get moving in a member's office. Now they are being approached from multiple angles. The message is reiterated in a way to reach them from different perspectives, constituents, and begins to gain legs to move forward.

I think most of what you are going to get out of this session will be from questions and answers, and I want to make sure there is enough time for the other Katherine to make her comments. I think I have touched on all the issues so thank you for your time.

Katherine Hayes

What I will try to do is fill in a couple of areas and examples of do's and don'ts that I have seen as a Congressional staffer on the Hill and as someone who has gone in and lobbied before, too. I have seen of my colleagues make huge mistakes. Maybe that will be helpful, too, and then turn it over to Q and A.

First, maybe filling in a few details . . . no two congressional offices are exactly alike. They all function very differently. If you have seen one, you have seen one. There are some offices that if you are going in on health care issues, that member of Congress or that Senator is very up to speed on health care. It is one of their key issues. They may be the Chairman of a Committee or a Subcommittee Chair. They may be a member of the committee. They may be very engaged on the issue and have a record; in that case, their staffer is very much up to speed. Sen. Stabenow, for example, when you go in and speak with her health care staff, you can be assured that they are going to know what's going on in the Committee. They will know the key issues. They will know the ins and outs of every single thing that you are asking for as a rule.

On the other hand, there are members of Congress who have health staffers, and the member of Congress or Senator, may not be a member of the committee of jurisdiction. In the House, you have the House Energy and Commerce Committee which has jurisdiction over Medicare, Medicaid, public health issues, and FDA. And the House Ways and Means Committee has jurisdiction over the Social Security Act which deals with many income security issues. They have jurisdiction over Medicare as well and share jurisdiction with the House Energy and Commerce Committee. And they also have jurisdiction over the tax code and some health

issues will come into play there. The House Education and Labor Committee deals with ERISA and a lot of the workforce training. If you are going into any of those offices, and their member is on the committee of jurisdiction, you can expect them to be pretty engaged with the programs within their committee jurisdiction.

On the other hand, you may have someone who is a staffer who works on health issues for a member who: A. has no interest in health care at all or B. they are interested in health care, but they are not on a committee of jurisdiction, and they aren't able to concentrate on that issue as much. For example, when I worked on the House side, I worked for Mickey Leland from Texas. He was on the Energy and Commerce Subcommittee which had jurisdiction over both health and the environment. So I got stuck with both issues. I knew nothing about the environment, absolutely nothing. And Mickey, frankly, wasn't that interested in it. So I had folks coming into meet with me on environmental issues. Honestly, I didn't care so much about them. But I was always polite and listened. But you may be in situations where you are meeting with a staffer who doesn't know anything about your issue area.

The value of a quick x, y, z review first...*you are giving them the foundation they need to talk with you about your issue without embarrassing them if they don't know what you are talking about.*

Katherine Hayes

When you go in and talk to them, the worst thing you can do is to say "I'm here to talk about this program, do you know anything about it?" You are putting them in a no-win situation. If they know something about it, they will say "yes." But if they don't know about it, they are likely to say "yes" because they don't want to admit that they are clueless. So what you should probably do is say, "As you know, this program does x, y, and z. Please stop me if you are already familiar with this." Just assume that they know this, but do a quick review. It is also a good technique to use with Senators. I used to start this way with every briefing with Sen. John Chafee of Rhode Island who was very

knowledgeable about health care. But he was involved in 100 different things. He was on the Intelligence Committee, he was Chair of EPW, and he was Chair of subcommittees. I used to say, "As you know, Senator, x, y, and z," and laid it out in two or three sentences. That way, you are giving them the foundation they need to talk with you about your issue without embarrassing them if they don't know what you are talking about.

Another quick thing is to know whom you are meeting with on staff. Congressional staffs generally have a chief of staff or in the House, they are known as administrative assistants. This is a mistake that some people make. When they are told they are going to meet with the administrative assistant or "AA," they may think they are getting a secretary. That's the chief of staff, the highest ranking staff person in the office. So don't be offended if you are asked to meet with the administrative assistant.

They generally have appointments secretaries or schedulers. It is important to start with them to get your appointment with the Senator or Congressman. If that isn't possible, they will refer you to the appropriate staffer. Also, on the legislative staff, you have a press secretary who deals with communications, who does the press releases, who deals with media generally. You have a legislative staff usually made up in most offices of a legislative director who supervises all of the legislative staff on all the issues. And then you have individual staffers who handle one or more issues that that member of Congress has assigned them to. Finally, you have legislative correspondents who answer constituent mail.

On the House side, you have less of a budget for your committee staff or for your personal office. You may have people who are both the L.A. and the L.C. Many offices have both interns and fellows. Some are paid and some are unpaid. We had a fellow in our office from HHS during health reform that folks would get really offended when I would say, "I am going to have you meet with our fellow," instead of meeting with me. But what they didn't know is that I had delegated all of those issues to that staffer. They had been in our office for two years and they were really the expert. That was the reason I was delegating to them. Fellows play key roles as do some interns in the office. Don't be discouraged if you are handed off to someone else. Quite frankly, the person I was handing it off to was a budget expert at OMB and knew so much more about it than I did. They were so much better.

Don't be offended if as Kathryn pointed out, you are only given 15 minutes in which to meet, because these staffers, particularly in the Spring, and sometimes in the Fall, every national association in the country has its annual meeting in Washington, DC. There were days in which I had ten to fifteen back to back meetings during the course of the day. It was hard sometimes to even get time for lunch or to go to the restroom. Please don't be discouraged if you are only given a short amount of time.

Kathryn made all the points on follow-up and communication with the office. One point I will make, is that since 9-11, it takes four to six weeks for a letter to get into a congressional office because it is sent to Pennsylvania for irradiation before it comes to Washington. Never send anything that has a plastic coating on it because the process of irradiating it melts it. You just throw it in the trash when you get it because you can't use it. If it is a photograph or something like that, you probably want to send it Fed Ex or UPS so that it doesn't go through the U.S. Postal Service.

Emails, if a staffer gives you their email address, and invites you to use it, feel free to use it. Never, ever, ever, give it out to other people and spam congressional offices. One thing that people don't know is that each office has a limited amount of space on the server for email. I had the home health agencies do this to me once. They literally spammed me personally, not the Senator's email which has a larger capacity, with requests. My mailbox filled up within three hours. I was out on the road in Indiana doing something and I couldn't come back in and delete it. The entire time I was in Indiana, I was unable to do anything because it shut down my

Blackberry. So there I was, four days in Indiana without any Blackberry communication. Needless to say, I wasn't happy with the association. (Brian: "You recommended cutting their funding?" "Yes, I did . . . no, of course not.")

I think that is about it. Know your issues. I will give you one example of not knowing what your member of Congress has done that can be very discouraging. When I was working for Sen. Bayh, he introduced legislation to give states the option to provide home and community based services without getting a federal waiver in Medicaid. That legislation passed. If you know the difference between an appropriated program and an entitlement program—an entitlement program—you go to the state and get them to expand eligibility—and this would have allowed them to go up to 300% of SSI. It's an entitlement program, and once it is set up, you don't have to go back for an appropriation. A group came in once with their association talking points. They asked Sen. Bayh to cosponsor—it wasn't really competing legislation—ours had already passed and been enacted as part of the Deficit Reduction Act. But they came in to ask us to cosponsor this other Senator's competing program that was appropriated. And we knew that it needed to be done but everyone knows how tight the appropriations process is, and to come in and ask Sen. Bayh to cosponsor this bill, which he did, but to know that it was not likely to get funded . . . and that it was going to have to compete, and would only be for very small grants, when the Senator had just gotten legislation enacted to provide an entitlement to this population, it didn't make sense. When I suggested that they go to their states to ask them to expand Medicaid eligibility in other areas, they were like "No! We just want you to cosponsor this bill." They weren't familiar with the programs they were talking about and what else was going on . . . it wasn't a very productive situation. He sponsored the bill but it never passed.

I talked a little about committee jurisdiction in the House but in the Senate, it is a little more clear cut because you don't have the sharing of jurisdictions. The Senate Finance Committee has jurisdiction over Medicare, Medicaid, and the tax code and the Social Security Act. The Health Committee has jurisdiction over the public health programs. And generally, the Finance Committee, with a few exceptions, covers entitlement programs. Once you get a change in law, in one of those programs, you don't have to go to the Appropriations Committee every year to get that program funded. So, one example of something that Sen. Chafee did, there was a problem with community health centers in that they were not getting enough funding each year. There was an authorization level that was never met by the Appropriations Committee because they get allocations. And they're told within each Committee such as the Labor & HHS subcommittee not only how big the pot of money is, it's like the authorizing committee sets the laws and what can be appropriated. The Appropriations committees actually appropriate the funds each year. If the funds are not appropriated, no grants or funds can be expended by the program. In an entitlement program, once it is put in place, it is the law, and the money is automatically spent.

One of the things that Sen. Chafee did, and I'll admit my Finance Committee bias upfront, but for years, they couldn't get adequate funding for community in-migrant health centers, 330 and

340 programs under the Public Health Service Act. Someone, a professor at GW, Sara Rosenbaum, some of you may have heard of her, she came to Sen. Chafee's office and said that she had an idea: "What if instead of the community health centers being underfunded, we set up a special reimbursement rate. We'll categorize community health centers as federally qualified health centers, some of you may have heard of FQHC, but we'll call them Federally Qualified Health Centers, and define them as those currently receiving funding under the Public Health Service Act. But also, all the other clinics across the country that qualify for that funding but aren't getting it because there is not enough, we'll designate them as lookalikes. They meet the criteria but they are not getting the funding. What we will do is give them reasonable cost reimbursement under the Medicaid program." What Sen. Chafee did was introduce legislation establishing Federally Qualified Health Centers—the grant eligible clinics and the lookalikes—and requiring the states to give them cost based reimbursement. I can't begin to tell you how many hundreds of millions of dollars these centers have received over the years and now receive, that have really dwarfed the Public Health Service grants. This made them able to expand all over the country.

If you can come up with a way to get it built into an entitlement program somehow, you won't have to go through the annual appropriations process. As I was going to say, Harkin's appropriation each year, he has to pay for CDC, the National Institutes of Health, even HUD maybe, but there are a host of competing programs for this relative small amount of money. So if you can figure out a way to get funding, to get it through Medicare or Medicaid or one of the other entitlement programs, that's the way to go.

Brian: The other point I was looking for was if you are going to a Finance Committee member's office, that might be something to talk to them about. If you are going to a member on Commerce or something else in the Senate, you may have to understand that they have a very different role. They might be able to write a letter to the chairman of the Finance Committee. You have to understand their committee assignments and what bills they have introduced.

Tomorrow we are really doing intro meetings—"This is who I am, I want to be available, this is the research we are doing . . ." It's not a heavy lobby day. But down the road as you want to advocate for particular issues, you have to understand who the staff person is working for. They may be on a committee that can't do anything for you. Then you have to figure out "What could they do?"

Katherine: One last thing to remember, I am from North Carolina. My senator was Jesse Helms. I knew, for example, that if I were advocating for AIDS at that time, it would not have happened, it would have been a bad meeting all the way around. You're likely to be met with hostility. There will be situations where you go into offices and there may be some hostility. Always remember that tomorrow is a new day, enemies might be tomorrow's allies. Still build that relationship. It is important to do that.

Discussion

- If my congressman is a physician, should I call him “Dr.” or “Congressman?” **Answer:** Call front office beforehand to establish his preference.
- I thought it would be interesting for you to talk about your fellowship at some point and how it has shaped what you plan to do. And it’s a yearlong fellowship? **Answer:** Yes, it is a year long fellowship. The program gave us the option to apply for a little extra support so I have been able to manage to extend it. Given where health care reform is, I am so glad to be able to stay on. Our fellowship end date was September 30. Who knew then how long this would go on . . . and we still don’t know if it is going to happen before the end of the year. But I am feeling very optimistic. But I am happy to talk about my experience, perhaps later.
- Is it appropriate to ask upfront how much time there is for the visit? **Answer:** Yes, there’s no problem asking them when you go in how much time they have, saying “I respect your time and want to know how much time we have to talk.”
- How should I address the staff members? Should I use Ms.? Or use the first name? **Answer:** Each office might be different; it tends to be more informal in my office. In fact, it annoys me when people will come in to talk with me, and every phrase starts with “Ms. Kietzman, Ms. Kietzman.” It sounds like a sales pitch! First names are often okay, take a cue from how they introduce themselves. If they use their first name, and you are comfortable using your first name, do it that way. **Brian:** A physician might be the exception even when they are outside the health care setting.
- What is the most effective way to present your research? **Answer:** Go in stating your purpose for being there. Keep the message very concise to engage them. Reading from a paper is not an effective way to engage them. So use your social worker/nurse skills to start a conversation. That’s when you might wind up staying for 30-45 minutes. That is better for staff. It’s definitely good to bring a one-page leave-behind that captures your main points and reinforces what you just said. Use your thank you post-visit to send material to review the major points of your visit. I find it helpful when they send something that reviews the three main points, etc. but don’t inundate them with material because of email inbox limits.
- May I ask for their email address? **Answer:** Yes.
- Recognize that it is a bad thing to alienate staff or a member of Congress, even when they say something so bad that it makes you want to lunge across the table and choke them, and frequently they will, don’t take the bait. You may have seen this note . . . the Finance Committee just marked up the health reform bill. My husband works for Chuck Grassley on the Finance Committee. Mark said that right in front of Sen. Baucus, they

had taped a card that said: “Don’t take the bait” with a little smiley face on it. I have thought about that. Even when I am dealing with my 16 year old son, my initial reaction is to feel anger or defensiveness. And that thought, “Don’t take the bait,” pops into my head. It really does help to keep things calm and don’t get upset. They may really disagree with you on something now but they might support you on something else down the road. Why annoy them? When you first meet with them, they are some lowly member of a committee; later they are the ranking minority member or Chair of the Energy and Commerce Committee. You never know where they will go, or where their staff will turn up next. If you had a nice relationship with someone on Sen. Stabenow’s staff, and now they are a key Finance Committee staff person, you really want to build the relationship even if you are not agreeing on everything.

Don’t make assumptions. During the 1991-94 health care debate, the fellow I was telling you about was in his fifties, very distinguished looking with silver hair, people often mistook him for Senator Durenburger. Here I was 28 years old, and frequently, we met with the president and CEO of Ford. He wanted to talk with us about health reform. He spent the whole time addressing the fellow, and Doug had only been in our office for a week. He didn’t know anything about Sen. Chafee or his positions yet this CEO spent the entire conversation addressing Doug, and never made eye contact with me.

- Have you ever had extreme disbelief at what people do or say when visiting their congressman? **Answer:** This goes back to know whom you are talking to. I went in with the Missouri Hospital Association. I worked for the state of Missouri for a while in the Medicaid program. And I went in with a hospital coalition to talk about Medicaid and S-CHIP. And the first thing they did was walk into William Clay’s office; he had been there a long time and was chair of the Congressional Black Caucus. “First of all we would like to thank you for your vote on the Balanced Budget Act.” And the staffer just sat bolt-upright in her chair and said “he voted against it.” Oops! “Because we thought it was inappropriate cutting of Medicare and Medicaid” and she just went off. Then the next guy tried. And he said, “We’re hopeful that as you move forward, you will support the cigarette tax.” She said, “My boss does not support increasing taxes on cigarettes.” It just kept getting worse and worse and worse. It was a nightmare. When things got really bad, my favorite thing was to say “What is your boss interested in doing this year?” And let them talk about themselves or their boss. **Answer:** In Sen. Stabenow’s office there is a certain decorum that staffers are expected to maintain. Generally, you are not going to be rude as a staffer. You will usually meet a staff person who will be nice because the boss at the end of the day is the constituents. Keep things in perspective. You listen and acknowledge what the constituent brings to the table and respect their opinion. **Answer:** Is anyone here from Iowa? No, well, I have heard that they are extraordinary in terms of how they respond to constituents. What they are

told is if someone comes in and wants you to clip their toe nails, you get down on your knees and you clip their toe nails!

- What was the most surprising thing in your last nine months, Kathryn, in your fellowship? **Answer:** There were so many things. To me, it was all new, and still is. It is so dynamic, the uncertainty, the ebbs and flows of information and activity. One of the most surprising things is the amount of power of staff. If you come in as a constituent, if it hits the ground at the right moment into the right set of ears, it again goes back to not underestimate the power of staff—regardless of title—to help or hurt you. If your story really moves them, they may be in a position to move your agenda in some way you couldn't imagine. Also surprising to me is how things can coalesce that may seem magical at times. An individual constituent's interest in something affecting them personally will somehow coalesce with the national coalition's efforts and then with an elected leader in a state, it's amazing how things can move forward. It has been powerful to see that come together on different issues in just my short experience.
- Do you have a newfound respect for the people who work on Capital Hill? **Answer:** I absolutely have respect for them. I respect their dedication, their long hours; it goes beyond the long hours though, it goes to their commitment and passion to the issues. And again, their talent. The staffers are just so impressive. I will leave the fellowship with respect for the whole Congress. Also, coming out of my doctoral work, with my narrow research agenda on paid family caregivers, and how they experience the world, the experience I've had on the Hill has broadened my thinking about health because I have been exposed to many other facets of the health care system. But also to how I am going to approach my research, both substantively and strategically, in thinking about where the common ground is for my research agenda for family caregivers and then link it more closely to health care systems and make that translation in a way that has policy implications. It has opened up my perspective topically back to the person and back up to the system again. Bringing information to folks, I might have a little better idea on how to do it now.

Reflections on the Day

- The Institute has been a valuable perspective on the real world that is separate from how we work most of the time. Also liked the tips for do's and don'ts.
- How to start the meeting and what to emphasize, taking the concrete from the abstract.
- It's making me think about where I want to be when I go home. How I will combine these elements and make them work for me.

- We focus on narrow research topics sometimes. It is great to open up to other research and ideas.
- Judy Feder's comments made me realize how research findings may be interpreted—for good as well as less than good outcomes.
- The Jim Lehrer Hour makes it look so easy. I have a new appreciation for the work of people in government.
- It has made me think about the demographics of Congressional districts and how important they are in persuading an elected official.
- I have not been involved in state policy in my state, mainly because of the control by religious elders and the 'brother' politics. I am encouraged to go home and do more now.
- I'm still in the middle of thinking this through.
- I have lots of positive connections to my delegation with local officials who are upward bound. I hope to become the go-to expert for junior members of Congress and Sen. Hillenbrand who will be up for re-election.
- In teaching policy, we use a common text and sophisticated role plays such as oral and written testimony before Congress. I really liked Toni Miles' idea of giving students a diagnosis slip and having students examine their insurance policies to analyze the care they are covered to receive.
- Be careful of (D) and (R) assumptions because they can trip you up.

4:00 PM ***“An Introduction to the National Academy on an Aging Society”***



Greg O'Neill, Director
National Academy on an Aging Society, GSA

I am losing my voice a little bit. I wanted to let you know that the weather outside is horrible. So the fact that you're inside this room, it's okay because it's rainy out there, it's gotten cold . . . it's not really 70 degrees and sunny outside!

I am glad to have gotten here a little early to hear the very interesting feedback about this morning that you all have had. Looking at the agenda, I can see that it is very fascinating and you have probably learned valuable things from expert speakers about how to communicate and frame your work. Nothing beats your having the ability to put what you do into a succinct format, so that when an opportunity arises for you to promote your work to a policy maker, a funder, or other influential person, you have what they call in Hollywood, the “elevator pitch” handy. Tomorrow you will have the chance to put that into practice, to take your expertise up to the Hill.

In many ways, that is what I do with the Academy at GSA. We take the expertise of our members in aging to the Hill and to the policy community through products like the Public Policy and Aging Report that I think all of you receive, thanks to the Hartford Scholars program for subscribing everyone. We also use other activities such as congressional briefings and user friendly, succinct e-newsletters. How do you push up your research? How will I move that forward? I will talk about that kind of thing as well.

And because you're all scholars in aging, I am not just going to tell you about resources that you can go to for information, but that we look to people like you to get content into our publications. The Public Policy and Aging Report has had articles from faculty scholars in this program. Our newsletter is used by quite a few people, especially in the teaching world. Public Policy and Aging Report is a print publication that comes out four times a year. But the e-newsletter comes out bi-monthly. It really has a very different audience. No one needed another print newsletter in the world of aging and policy. So we listened to what people said they needed. A lot of people teaching policy in the country wanted to get their hands on all the stuff that was happening here in government and at the state level, and even globally. And that is the newsletter we have come to produce. We have over 2,000 subscribers in just over a year. A lot of them teach aging and policy courses. We read everything from Kaiser Family Foundation reports to over 150 other newsletters that we subscribe and compile into a very

brief newsletter. And everything we send to you, you can get with one click. We are giving you the reports that people on the Hill are using, think tanks are pushing to the Hill, etc. You should always let us know where you see a key report in your state, maybe it's something you had a role in making happen, that you think we should know about. And our newsletter is free, too! The PPAR is a subscriber publication but the newsletter is free. There is an example of it in the handout that Linda gave you.

The other thing that we do at the Academy is the Policy Series within the meeting. We give you a special handout in your Conference package to pull out some of the key policy sessions. The draft of that is also in the materials that I gave you. So if you want to specifically look at the over 400 sessions that relate to policy, you should look at that.

Linda also mentioned that I head up the Civic Engagement in Older America project at GSA. That was a five year grant from Atlantic Philanthropies to stimulate research on civic engagement in the gerontological community. And we did a lot of things from paper award programs to policy initiatives. This turned out to be a bi-partisan issue that moved very quickly.

Looking back, no one would have expected that but it started with the White House Conference on Aging where Bob Blancato was very influential in convincing the chair, Dorcas Hardy, to make this one of the five major issues at the White House Conference on Aging which many people felt was not a very effective conference in moving policy forward. But what it did was get a lot of people together who felt the things developed there were very important. They took them back to their states. Things are just so different today. You can email stuff to people. You can twitter stuff to people.

And this stuff stayed very much alive after the White House Conference on Aging even if the Conference itself hadn't promoted it. And then around came a lot of legislation on national service that this was just tailor made for. The language went almost exactly into those bills. And then we had the occasion of electing a president who felt strongly about service from the beginning. Both candidates, McCain and Obama, had very strong service backgrounds and both said it would be a key part of their presidency if they were elected. But Obama put that into action when he signed the Serve America bill, the first bill he signed in April. Still to be appropriated is the six billion dollar price tag. It would really increase all kinds of national service opportunities but particularly those for older adults. There is a lot of innovation in there; this Administration is about social innovation, it's one of the key words for them. There are a lot of interesting programs in there to bring retired, older adults back into schools for mentoring based on existing models and some new ones. There are silver scholarships for those to make mid-life transitions. We'll see in this budget climate whether any or all of that will be funded.

Linda: I just want to point out, Greg, that that is a really good example of the convergence of research and policy where those two worlds did come together and work together leading up to the act itself.

Greg: Yes, people had been doing research and they were ready when there was an opportunity for hearings held . . . Brian and I did a congressional briefing. People had opportunities to give testimony and to see very quickly the fruits of their labor turn into an actual bill that was enacted, which was neat because many bills never reach that status.

Linda did say that I should talk a little bit about the Health and Aging Policy Fellows program. And you met Kathryn Kietzman earlier today. This is a program in its first year. For a lot of you who are starting to get “policy feelings,” the Health and Aging Policy program is really a remarkable program. Before it existed, there was really nothing like it. There was a Heinz Fellow in Aging but that was one person in one year. This really instantly creates a cadre of nine people, residential and nonresidential fellows. And the information is also in the packet.

I will give you the big picture on why this is so important. These people are not just bringing their aging expertise to the Hill on a single occasion like you will tomorrow. This is really putting them on the Hill! So they become legislative assistants in Congress or they’re working as professional staff in the executive agencies. You can see from their bios what they were doing. It turned out to be the most unbelievable year to start a program like that. With health reform, you send nine health and aging fellows to the Hill. One ends up on the Senate Finance Committee; they end up in the major offices where everything is moving. So they had an unbelievable life changing event. Many of them are staying on; many of them have moved permanently to this area.

This is the kind of thing you may want to look into further. I did put information into the package on a reception they are having at GSA on Thursday evening. They will be presenting there. Last year, they actually spoke here at the Institute. The program is directed by Harold Pincus at Columbia University.

We have found that working with these Health and Aging policy fellows has been excellent for us. They are giving us real time work and they are having amazing experiences. Many of them were based in universities. Some had just finished their dissertations. They are doing things in one hour that before they couldn’t imagine doing in one month. That’s how fast things move.

Finally, I want to emphasize that if you look at GSA as a resource for both information and as a vehicle for pushing things out that you are interested in, you will find that we have quite a bit at the Public Policy Institute. We work very much one-on-one with members. If it is testifying that you are interested in, it is always good to start by writing something for publication and making sure you are part of GSA’s referral database because that’s where we go with key words to look for expertise to recommend people. Put yourself in that database if you are not

already. It's on the main geron.org website. It would say Expert Referral database. You have to log-in as a member. It needs to be on a log-in basis because you want to be able to give us your email addresses, your office phones, etc.

Linda: I just want to point out that Brian has been a consultant to GSA the last two years and is just a wonderful addition for us to expand our efforts and stay on top of the issues. As some of you have pointed out, he does the monthly column in our newsletter which has drawn a lot of compliments. It has helpful tips to help our members to stay informed. I wanted to acknowledge his work.

Greg: Yes, the Policy Series is what Brian put together. As you know, the abstract submission process was done months ago. It is not really conducive to timely policy issues. So we wait to insert these at the last minute. Someone mentioned death panels earlier. We have a session on that with Dianne Myer and Charles Sabatino from ABA's Law and Aging program and Monsignor Chuck Fahey. We have a very good session on the economic downturn, on health care reform as well, with two of the Health and Aging fellows, Toni Miles and Gretchen Alkema, and John Rother who is the Director of public policy at AARP. So be sure to look for those. That is the kind of cutting edge policy issues that I think you are becoming interested in.

One more thing, the first Atlantic Philanthropies grant on Civic Engagement was to stimulate research. We moved quicker than anyone thought we could towards actual policy action with large bills proposed and then enacted. Now it has changed to see how we can get appropriations for these programs that have been created. The second part of the grant is to create a public policy action center, what we are calling a "Research and Action Center" where we will track what's going on in the states and federal level on issues relating to older adults' civic engagement. It will be everything from life long learning to workforce issues to volunteering so that we have a one-stop knowledge management hub.

This is an interesting grant because there are three parties who are awarded these grants: GSA, NCOA which has a much greater capacity to get the grassroots advocacy, and then to Brian. Brian will be creating something that we have never had before—a legislative advocacy team focused on federal legislation coordinating Age for Action, this group that came out of the Atlantic funded entities that were doing civic engagement work. Age for Action came out of NCOA coordinating that legislative advocacy with the Academy's website that will have resources on the research, policy development, and a place where one could be involved in advocacy and legislative work. The three of us were asked by Atlantic to put the proposals together in order to coordinate our efforts. It should be a lot of fun and provide a lot of opportunities for people to get involved.

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Scrapbook

