Approved: January 26, 1994
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on January 19, 1994 in Room 423-S of the Capitol.

All members were present except:
Rep. Bishop, absent
Rep. Freeborn, Rep. Goodwin, Rep. Weiland, excused.

Committee staff present: Emalene Correll, Legislative Research Department
William Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Representative Greg Packer
Representative Mills (for Patricia J. Kissick, Mt. Hope Community Development, Inc.
Betty Jo Banks, President of Kansas Professional Nursing Home Administrators Assn.
Rheva Victor, Administrator, Eudora Nursing Home
K. J. Langlais, Administrator, Cherokee Lodge, Oskaloosa, Kansas
Ellen Elliston, Director of Patient Support,
St. Francis Regional Medical Center, Wichita, Kansas
Monica Flask, President, Society for Social Work in Health Care
John Grace, President/CEO, Kansas Health Care Association
Mary Matzke, Director of Outpatient Services, Onaga Community Hospital
Sherry Briggs, Shawnee Mission Medical Center
John Kiefhaber, Executive Vice President, Kansas Health Care Association
Tom Bell, Kansas Hospital Association
Representative Forrest Swall
Mr. Ed Finley, Johnson City, Kansas

Others attending: See attached list

Chairperson Flower called the meeting to order with a reminder of the invitation by Secretary Whiteman of meetings tomorrow with Dr. David Hawkins giving a presentation on an approach to reducing adolescent problems. She encouraged all members to attend if possible, and to notify the office of Secretary Whiteman if able to attend.

Chair drew attention to the agenda, requesting a staff briefing on **HB 2581.**

Ms. Correll explained **HB 2581** noting it would amend statutes in the existing Adult Care Home licensing law, by deleting Sub.sec. (5) from that statute, and also would repeal 39-966 enacted in 1991 that created pre-assessment.

It was noted the Joint Committee on Rules and Regulations introduced this legislation. Also noted, hearings were held by the Joint Committee on Rules and Regulations as well as the Joint Committee on Health Care Decisions for the 1990s on **HB 2581.**

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE, Room 423-S
Statehouse, at 1:30 p.m. on January 19, 1994

HEARINGS BEGAN ON **HB 2581.**

Chairperson Flower requested each conferee limit their presentation to four minutes since there is a large number scheduled to offer testimony.

Rep. Packer offered handout, (Attachment No.1) He stated the testimony is from comments addressed to him in a letter received from Jan Jenkins, Administrator, Aldersgate Village, Topeka, Kansas. He drew attention to some of the problems that facility is experiencing, i.e., deadlines not being met for access; residents, families, facilities are not being notified by Bock Associates in a timely manner; assessment results being sent to incorrect facilities; resident choice of assessors not being honored by Bock Associates. Since the inception of the assessment program, only two residents have been determined to be "inappropriately placed" at Aldersgate. All the problems mentioned have had an adverse affect on the residents. He urged support of **HB 2581.**

Rep. Mills offered comments in behalf of Ms. Patricia Kissick, Administrator of Mount Hope Community Development, Inc. who was unable to attend in person. Rep. Mills noted out of 41 prescreens there was only one resident who did not enter their facility and this one individual was prescreened to determine if she needed active mental health care. All options are studied before admittance to their facility. Prescreening is an enormous obstacle for the elderly trying to access the system and they can only do it with assistance of nursing homes, Area Agencies on Aging, hospitals, or SRS. It was noted, it is very difficult to obtain copies of the prescreenings from Bock. The $6 million spent could be better used on services, i.e., case management. He questioned why tax dollars are awarded to a company from outside the state of Kansas to perform prescreenings. He urged support of **HB 2581.**

Note: Copies of Ms. Kissick's testimony will be provided tomorrow to each Committee member.

Betty Banks, President of Kansas Professional Nursing Home Administrators' Association, (Attachment No.2) , stated support of **HB 2581.** She noted the original intent of **SB 182** was to divert to Home and Community Based services and to identify non-eligible nursing home applications. This process has not been successful. Statistics reflecting denials indicate a very small number have been channeled to Home Community Based Services. She expressed concerns of the vast amount of money being spent on a program that isn't working. She noted there is huge opposition to the manner in which the program is being administered, as was testified to during the Interim Committee hearings in October on this issue. She urged favorable consideration of **HB 2581.**

Rheva Victor, Administrator, Eudora Nursing Center, (Attachment No.3), stated support of **HB 2581** and noted the decision to enter a nursing facility is very difficult for everyone involved. The licensed social worker, and the director of nursing, carefully interview each potential resident and evaluate their health care needs. Their experience has been that individuals seeking placement at their facility have already exhausted both their family and community resources before considering placement. Adding the preadmission assessment and referral program to the placement process adds stress to families who do not understand the necessity for the assessment which delays admission. She urged a favorable vote to repeal preadmission assessment and referral and to use the money spent on this program to fund services that are needed.

K.J. Langlais, Administrator, Cherokee Lodge in Oskaloosa, Kansas urged support of **HB 2581.** Prior to the prescreening process, SRS already had a mechanism in place to make sure residents were medically and financially qualified to receive Medicaid applications. The only requirement the prescreening program directs, is that the Federal Government requirements are met, a review of all residents for mental retardation or mental illness is made, and that appropriate services are offered. One point of rationale for **HB 2581** was to save money, and this is not what has occurred. She questions why this kind of money is being needlessly spent. She detailed costs for families of patients waiting for the screening process to be completed, so that placement can be made. If 24 hour care in their home is needed, costs can be up to $250 per day. A continued hospital stay can be $350 plus, per day.

Ellen Elliston, Director of Patient Support Services at St. Francis Regional Medical Center offered hand-out (Attachment No.4). She stated that data coming from the assessment program indicates the program just isn't working. Many are aware of the problems, especially since the contract for prescreening was awarded to Bock. She highlighted concerns. They have been told to screen anyone who was even considering entering a nursing home. Now Bock and SRS are implying this was done just to generate income for the hospitals, when in reality they were only following SRS instructions. Patients are being denied their right to choose a screener; hospitals have experienced added costs due to the handling of the preadmission assessment; data is being misrepresented in reporting diversions. She encouraged members to repeal **HB 2581.**

Monica Flask, President, Society for Social Work Administrators in Health Care, (SSWAHC), offered hand-out (Attachment No.5). Their organization believes the preassessment program as currently being implemented is a waste of taxpayer dollars, a waste of time, an intrusion on the rights and privacy of private citizens. Their organization had debated whether or not to support re-design of the Kansas Preadmission and Referral Program, (KPRP), rather than an outright repeal. One concern had been what appeared to be an overt prejudice on the part of SRS against hospital discharge planners, indicated in Secretary Whiteman's letter to Kansas Legislators on January 10, 1994. It is clear that SRS neither understands the discharge planning process that occurs in hospitals, nor trusts information supplied by their organization. She noted that despite the apparent opinions of SRS, to the contrary, they believe their goals and interests to be the same, i.e., to cut costs, provide services which keep people at home longer, be efficient in the delivery of services. She stated the preassessment program is not adequately meeting any of these objectives. She urged passage of **HB 2581.**

John Grace, President/CEO of Kansas Association of Homes for the Aging offered handout, (Attachment No.6). He stated that the Preadmission Assessment and Referral program has been in effect for over a year and has not met goals originally established, i.e., to assist individuals in assessing their health care needs; to provide information about community services; to gather data on the needs for and the creation of community based services. He stated those people he represents, are asking the Committee to re-examine what is currently occurring in communities across the state. Rather than trying to impose a mandated program operated out of Topeka that requires over $2 million a year in state and federal funds, we encourage Committee members to utilize and strengthen existing programs and services in the local communities. He drew attention to the Minnesota program, and noted their records indicate that after a 10 year ongoing prescreening program, they have decided that prescreening for nursing home admissions is occurring too late in the process. He noted Area Agencies on Aging currently are mandated by federal law to provide information to the elderly regarding services. He urged support for the repeal of the current Preadmission Assessment and referral program. His organization is asking that this ineffective government program be eliminated.

Mary Matzke, Director of Outpatient Services, Community Hospital, Onaga, Kansas offered a handout, (Attachment No.7). She stated, the assessment program is not delaying nursing home entry because the preadmission assessment occurs too late to be successful for most clients and is a duplication of efforts. There is a lack of emphasis on the information/referral component; because there is a lack of emphasis on the information/referral component; because current community long-term care services available are inadequate. She recommended repeal of current law in **HB 2581,** and a begin again approach. A good idea gone bad has been created, problems continue with poorly trained assessors, delays and lack of coordinated efforts for information and referral data continue. Funding that could be better utilized to accomplish the original intent of the bill would help. Better utilization of existing professionals, target the medicaid population to focus efforts to reduce medicaid funding or nursing home care; plan and develop funding of additional support services utilizing the information and expertise available in Kansas would all help to alleviate current problems.

Sherry Briggs, Shawnee Mission Medical Center, stated that today she is representing the Kansas Hospital Association. She offered handout (Attachment No.8). Their organization is very committed to working with the staff of SRS, Area Agencies on Aging, and community agencies available to patients. Firstly, they want patients to receive what they need. She outlined the procedure of what it takes to place a patient from a hospital setting to a nursing home setting. She drew attention to the Missouri program, gave background information on that program and noted it works very well. The Missouri screening program is not restrictive, not duplicative, and is working well, she stated.

John Kiefhaber, Executive Vice President, Kansas Health Care Association offered testimony, (Attachment No.9). He stated Kansas Legislators were told if they reduced the number of admissions to nursing homes, and diverted those individuals to community based long term care services, the Medicaid program could save millions of dollars. The reality of this has been demonstrated clearly over the past year, substantial numbers of patients will not be diverted from nursing homes. He drew attention to Attachment No.9, i.e., documentation from federal government studies, (Review of Community Care Program Myths). He stated home and community care programs should be recognized for that it is---an addition of new services and benefits for people who have a choice to use them, and an increase in Medicaid program costs. He urged favorable passage of **HB 2581.**

Tom Bell, Kansas Hospital Association, drew attention to a letter to SRS from the Kansas Hospital Association, (see Attachment 10, in reply to a memo from Secretary Whiteman to Kansas legislators. He stated, it was said that the Kansas Hospital Association, "has fought against implementation of assessment and referral for years". Mr. Bell stated, this is not the case since Kansas Hospital Association did not testify either way on **SB 182**, largely because many of the people in the hospitals said the goals of the bill were laudable. It has been only after talking with those people, many of whom have testified today, that the Hospital Association decided to support **HB 2581.** He stated, hospitals do at times react to new laws, however, their Association has never received so many calls regarding an issue as with the preassessment screening program. This too, was instrumental in their Association taking the position to support **HB 2581.** When talking to hospital people, they hear over and over, "we are not opposed to the current program and the best way to deal with it is to start over and redesign it.

Committee members asked numerous questions of conferees. There was a lengthy discussion regarding diversion or denial of patients during the preassessment process. It was noted, a private pay individual has every right to choose a nursing home facility if they wish to do so, regardless of any screening process. Some facilities have been given instructions contrary to this option. It was determined, a real problem does exist in the instruction of persons involved in the screening process and admissions to nursing home care facilities. Lengthy discussion regarding the reimbursement costs to hospitals for the discharge planning, assessment and referral procedures. Discussion was held regarding, perhaps a more basic or simple form could be used by hospitals for this program, therefore cutting down on time on the part of the hospitals to prepare the necessary data.

Mr. Ed Finley, Johnson City, Kansas answered questions from the prospective of a small rural hospital.

Rep. Swall offered a handout, (Attachment No. 11), testimony concerning preadmission assessment and referral prepared by Rosemary Chapin, KU School of Social Welfare. Ms. Chapin, he noted has comprehensive knowledge of what is going on around the country regarding long term care.

Chair adjourned the meeting at 2:55 p.m.

The next meeting is scheduled for January 20, 1994.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Jan 19, 1994

NAME	ORGANIZATION	ADDRESS
Tom Bell	KHA	
Donna Whiteman	SRS	6th Floor Docking
Sheryl Buggs	SMMC/SSWAHC	
Jane Ford	KHAssoc	Topeka
Annette Siebert	KAHA	Topeka
[illegible]	Topeka, atty. Gen. Small	
Doug Johnston	Planned Parenthood	Wichita

Aldersgate Village

7220 SW Asbury Drive
Topeka Kansas 66614-4718
(913) 478-9440

January 17, 1993

Representative Greg A. Packer
Statehouse
300 SW 10th Ave., Room 181-W
Topeka, Kansas 66612-1504

Dear Representative Packer:

This letter is in regards to HB 2581. I urge you to support this Bill and talk with members of the House Public Health and Welfare Committee before January 19, when it comes up for Hearing.

Aldersgate Village is a full continuum of care retirement community providing services to over 300 older adults. Our 60-bed Medicaid Certified Nursing Facility has a reputation of providing high quality rehabilitation care. The number of resident admissions and discharges average 1 to 2 per week.

The Kansas Nursing Facility Assessment and Referral Program, implemented October 1, 1992, by the Kansas Department of SRS, has been confusing, combursom, ineffective, and expensive. Results,diversion rate figures are likewise.

Examples of problems we have experienced include:

- Deadlines are not met by Assessors.
- Residents/Families/Facility are not notified by Bock Associates,Assessment findings within the time period required.
- Assessment results are sent to the wrong facilities.

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Attm #1.

- Residents choice of assessors are not honored by Bock Associates; in one case a male resident requested a male assessor from the list and instead a female assessor came wearing blue jeans and a punk hair-style.

Since the inception of the program, over 85 assessments have been completed on residents admitted to the Aldersgate Nursing Facility. Two (2) of these residents have been determined to be "inappropriately placed." One (1) of these residents requested admission for temporary care and was discharged after 4 days. The other resident was admitted from the hospital following hip surgery complicated by an infected or draining incision. We were told by Bock Associates, when we questioned the accuracy of this assessment, that the assessor had not completed the assessment correctly (ie. several areas were not assessed). This resulted in a finding of "inappropriate placement", and another assessment would not be done.

On October 13, 1993, I sent a letter to Bock Associates requesting assessment results on 13 residents admitted and assessed between January 28, 1993, and September 10, 1993. Neither residents nor the facility had received results. To date, we still have not received 6 of these assessments.

The examples go on and on! The adverse affect on residents receiving Medicaid Assistance, due to delays, mishandlings, and inaccurate assessments is apparent. Diversion rates cannot be accurate.

I urge you to support HB 2581 and talk with members of the House Public Health and Welfare Committee before Hearings begin on January 19.

Please contact me if I can offer further clarification.

Sincerely,

Jan Jenkins

Jan Jenkins
Administrator
478-9440

JJ/lm

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Attm #1, 2
HB 2582

KANSAS PROFESSIONAL NURSING HOME ADMINISTRATORS ASSOCIATION

3601 West 29th
Topeka, Kansas 66614
Phone: 913—273-4393

January 19, 1994

Kansas Professional Nursing Home Administrators Association (KPNHAA) wishes to go on record as supporting HB 2581.

We represent over 250 nursing homes in Kansas. As President of KPNHAA, I address the fact that the original intent of SB 182 was to divert to Home & Community Based Services and to identify non-eligible nursing home applicants. This simply has not been successful. Statistics reflecting denials tell us that a very small number have been channeled to HCBS.

Spending the vast amount that was allotted to the program leads us to believe we need to discard the badly broken instrument in favor of services for the elderly. The administration of the program has produced huge segments of opposition ranging from the private sector to the health care providers. This includes hospitals, social workers and nursing homes, as was evidenced in the interim committee hearings in October.

Our united appeal to you is to vote yes on HB 2581.

Thank you.

Betty Jo Banks
President, KPNHAA

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Attm #2

TO: The House Public Health and Welfare Committee
FROM: Rheva Victor, Administrator
Eudora Nursing Center
DATE: January 19, 1994
RE: HB 2581

Madam Chairman and members of the Committee, thank you for the opportunity to present testimony about the preadmission assessment and referral program.

I will begin by describing Eudora Nursing Center. We are a community-owned, 100 bed freestanding nursing facility. Our occupancy in 1993 averaged 96% and we admitted 36 new residents.

Of those 36 residents, 13 came from the hospital, 4 from another nursing facility and 19 from their homes. Of the 36 residents, all were assessed as needing nursing facility level of care and approved for placement. No one seeking admission to Eudora Nursing Center has been denied or diverted as a result of preadmission assessment and referral.

We support community based services and the choice of individuals to remain in their own home. In fact, in 1993, as a result of care received in our facility, 8 residents improved enough to return to their homes. We also provide information to the community about services available to assist individuals to remain in their home.

Of our admissions since July, we have experienced extreme difficulty in obtaining assessment information. It took until October 1, to receive written information on residents admitted in August. Currently, we are waiting on results from 4 assessments for our residents. For example, a long-term resident who applied for medicaid had to make a second request for a level one screening. Applications for medicaid are delayed pending assessments. It now takes an average of 60 days instead of 30 to complete the medicaid application process. In addition to causing increased family stress, it also places a monetary burden on the facility.

The decision to enter a nursing facility is very difficult for everyone involved. We are committed to providing necessary and appropriate services to those persons needing 24-hour care. Our licensed social worker and director of nursing carefully interview each potential resident and evaluate their health care needs. Our experience has been that individuals seeking placement at Eudora Nursing Center have exhausted both their family and community resources before considering placement. Adding the preadmission assessment and referral program to the placement process has added stress to families who do not understand the necessity for the assessment which delays admission and has not resulted in anyone remaining in the community.

Therefore, I ask that you vote to repeal preadmission assessment and referral and use the money spent on this program to fund necessary services.

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TESTIMONY PRESENTED TO KANSAS LEGISLATORS
January 19, 1994

RE: Preadmission Assessment and Referral Program
Senate Bill 182

I am the director of Patient Support Services at St. Francis Regional Medical Center. I also serve as a member of the Continuous Quality Improvement team that meets with SRS and Bock to discuss the activities of the preadmission assessment program. I have a master's degree in Medical Social Work and am currently working on a second master's in Health Administration. I have been in medical social work for 14 years, and have served as a director of hospital social work for 7 years. I am currently the director of a consolidated department that includes social work, discharge planning and six other patient support services.

On March 23, 1992, I spoke to the Senate Public Health Committee in favor of the adoption of preadmission assessment because I believed in the goal SRS was trying to achieve - the goal of providing more services in the community that would allow people to stay at home as long as possible rather than being placed in a nursing home. As a professional, I have personally seen the desire of patients to stay in their own homes. And as a daughter I am currently working with my brother to make it possible for my 85 year old mother in Texas to stay in her home rather than go to a nursing home. This makes me doubly aware of the need for community services.

During my earlier testimony I stated the concern that this program, if not carefully administered, could add to the overall cost of health care in Kansas by adding to the cost of hospitalization. I stressed that if we added cost to any part of the overall system, we had defeated our purpose since shifting costs in the health care system is not the answer to the crisis we are all facing.

My experience with the preadmission program during the last year, has convinced me that the program has failed to meet the stated objectives. It has added to the expense of hospitalization by adding unnecessary time to the discharge planning process and created unnecessary confusion for hospitals and patients by adding layers of bureaucracy to the system. The directors of social work in the other Wichita hospitals have also experienced major problems with the program, and I am here speaking for all of the hospitals in Wichita when I encourage you to **repeal a program that has failed in its original goal.**

Many of you are already aware of the problems that have occurred, especially in the last few months since the contract was awarded to Bock. I will only highlight a few:

1) **Data is being misrepresented in reporting diversions.**
During the original training presented by SRS when the program began, we were told to "screen anyone who was **even considering** entering a nursing home". As experienced assessors we were concerned that this included people we knew could end up going home if their condition improved. I brought this issue before the CQI team and was told by an SRS representative that they wanted everyone screened so they could collect data. It was stressed to SRS from the very beginning that these patients could not be considered as diversions since they did not fit the criteria that SRS set for diversions. Now we find that following SRS instructions has resulted in two problems:

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By following SRS directions, hospitals generated more screens than would have been necessary if we had been given different screening instructions. And to make matters worse, SRS and Bock are using those numbers of early screenings against the hospitals, with the implication that we were screening patients just to generate income when in reality, we were following SRS instructions.

SRS and Bock are using the original data erroneously by claiming that the patients (who we knew were questionable nursing home placements) were "diverted" from placement by the preadmission screening. **That is a totally false conclusion and grossly misrepresents reality.**

2) Hospitals have experienced added costs due to the handling of the preadmission assessments. It would take too much time to go into detail of the many mistakes, delays, and lack of professionalism that we have experienced in dealing with this program. But I would like to mention two major concerns of hospitals.

a) **Hospitals have been denied the approval to serve as screeners even when they have offered to work below costs thus resulting in costly delays and poor quality of services provided to patients and families.**
Hospitals have often been denied approval without adequate explanation or the opportunity to discuss or negotiate. The inablity to complete screens has complicated the discharge planning process unnecessarily. Now SRS is saying that there will be a 4.5 day wait for the completion of assessments. This delay would not be happening if hosplitals had been allowed to continue acting as assessors.

Explanations were not given as to why we were denied, nor were we given a chance to discuss the denials. Letters went unanswered, phone calls were not returned, and inquiries were dealt with in a totally unprofessional manner. Dispursions were cast unfairly on hospitals, implying that they were acting out of self interest when we tried to get the problems resolved. A recent quote from Donna Whiteman stating "Part of the reason for opposition to preadmission assessment and referral is that in order to do the job right, real work is involved." is so outlandish that it will go without comment other than to say that this one statement convinced me that we had hit an impass and the existing problems in the program would never be recognized or resolved.

b) **Patients are being denied their right to choose a screener.**
Because many of the hospital social workers have been denied approval to serve as screeners, they are unable to complete their discharge planning activities as required by Joint Commission and Medicare, and as requested by patients and families. Instead of having their choice of a social worker who has an established relationship with the patient and family, outside screeners are assigned by Bock who do not know the patient, are unfamiliar with hospitals systems, and do not have knowledge of the community services that are available for patients.

The quality of the screeners that have been sent to the hospitals is questionable. This was discussed at a recent CQI meeting and the Bock representative admitted that they had no way of screening or qualifying the people who apply to be screeners. Hospitals are held to strict quality standards and take pride in the service they deliver. Many of the screeners that have appeared in hospitals do not meet these standards.

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Hospitals as a whole were not in favor of this program when it was introduced. I was in a minority when I spoke in favor of the program, but I held to the belief that we could make the program work to the benefit of the state and the elderly population. Unfortunately I have seen that the program is a failure. It adds cost, confusion, and bureaucracy to an already overburdened health care system. We see erroneous uses of data, poor communication, and blame being shifted to others instead of correcting the existing problems.

The best interests of patients and the state are not being served. Poor quality assessments are being completed by people who are unaware of community services. The "referral" component of the program is not being fulfilled in many cases. The only good result of this program is that I have seen common interests being expressed by workers in community and state agencies. Everyone wants to see more services provided for the elderly, but this program is defeating that purpose. It is misdirecting money and creating many more problems than it is solving. SRS and Bock are not showing any admission of the exisitng problems nor are they suggesting any real solutions. It is time for us to give up on this program as a program that was not planned out thoroughly enough before beginning, has been misdirected, and is not meeting the goals of the original bill. The existing problems are so great there is no way to redeem the program. The only wise action at this time is to delete it.

On the behalf of the hospitals in Wichita, we would go on the record saying that the Preadmission Assessment and Referral Program is beyond redemption and should be repealed,

Ellen Elliston, LMSW

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1-19-94
Attm # 9
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PUBLIC TESTIMONY
HOUSE HEALTH AND WELFARE COMMITTEE
RE: HB 2581

SOCIETY FOR SOCIAL WORK ADMINISTRATORS IN HEALTH CARE
SUNFLOWER CHAPTER
Monica Flask, President
January 19, 1994

The following testimony is presented by the Sunflower Chapter of the Society for Social Work Administrators in Health Care. Our organization represents social work administrators from hospitals. home health, and hospice agencies throughout Kansas, excepting the northeast corner. We **support** HB 2581, which repeals the Kansas Preadmission and Referral program, for the following reasons:

1) We believe the program, as it is currently being implemented, to be a waste of taxpayer dollars. We have stated since the beginning of this program that it is a duplication of services already provided for 50-70% of the persons admitted to nursing homes. These persons are admitted directly from the hospital and have already been screened by a social worker or discharge planner. It is a waste of money to duplicate this process when the money could be used to increase services which keep people in their own homes.

2) The current program is a waste of time. Social workers and discharge planners are now having to spend time explaining forms, making phone calls, and faxing information to the State in a cumbersome system which is far more expensive than it needs to be to meet the goals of the State. The time of the professionals involved could be much better spent on more client contact, to disseminate information about community services. As it stands now, the time spent on the KPAR program is diverted from clients who do not have such immediate needs, but could benefit from the preventive aspects of community services.

3) The determination component of the KPAR is an intrusion on the rights and privacy of private citizens. When consumers decide on nursing home placement, it is almost always a last resort. The resident-to-be is likely to be grieving and family members often grieve and feel guilty as well. It is inappropriate to have this decision questioned, and a "determination" rendered by someone who has never met the consumer or the family. Secretary Whiteman states (Letter to Kansas Legislators dated 1/10/94) that SRS has not received a single consumer complaint. This is not surprising, because the average person doesn't complain to large government agencies. However, those of us involved in the process have heard many complaints.

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attm # 6

4) The KPAR program is an attempt to do the right things with the wrong people at the wrong times. It is too late to give information to most people at the nursing home door. By this time, the person requesting admission has already misused medication, developed a bedsore, or fractured a hip. The family is already worn out and too tired to consider giving it another try. Information and referral needs to be done earlier. It may be difficult to encourage consumers to utilize services earlier, but we do not believe it to be impossible.

Our organization continues to support the goals of the KPAR program. However, we believe the current program does not meet these goals. The diversion rates presented by SRS are highly questionable and probably cannot be supported at all. The diversion rate for hospital patients is essentially 0%.

It has been stated by SRS that the "significant problems in the first six months of the program have been resolved" (Letter to Kansas Legislators dated 1/10/94). We believe this to be absolutely untrue. Confusion continues to abound. Services are still being duplicated at an unwarranted expense and the data base is shaky at best. While modifications have been made in the assessment instrument and the process itself, the modifications are minor and do not address the essential flaws in the program design itself.

Our organization has debated whether or not to support significant redesign of the KPAR program rather than outright repeal. One of our great concerns has been what appeared to be a covert prejudice on the part of SRS against hospital discharge planners. That prejudice was made overt in Secretary Whiteman's letter to Kansas Legislators (1/10/94), where she states,

> "Part of the opposition to preadmission assessment and referral is that in order to do the job right, real work is involved. It is much easier to refer someone to nursing facility care than it is to set up a plan of care outside a nursing facility in the community. Even in communities where community-based services are abundantly available, there is more work involved in setting up community services."

It is clear that SRS neither understands the discharge planning process that occurs in hospitals, nor trusts information supplied by our organization which is in direct opposition to the above statement. We do not wish to address the "real work" issue, because that insult is ludicrous. However, we do wish to state once again, emphatically, that nursing home placement is **much** more difficult to do and more time-consuming than community referrals. Nursing home placement is often traumatic and time-consuming for hospital staff and patients/families as well. There is a significant disincentive for everyone involved. We have stressed this fact to SRS on several occasions, but it is clear they do not believe the people who do this "real work".

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It is this kind of prejudicial thinking and oppositional attitude which has created the monster that the KPAR program has become. We do not think this problem can be fixed in any reasonable length of time. It's time to cut our losses and start over with a program based on facts and current resources instead of prejudice and inefficient duplication.

Despite the apparent opinions of SRS to the contrary, we believe our goals and interests to be the same. We want to cut costs, provide services which keep people at home, and be efficient in our delivery of service. We do not wish simply to maintain the status quo - it clearly is not working. However, we do want to be a part of programs that achieve their objectives and provide real benefits for the consumers and taxpayers of Kansas. We also want to respect the rights and dignity of our consumers. The KPAR program is not adequately meeting any of these objectives. We urge you to vote for repeal of HB 2581 and work to develop programs which do address these needs.

PH&W
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Attm # 5-3
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KAHA
Kansas Association
of Homes for the Aging

40
Years of Service

"Remembering Yesterday,
Investing Today,
Creating Tomorrow"

MEMORANDUM

TO: The House Public Health and Welfare Committee
Representative Joann Flower, Chair

FROM: John R. Grace, President/CEO JRG

RE: Support of House Bill 2581

DATE: January 19, 1994

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Thank you for the opportunity to provide testimony regarding House Bill 2681, to repeal Pre-Admission Assessment and Referral.

The Kansas Association of Homes for the Aging is a trade association representing over 140 not-for-profit retirement and nursing facilities throughout Kansas.

Pre-Admission Assessment and Referral has now been in effect for over one year. The program, in our opinion, has not met the three goals that were originally established;

1. To assist individuals in assessing their health care needs;

2. To provide information about community services; and

3. To gather data on the need for and creation of community-based services.

The first goal, assisting individuals in assessing their health care needs, is built on the assumption that this is not occurring now. Hospitals are conducting extensive discharge planning through their social workers who are very familiar with services available in the community. In fact, they are required by law to evaluate the person's needs and match them with services. Persons being admitted to nursing facilities directly from the community are receiving care from a variety of sources, including both formal services and informal services from family members, neighbors and

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friends. Studies have shown that these are the people assisting with decisions about nursing facility placement.

So the assumption that an "assessment" is not occurring is incorrect. If additional advice or consultation is needed in some cases, the Area Agencies on Aging (AAA) cover every county in the state and have Case Managers for assistance in this process. If additional time is needed for these individuals, then the legislature could appropriate state funds for this function.

Keep in mind that the "assessment" of an individual at the time of admission to the facility really occurs too late in the process. This was confirmed by a study in Minnesota that states that the process of screening and referral needs to occur early, when the older person's health and social condition begin to decline.

The second item relates to providing information about community services. Once again, the AAA's are responsible and mandated by law to provide for the information and referral for older persons. If the legislature would like to increase those services, we're all in favor of it. Our facilities are providing information to older people and would be willing to provide more information as available community services increase.

Third, data is currently gathered by the Area Agencies on Aging, by the Kansas Department on Aging, and by the Kansas Health Care Data Commission, and numerous other groups. If you were to ask AAA directors, or anyone involved in community-based services such as home health agencies, hospital discharge planners, etc., they could tell you the kinds of community services that are needed.

In conclusion, we are asking the committee to reexamine what is currently occurring in communities across our state. Rather than trying to impose a statewide mandated program operated out of Topeka that requires over $2 million a year in state and federal funds, we encourage you to utilize and strengthen existing programs and services in the local communities. The real goal of all of our efforts is to support local services for the elderly and to fund those services for the people who need them.

We support HB 2581 and the repeal of the current Pre-Admission Assessment and Referral program. Thank you very much Madame Chairman and members of the committee. I'll be glad to answer any questions.

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COMMUNITY HOSPITAL, ONAGA, INC.
120 WEST EIGHTH STREET — TELEPHONE 913 889-4272
ONAGA, KANSAS 66521

January 19, 1994

Address to Legislative Hearing

Good day, My name is Mary K. Matzke, and I am Director of Outpatient Services at Community Hospital, Onaga. Community Hospital Onaga is a 30 bed rural hospital in northeast Kansas. Part of my responsibilities are to supervise the home health, hospice, and senior care act services that are provided in our health care system. I have been serving as a member of the Task force developed to address the problems with Preadmission assessment and referral. Some excellent recommendations have been made to address some of the problems. However, I support repeal of the preadmission assessment and referral program for the following reasons.

The preadmission assessment and referral program is not achieving its goals as originally intended of reducing costs and providing options for community based alternatives. Furthermore it cannot be "fixed" to be successful under its current contract. The assessment program is not delaying nursing home entry for the following reasons.

1. Preadmission assessment occurs too late to be "successful" for most clients and is a duplication of efforts already undertaken by hospital discharge planners, home health nurses, and AAA case managers.

2. There is a lack of emphasis on the information/referral component.This component is not being implemented or only partially implemented. Assessors are not local and are not knowledgeable about local services. Delays in referrals to AAA and community services can result in patients falling through cracks.

3. Most importantly, current community long term care services available are inadequate. Many are underfunded, limited or not available. As a result, even if clients are acceptable for diversion-there is a lack of resources to meet their needs. This is especially true in the rural areas.

Recommendations

1. Repeal the bill and start over. As one task member stated, "this is a good idea gone bad". Continued problems with poorly trained assessors, delays, lack of coordinated efforts for information and referrals and no data to support successful diversions justify its elimination. The funds can be better utilized to accomplish the original intent.

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2. Allocate more funding into existing community support programs such as SRS homemaker, KDOA's Senior Care, meal delivery, chore services, and housing alternatives. To provide alternatives to institutions, more community based services must be developed and available. Existing programs with waiting lists and limited funding contribute to premature entry into nursing homes.

3. Utilize the existing professionals: hospital discharge planners, AAA case managers, and SRS staff to educate the general population on alternatives to nursing home admission. Common training and use of a common assessment tool for data collection can accomplish many of the original goals of the preadmission assessment and referral program without the administrative expense and duplication.

4. In new preadmission assessment legislation, target the Medicaid population. This focuses the effort to reduce Medicaid funding of nursing home care and would be a much smaller group. This is compatible with Washington's program. SRS staff could be responsible for this population or could subcontract the service at a much lower cost than is currently being expended.

5. Actively plan for development and funding of additional support services utilizing the information and expertise available currently in Kansas. Substantial information is available from the Department on Aging, AAA case managers, SRS staff, hospital discharge planners, nursing home representatives, and consumers that will ensure the most appropriate targeting of needs and services.

I would like to conclude my remarks with this story. A man is desperately working to pull people out of the river as they float by him. Because the work is hard and the water is fast, he calls for help. A second man comes and watches the first struggle at the river bank. After a short time, the first man cries, "Aren't you going to help me? Look at all of these people floating by!" The second man states " Yes, but maybe first we should find out why that guy upstream is pushing people in!"

Nursing home pre-assessment is like pulling people out of river, for many it is too late, they are already too far down stream and only a few can be saved. Not enough support services are currently available to provide life boats or bridges across the river. Until we provide more life boats, people are going to continue to float down river or drown. To keep individuals from "falling in", early intervention and coordinated efforts are required between all providers of long term care services. As legislators, you must decide where funding is most appropriate. Is it in labor intensive and duplicative personnel to pull a few people out of the river? Or is it in designing and funding alternatives to prevent them from ever falling in the water?

Thank you.

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KANSAS HOSPITAL ASSOCIATION

Memorandum

Sherry Brigg

Donald A. Wilson
President

January 19, 1994

TO: House Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: **HB 2581--Nursing Facility Preadmission Screening Program**

The Kansas Hospital Association appreciates the opportunity to present testimony in support of HB 2581, which would repeal the current nursing facility preadmission screening program.

In testimony presented during the month of December, 1993, SRS listed the goals of the Kansas Preadmission Assessment and Referral Program (KPAR):

1. Compliance with certain federally mandated preadmission screening requirements;

2. Provision of information regarding community-based alternatives to all persons seeking admission to a nursing facility;

3. Increase access to community-based long term care services in all areas of the state;

4. Create a comprehensive data base that identifies the availability of community based services statewide;

5. Reduce Medicaid expenditures for institutional long term care services by developing and expanding community based alternatives; and

6. Reduce the number of persons in institutional care whose needs could be met in a community setting.

Everyone agrees that these are laudable goals. When SB 182 was debated during the 1992 legislative session, KHA remained neutral, largely because so many individuals working in hospitals were committed to these goals. Now, however, KHA supports repeal of the current KPAR program. The problem, as we see it, is that the current program has instituted a costly and confusing new state bureaucracy without making much progress toward meeting these important objectives.

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First, it is still unclear to us how passage of state legislation is necessary to comply with the federal law in question, especially when a number of other states apparently do so without state legislation. Second, those individuals who are involved in the hospital discharge planning process state that the KPAR provides no additional information to patients than was provided before the passage of SB 182. Third, access to community based long term care resources continues to be a problem in all parts of the state in spite of the KPAR program. Fourth, even though the KPAR program has been in place for over a year now, there is still no comprehensive data base. Fifth, anyone who examines the long term care portion of the SRS budget knows that expenditures for nursing facilities have not been reduced. Sixth, because of the lack of any reliable data, it is at best unclear whether the institution of this program has itself reduced the number of persons in nursing facilities whose needs could have been met in a community setting.

Today, the committee has heard from a number of individuals who work in hospitals and have been directly involved in the implementation of the KPAR program. Hopefully, their perspective on the various problems plaguing the program has been helpful. It is not an exaggeration to state that the KPAR program has generated more negative comments from hospitals than any health related state issue in recent memory. In general, the concerns we continue to hear from hospitals center around the following issues:

- The numbers generated by the state are confusing. For example, the 1993 annual report for the KPAR program states that the diversion rate went from 7.5% in June to 14.5% in September to 45% in December. Hospitals report to us that diversions from nursing homes are extremely rare. In fact, most hospitals that have contacted us report zero diversions.

- Even if non-institutional care is more appropriate for a given individual, often that care is not available in the community.

- Assessors that have contracted with the KPAR program often do not live in the community and are consequently not familiar with community based alternatives. In addition, those individuals are usually not familiar with hospital staff or procedures.

- The current program does not sufficiently recognize the hospital discharge planning process, which is mandated by federal law. The state has stated that this process does not make individuals aware of alternatives to institutional care and that the information obtained in discharge planning is "inconsistent." Discharge planners disagree with the state's contention that it is easier to place someone in a nursing facility than in community based services.

- Hospitals are concerned that they have been blamed with administrative problems of the program. For example, in a recent communication to legislators, SRS stated that previously "assessments were done without prior authorization, resulting in thousands of unnecessary assessments." In fact, those who initially trained assessors advised them to begin the process early even if they weren't sure the patient would end up in a nursing facility. SRS previously presented legislators with testimony from the program contractor that suggested many of the problems were because "hospitals do not wish to comply with state and federal regulations pertaining to Medicaid-certified nursing facility admissions." This testimony also suggested that

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communication problems were the fault of providers, because the program contractor was "now communicating clear and consistent information."

There are a number of alternatives to the current program. For example, at the October joint meeting of the House and Senate Public Health and Welfare committees, the Kansas Association of Homes for the Aging presented statutory options that would maintain a preadmission screening program. Recently, Rosemary Chapin of the KU School of Social Welfare outlined the Missouri program to the Senate Committee on Public Health and Welfare. Her testimony describes the Missouri program as follows:

> "The Division of Aging, which is part of the Missouri Department of Human Services, maintains a hotline to coordinate preadmission screening. Hospital discharge planners or nursing facility social workers must call this number if they have a Medicaid eligible person in need of long term care. The Division of Aging case manager is responsible for assigning a referral number to this person. They must have this number before receiving a complete preadmission screening and referral to service. A preliminary assessment of the client is done by phone. If the state case manager and the hospital discharge planner or social worker concur that the person obviously needs nursing facility placement (i.e., comatose, hip fracture), then the person receives a referral for nursing facility placement without further assessment. However, if it is likely that the applicant can be rehabilitated and ready for community based services in 60 or 90 days, the case is flagged for a post-assessment at that time. It is hoped that this method will save valuable time on cases where nursing facility placement is clearly needed and precipitate return to the community for clients who can do so."

Kansas hospitals are not opposed to the concept of preadmission assessment and referral. Such a program, if done properly, can benefit the elderly and disabled of the state. But the process must involve and integrate all entities such as consumers, communities, providers and advocates. To date, the current KPAR program has been anything but unifying. We are opposed to its continued implementation and urge the Legislature to repeal it and consider other options.

Thank you for your consideration of our comments.

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TESTIMONY

before the

HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

by

John L. Kiefhaber, Exec. Vice President

KANSAS HEALTH CARE ASSOCIATION

House Bill 2581

"AN ACT ... relating to assessment and referral services prior to admission..."

Chairperson Flower and members of the Committee:

The Kansas Health Care Association, representing over 200 professional nursing facilities throughout the State, appreciates the opportunity to speak in support of passage of House Bill 2581. We feel the bill as drafted is a quick and simple solution to an ongoing and complicated problem -- namely the institution of the Kansas Preadmission Screening and Referral Program one year ago.

As we testified to at recent hearings of the interim Joint Committee on Public Health and Welfare, the program was begun under the belief that nursing facilities have been providing care to many persons who could be cared for in their homes or communities -- at a lesser cost to the Medicaid program. Kansas legislators were told that if they reduced the number of admissions to nursing homes -- and diverted those individuals to community-based long term care services -- that the Medicaid program could save millions of dollars each year. The reality is that this program, as has been demonstrated clearly over the past

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12 months, will not divert substantial numbers of patients from Kansas nursing homes.

The reasons for this fact are illustrated for you in the attachment pages to my testimony today. These pages are a completely new write-up, with documentation from federal government studies and other academic sources, explaining why the Kansas Preadmission Screening and Referral Program cannot do what SRS wishes it could.

(REVIEW OF COMMUNITY CARE PROGRAM MYTHS)

The Kansas Health Care Association has no objections to home and community based services being developed for people who do not need nursing home care -- many of our members offer those services now. But we do object to a State program that promises to redirect program funds from the thousands of elderly, infirm Kansans who need 24-hour per day nursing care to another group of people who can live in their homes with some assistance. As we have seen today, these are two completely different groups of people. Home and community based services should be recognized for what it is -- an addition of new services and benefits for people who have a choice to use them -- and an increase in Medicaid program costs.

The Kansas Health Care Association recommends that House Bill 2581 be passed out of this Committee favorably.

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KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

Tom Bell

January 17, 1994

The Honorable Donna Whiteman
Secretary
Kansas Dept. of Social & Rehabilitation Services
915 S.W. Harrison
Topeka, KS 66612

Dear Secretary Whiteman:

I was disappointed when I received a copy of your January 10 memo to Kansas legislators concerning the "KHA attack"on the preadmission assessment and referral screening program (KPAR). We certainly respect your right to your opinion regarding this program and we understand your arguments in favor of continuing the present course of the program's administration. We are, however, concerned about several of the allegations and statements made in this memo. Since these statements were made to all Kansas legislators, we think it is important to make you aware of our specific concerns.

First, you stated that KHA "has fought against implementation of assessment and referral for years." During the debate and discussion surrounding the passage of Senate Bill 182, KHA remained neutral, largely because of our members' commitment to the goals that were the basis for most legislators' support of the legislation. I do not recall anyone representing KHA testifying on SB 182. As a matter of fact, I do recall that a representative of one of our member hospitals testified in general support of the legislation, again because the goals of the bill were laudable. Given the many problems with this program, I am confident that person is no longer very supportive of the law. The fact remains, however, that your assertion KHA has fought against the implementation of preadmission screening "for years" is simply not the case.

Next, you state that our support for repealing the current program is "irresponsible." Again, we disagree. In my opinion, hospitals have been very patient concerning the implementation of this program. As you may recall, we met several times with your previous contractor regarding difficulties that had arisen. We also wrote to SRS in July, August, October and November concerning the growing concerns hospitals had with the situation. We have attended various meetings of the continuous quality improvement committee for the program, and we met with SRS staff in October. At the time the combined public health committees

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met in October to consider the issue, we had some hope that the many difficulties could be resolved. In fact, SRS staff indicated they wished to continue meeting with us. Unfortunately, no further invitations were offered. You did, however, form a task force to examine these issues. This task force did not meet until December, giving it roughly one month to come up with solutions to problems that had festered for almost a year. In addition, it was made clear to our staff that SRS was not interested in KHA staff being involved in the task force. It was not until this time that KHA finally made the difficult decision that the current program should be abandoned and policymakers should go back to the drawing board. I am sorry you have chosen to call our actions irresponsible, but I can assure you that they were undertaken only after much thought and discussion.

You have also told legislators in your memo that supporting repeal of the current program would "negate any chance this state has to provide needed services to the elderly." We would argue, as I'm sure would others, that the current program has itself caused such results.

Just the hassle that has been created in delaying discharges from hospitals to nursing facilities has hindered some services. In addition, funds used to administer this program could have been better spent in developing some of the much needed services everyone agrees should be offered.

You stated the administrative problems that did arise were "primarily the result of implementing a complex program involving all facets of the medical community in Kansas--some of them in opposition to the program--in a very limited time frame." We agree that the program involves all facets of the medical community in Kansas. That is all the more reason that every facet of the medical community in Kansas should have been involved in developing the program. We don't necessarily agree there was a short time frame. The Kansas Legislature passed SB 182 in 1992, to become effective in January of 1993. Your department was given eight months to begin preparation for implementation. The fact that a new contractor chosen after six months implemented major changes in the program does not mean the time frame to begin the program was inadequate. We also feel that the "administrative problems" you chose to outline did not tell legislators the whole story. You focused on problems that your agency has in the past blamed on hospitals instead of mentioning any of the numerous other problems plaguing the program that might focus on your agency or Bock Associates.

Your memo states that prior to the KPAR program, the hospital discharge planning process was "inconsistent", implying that the program has improved discharge planning. I think most hospitals in the state would strongly disagree. As you know, discharge planning is specifically mandated by federal law and the state of Kansas surveys hospitals to determine compliance with this law. You need only consider the many examples of discharge delays and confusion because of the KPAR program to conclude that it has done nothing to assist the discharge planning process.

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When you told legislators that part of the reason for opposition to the program was that "in order to do the job right, real work is involved," you implied that hospitals are not willing to do the "real work" necessary to make a program successful. I think this was an especially unfortunate comment. I had hoped your agency was aware of the "real work" hospitals were doing in Kansas. From organizing airlifts of medical supplies to desperate people in the former Soviet Union, to treating thousands of Medicaid beneficiaries at reimbursement levels far below the cost of the care, to helping SRS implement prenatal care programs...the list of "real work" done by hospitals goes on.

The problem, as we see it, is that this program is simply not working. Contrary to your assertion, legislative intent is not being followed and the goals upon which everyone agrees are not being met. This is the primary reason we think the current program should be repealed. It is time to admit that the efforts to this point have been a failure, and time to begin again with a truly cooperative attempt involving all those affected. We think memos such as the one you wrote to Kansas legislators stand in the way of such an attempt, but we reiterate our willingness to be involved in such a process.

Sincerely,

Donald A. Wilson

Donald A. Wilson
President

cc: Sen. Sandy Praeger
Rep. Joann Flower

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BACKGROUND

ahca

American Health Care Association

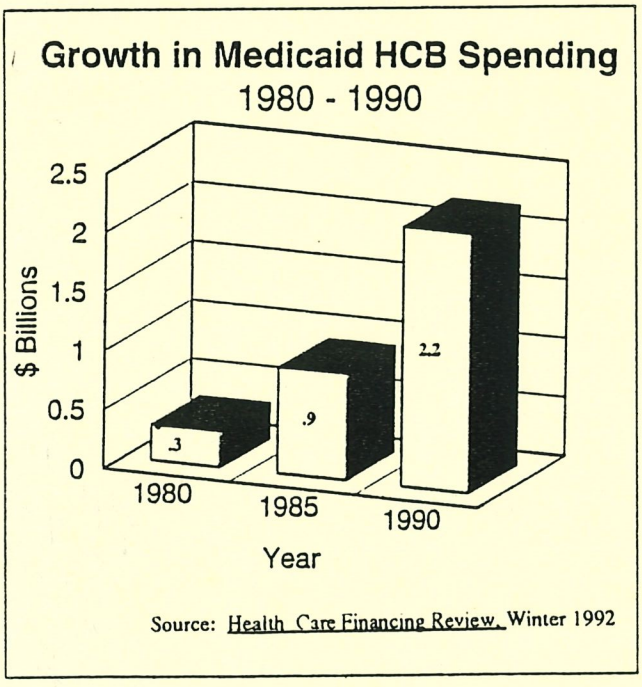
Contact: Claudia Askew
202/898-2855

HOME CARE & NURSING HOME CARE: SERVING SEPARATE POPULATIONS

As the 76 million Americans born during the Baby Boom years grow older, the search for attractive alternatives to nursing home care gains intensity. Over the years, home and community-based care (HCB) programs have become increasingly popular with lawmakers, the media, and the public.

Government spending reflects this widespread longing for HCB care. From 1980 to 1990, Medicaid spending on HCB programs increased from $300 million to $2.2 billion, according to the Health Care Financing Administration (HCFA). Today, all states offer HCB programs; the District of Columbia does not.

Supporters justify the need for HCB care by asserting that it is a cost-efficient *alternative* to nursing homes. While public sentiment for HCB care is high, three myths about nursing facilities and the people who live in them perpetuate the misperception that HCB care is a cost-effective substitute for nursing home care.



Source: Health Care Financing Review, Winter 1992

MYTH #1: Home And Community-Based Care Will Reduce The Total Cost Of Long Term Care.

Several studies that explore whether HCB care can be a viable and cost-effective substitute for nursing home care reveal that HCB care actually *increases* the total costs of long term care.

HCB care is a "new service directed at a new population," explains William Weissert, director of the Program on Aging at the University of North Carolina. (1) Consequently, communities that offer HCB programs spend more resources on long term care than do communities without HCB services.

Over the years, study after study has proven that HCB care does not reduce the costs of nursing home care:

***Institute for Health Policy (1993):** "Increased financing for HCB services may be desirable but will not significantly influence nursing home expenditures. The underlying assumption is that the delivery system is correct, but funding is inadequate. ...We must seek to justify HCB on grounds other than cost effectiveness or clinical efficacy: the debate should focus on how much community care we are willing to purchase as a society, rather than how much money we can save by purchasing these services." (2)

***The Brookings Review (1990):** "Given the choice between nursing home care and nothing, many elderly people will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset small reductions in nursing home use." (3)

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SOURCES:

(1) Weissert, William. "Seven Reasons Why It Is So Difficult To Make Community Based Long Term Care Effective." Health Services Research October 1985; 20:4.

(2) Hallfors, Diane Dion. Center for Vulnerable Populations, Institute for Health Policy, Brandeis University. "State Policy Issues in Long-Term Care for Frail Elders." March 30, 1993; 8.

(3) Wiener, Joshua M. and Katherine M. Harris. "Myths and Realities: Why Most of What Everybody Knows About Long-Term Care is Wrong." The Brookings Review Fall 1990; 32.

(4) Wooldridge, Judith and Jennifer Schore. "The Evaluation of National Long Term Care Demonstration: 7. The Effect of Channeling on the Use of Nursing Homes, Hospitals, and Other Medical Services." Health Services Research April 1988; 23(1):130.

(5) Ibid.,141.

(6) "Medicaid: Determining the Costs...,18.

(7) United States Deparment of Commerce, Bureau of the Census.

(8) Lewin/ICF estimates based on data from the 1985 National Nursing Home Survey, and the Brookings/ ICF Long Term Care Financing Model.

(9) Leon, J. and T. Lair. "Functional Status of the Non-Institutionalized Elderly: Estimates of ADL and IADL Difficulties." DHHS Publication No. (PHS)90-3462 (June 1990). National Medical Expenditures Survey Research Findings 4, Agency for Health Care Policy and Research, Rockville, MD. Public Health Service.

(10) Vladeck, BC. "Long-Term Care for the Elderly: The Future of Nursing Homes." Western Journal of Medicine February 1989; 150:215-220.

(11) United States General Accounting Office. "Medicaid: Determining the Cost-Effectiveness of Home and Community-Based Services." April 1987; 3.

(12) United States General Accounting Office. "The Elderly Should Benefit From Expanded Home Health Care But Increasing Those Services Will Not Insure Cost Reductions." December 7, 1982; 43.

(13) "New York Officials Sound Alarm Over Burgeoning Home Care Bill." Reimbursement Bulletin February 16, 1993; 5 (17): 6.

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MYTH #3: Home And Community-Based Care Will Reduce Nursing Home Utilization.

The services offered in nursing homes and the services provided by HCB care simply cannot be compared. Study after study — spanning more than a decade — has shown that substituting HCB care for nursing home care is unrealistic because separate populations utilize each service.

Consider the following:

* **General Accounting Office, 1987:** "HCFA now assumes that all those receiving home and community-based care otherwise would use nursing homes ... HHS funded research and demonstration projects do not support this assumption. Many people who have participated in community care demonstration projects would not have entered a nursing home had the community-based care been unavailable." (11)

* **General Accounting Office, 1982:** "When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care." (12)

CONCLUSION:

More than a decade of government studies, pilot projects, and demonstration programs have exposed the fallacy of assumptions that: a) HCB care will reduce the total cost of long term care; b) nursing home residents generally can care for themselves with minimal assistance; and, c) HCB care will reduce nursing home utilization.

It is a time-tested fact that HCB care *does not* reduce the cost of long term care; it actually increases the amount spent on those services. It is a time-tested fact that nursing home residents generally cannot live on their own. It is a time-tested fact that HCB care and nursing homes serve different populations.

The myths about the intersection of HCB care and nursing homes persist because the public has expressed a strong and understandable desire to receive care in the most comfortable and familiar setting possible.

But that sentiment cannot mask the reality. Many jurisdictions are beginning to confront the myths used to justify HCB care. Witness, as reported in the Reimbursement Bulletin, the recent problems in New York, which consumes a full 63 percent of all Medicaid dollars spent on home care:

"Panicked by forecasted increases in the elderly population, New York wants to scale back on home care — the fastest growing item on the state's $13.9 billion Medicaid tab. The New York Department of Social Services reports that annual costs for home care have doubled in the past four years to $2.4 billion. While Medicaid officials still see home care as cost-effective, they are also admitting that it can be more expensive than nursing facility care in some cases. This is especially true when it is used as a primary care service rather than a supportive service." (13)

The American Health Care Association (AHCA) believes that while the need for nursing home services will grow, HCB programs are a vital part of what long term care can offer.

Appropriate care in the appropriate setting is in the common interest of all providers — providers of HCB care and providers of nursing home care — as well as of those needing long term care.

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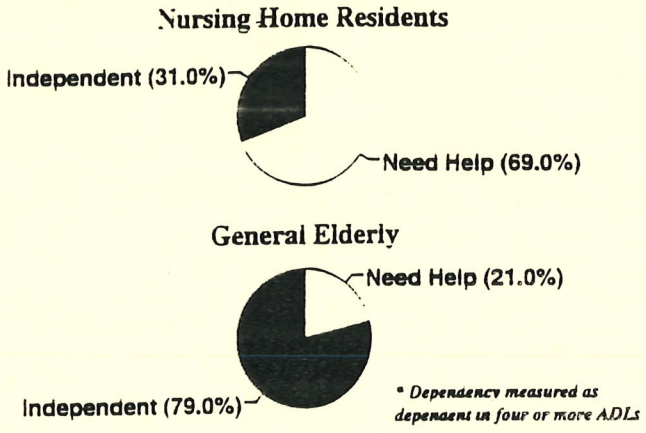
***Health Services Research (1988):** "The overall conclusion that the demonstration services led to increases in average costs is quite certain." (4)

***Health Services Research (1988):** "The increased cost of case management and expanded community services exceeded the cost savings from reduced nursing home costs." This study concluded that overall long term care costs associated with adding a HCB care benefit increased between 6 and 18 percent. (5)

***General Accounting Office (1987):** "For the majority of...clients receiving home and community-based services under the project, these services represented added costs for a new Medicaid benefit rather than a cost-effective substitute for nursing home care." (6)

ADL Dependency* in Nursing Home Residents and General Elderly



Source: National Medical Expenditures Survey

Myth #2: Nursing Home Residents Generally Can Care For Themselves With Minimal Assistance.

Most of the public erroneously assumes that nursing homes provide custodial care for older, generally ambulatory people. But the typical nursing home resident is older and needier than a decade ago.

According to the U.S. Census Bureau, 22 percent of Americans aged 85 and older live in nursing facilities. In 1960, only 5.6 percent of Americans were 85 and older. That figure skyrocketed to 10.3 percent in 1990. (7)

Octogenarians, of course, suffer more chronic and serious medical problems than the "young" elderly. But no matter how old, a typical nursing facility resident simply is unable to live independently — even with daily visits from a health care professional.

A full 69 percent of nursing facility residents age 65 and older need help with four or more activities of daily living (ADLs), which include transferring, toileting, feeding, bathing and dressing, and mobility. (8) This compares to only 21 percent of the general elderly population. (9)

Nursing facilities, no longer the custodians of yesterday, have adjusted to meet this demand for complex medical services.

More and more nursing homes — already equipped to handle serious medical needs that cannot be accommodated in a home setting — are beginning to specialize. They are offering, for example, special AIDS, Alzheimer's, and rehabilitation units.

Nursing facilities also are moving rapidly into the "subacute" market, providing services for people who need skilled care, but do not require the expensive, acute-care services of a hospital. Examples of subacute services include intravenous therapy, complex wound management, and rehabilitation for orthopedic stroke patients.

Bruce Vladek, head of HCFA, has recognized the importance of nursing facility care to the elderly American.

Vladeck wrote in a 1989 article: "... there is little question that in most communities, most nursing home residents are pretty ill and pretty disabled. Almost all have multiple, serious medical problems; perhaps as many as half have significant cognitive impairments. "Continuing growth in the number of impaired elderly persons necessitates a continued reliance on nursing homes to care for at least those who are most impaired or most lacking in other supports..." (10)

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TESTIMONY CONCERNING

PRE-ADMISSION ASSESSMENT AND REFERRAL

Introduction

Thank you for the opportunity to talk with you about preadmission assessment and referral. I believe this is an important component of the state's effort to create a long term care system that is both cost effective and offers consumers real options for receiving necessary care outside of institutions. In survey after survey the majority of consumers have indicated they want to receive community based long term care services. Yet, the state continues to devote the vast majority of its resources to institutional care.

First, I would like to talk about what policy analysts at the national level have had to say about how states can build effective long term care systems. Time and time again, pre-admission assessment is pointed to as one of the essential components in building an effective system. Second, I would like to speak briefly about other state's experience with pre-admission assessment. Since I was asked to do this presentation only two days ago, this component is limited to the states that I am already familiar with and is not intended to be comprehensive but rather to convey the experiences of these states. Third, I want to talk with you about the importance of pre-admission assessment and referral in the Kansas long term care system. I will also suggest some changes and additional components that I believe are crucial to the development of an effective long term care system in Kansas.

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Pre-Admission Assessment as an Integral Component of an Effective Long Term Care System

State long term care reform has been the subject of a number of studies during the last half of the 1980s and early 1990s (Justice, 1988; Pendleton, Capitman, Leutz, & Omata, 1990). Public sector responsibility for long term care system development has belonged primarily to the states. Although federal financing via the Medicaid Program has been a major source of funding, the states administer and share in the funding of Medicaid. The Medicaid program has been the predominant source of third party long term care funding. It is the states that shape the strategy for these expenditures. Therefore, analysis of state's attempts to reform their long term care systems, especially initiatives to develop statewide community care systems, can provide information to state policymakers attempting to develop new community based strategies for their state.

One of the most comprehensive studies done was that of Capitman, et. al. This study explored the level of development of the public service delivery systems for long term care for the aged for all states. The condition of current states' systems was reviewed in terms of infrastructure for implementation of an expanded and integrated national program. The eight components thought to be necessary for optimal management of high-quality, comprehensive, cost-effective, community-oriented long term care delivery were identified. They included a single service entry point, pre-admission screening; comprehensive assessment, planning and case management, as well as components designed to increase the supply of community based services.

Few states were found to have coordinated components in place to implement an integrated national program. No state had all of the necessary components. However, a number have five or more components (Connecticut, Illinois, Maryland, Minnesota, and Washington). Beyond the barrier to effective system development that lack of these components creates for the individual states, this situation also poses a difficult challenge to the initiation of an expanded and coordinated national program. A number of other

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studies also point to the importance of pre-admission screening or assessment as a cornerstone of an effective long term care system.

To summarize the major points of this first segment of my presentation, national policy analysts have indicated time and again that an effective pre-admission assessment screening program is crucial to the development of a comprehensive cost-effective long term care system. However, it can not stand alone and must be linked to other components.

Why do policy analysts indicate pre-admission assessment is critical? Historically, major reasons that states have implemented nursing home preadmission screening/ assessments are: 1) to insure that persons admitted to nursing homes have needs consistent with the level of care provided in such facilities; and 2) to control access to institutional care and, consequently, public costs associated with funding nursing home care (Polich & Iversen, 1987). States have coupled pre-admission assessment with case mix reimbursement and moratoriums on bed expansions to insure a nursing home population with needs commensurate with that level of care.

Another increasingly important function of pre-admission assessment is the use of the assessment to determine eligibility for various home and community based services and to create the link that people need to access those services. In states where pre-admission assessment/screening has been successful, this linkage function has been a major focus. I now want to discuss, in more depth, the experience of other states in the area of pre-admission assessment. In particular, I will discuss Minnesota and Missouri's experience. I also will discuss findings from Connecticut, Virginia, and South Carolina.

Pre-Admission Assessment/Screening in Other States

Faced with rising long term care costs and an institutionalization rate that was among the highest in the nation, in 1983, Minnesota began implementation of a number of steps designed to slow the growth of institutional care (Polich, 1988). These included: pre-admission screening of all applicants to nursing facilities, increased funding for services for people screened who are eligible for Medicaid or would be eligible within 180 days due to

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spend down; a moratorium on new nursing home beds, and case mix reimbursement to improve access for heavy care clients and to reduce the incentive to admit light case clients.

Public case managers, (government employees, who are usually nurses or social workers) do the bulk of the assessments. At various times, hospital discharge planners have also done part of the assessments. These public case managers are integrally involved in getting needed services for the people who choose community based services. The initial screeners may also be the people who do ongoing case management. In any case, the emphasis is not on simply assessing the client and making a referral. The emphasis is on the assessment as a vehicle or doorway to link people to community based services. Studies of the Minnesota system have pointed to the importance of connecting people to services earlier, before they get to the crisis point that often accompanies an application to the nursing home. However, this research is certainly not viewed as evidence that pre-admission screening should be repealed. In conversations with the state officials who crafted the Minnesota system, I asked if they had considered repealing pre-admission screening. The answer was a resounding "No." The point of studying the system was to figure out how to make it more effective.

Missouri also has been recently working on the development of their pre-admission screening program. Missouri's current initiative to develop community based long term care, called Missouri's Care Options, received its impetus from a two year planning effort funded by the Administration on Aging. In Missouri, the total number of Medicaid-funded nursing home days increased precipitously in the 1990-1991 time period. The increase was well above the national average. At that time policy makers were considering abolishing pre-admission screening. Instead of abolishing it, they redesigned it.

The planning initiative, begun in the Fall of 1990, was a collaborative effort between the Missouri Division of Aging, the University of Missouri, and the Missouri Alliance for Area Agencies on Aging. The initiative was organized to address the following problems: "(1) to reduce the institutional bias of state policy and to enhance the ability of the elderly

to remain in less restrictive care settings; (2) to stimulate the statewide development of the full continuum of L.T.C. services to meet unmet needs; (3) to improve the coordination of care provided by the variety of service providers and programs; and (4) to ensure that all L.T.C. services in Missouri provide an adequate quality of care and life in order to protect the health and well-being of Missouri seniors" (Walker and Snyder, 1992).

Regional planning committees provided information to a state planning committee and statewide policy recommendations were developed. A legislative package based on these recommendation was passed in the Spring of 1992 and the initiative called the Missouri Care Options, was implemented in January of 1993. Missouri's initiative outlines how a state with a state administered system of service is implementing community based long term care reform.

The 1992 Missouri legislature passed the Missouri Care Options package of community based long term care reforms. As in Minnesota, elderly Missourians had identified lack of access to community based long term care as a major area in need of reform. The Missouri reform initiative focused on improvement of the pre-admission screening/case management process for Medicaid eligible applicants to nursing facilities and for home and community services paid through Medicaid. However, Missouri opted for a centralized approach. The Division of Aging, which is part of the Missouri Department of Human Services, maintains a hotline to coordinate pre-admission screening. Hospital discharge planners or nursing facility social workers must call this number if they have a Medicaid eligible person in need of long term care. The Division of Aging case manager is responsible for assigning a referral number to this person. They must have this number before receiving a complete pre-admission screening and referral to service. A preliminary assessment of the client is done by phone. If the state case manager and the hospital discharge planner or social worker concur that the person obviously needs nursing facility placement (i.e., comatose, hip fracture) then the person receives a referral for nursing facility placement without further assessment. However, if it is likely that the applicant

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can be rehabilitated and ready for community based services in 60 or 90 days, the case is flagged for a post-assessment at that time. It is hoped that this method will save valuable time on cases where nursing facility placement is clearly needed and precipitate return to the community for clients who can do so.

The Care Options Program attempts to equalize access to home-based services for all patients who need less intensive care and supervision. State funded clients are required to have at least a preliminary screen by the Division on Aging. Coordination of hospital discharge for the elderly begins soon after hospital admission. Local Division of Aging staff are to contact the planner within one working day to schedule a face-to-face assessment of the patient which includes family members if appropriate. This same plan of action is used for elderly who transfer from acute care beds to hospital based extended care beds (but not from acute care beds to "swing" beds).

The assessment serves as the basis for arrangement of home care services based on client choice. Arrangements are made by hospital staff with the assistance of Division of Aging staff. State payment for care is activated by the referral number and screening date whether the agreed upon plan is community or facility based.

Although many hotline referrals occur through the formal inquiry process, they may also be made directly to the Division of Aging hotline by family members, friends, in-home service providers or other community members. The client makes the final decision regarding where the care will be received.

Nursing facility post-admission screening may be initiated in a number of ways. Rehabilitative placements and facility residents with low minimum data set (MDS) point counts will be flagged for reassessment. (THE MDS is an assessment instrument that is completed by nursing facility staff for submission to the Division on Aging.) A volunteer ombudsman is to be used in the post-admission screening process as a source of family support and in providing background information.

The initiative includes additional staff for pre-long-term care screening and subsequent case management, and additional staff for post-admission screening of persons in skilled nursing facilities to identify those who are able and want to transition back to the community. The reimbursement playing field is also leveled by extending retroactive reimbursement for eligible clients to in-home service providers. The legislature has instructed the Division of Aging to perform a "gatekeeping" function for access to state-funded long-term care, to assure that alternative options are explored. The nursing home diversion plan is an attempt to insure that people are aware of all care options available to them so that they can receive care in the most appropriate setting, rather than an attempt to prevent nursing home entrance. A key to the success of this new concept is that community based services are available and as easily accessed as nursing home placement. State staff have reported that the program has been successful in its first year of operation. Substantial cost avoidance has been achieved for the 600 applicants for whom nursing home entrance has been delayed. More importantly funds have been redirected so that more people can be served with available resources.

Evaluations of pre-admission screening assessment programs in Virginia, Connecticut, and South Carolina also supported the importance of continuing these efforts. However, I must stress, and all the literature stresses, that pre-admission is but one of the essential components of the infrastructure a state needs to develop an effective long term system. Other components are also essential if pre-admission assessment is to be effective. This brings me to my next topic, which focuses more specifically on Kansas.

Pre-Admission Assessment and Referral in the Kansas Long Term Care Systems

When I report findings from the literature on other state's pre-admission and referral program, it sounds as though the process has been a smooth one in other states. However, I have talked with people involved in the development of the programs in Minnesota and Missouri and they have told me that, as in Kansas, the road has been bumpy. The implementation process has had to be reworked from time to time.

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I am solidly in support of mandatory pre-admission assessment in Kansas. I would prefer a strong role for the public case manager. I think it is essential to use pre-admission assessment as a vehicle to actively link people, often in crises, to the necessary community based services as quickly as possible, and not to just refer them. This brings me to two additional essential components that must be strengthened if our community-based system is to be effective. We must have more public case managers to help people access services, and we must develop more informal and formal community-based services. One component, no matter how essential, can not stand alone and be successful. Remember, the state receives federal matching funds to do pre-admission assessments. It only makes sense to use the assessment contact, paid for in part with federal dollars, as effectively as possible. There are multiple functions that can be accomplished during that contact. One is to meet the federal mandate for screening and draw down federal funds. Another equally important function is to create an effective doorway to community based services for those who choose them.

Instead of considering repealing pre-admission assessment, a component of long term care identified time and again in the literature as critical, I urge building upon that process. Targeting of resources is crucial if we are to build a long term care system that is effective and that we can afford. Pre-admission assessment is a vehicle for targeting services. However, we also need to put other essential components in place so that Kansas can build a cost effective system that provides consumer choice.

I have attached some charts in the Appendix that show the projected growth in the 85+ population by 1995. In Kansas, this population is expected to increase by 51% between 1990 and 1995. This is the population most likely to need long term care. The state needs to work diligently to direct those people for whom community based services would clearly be more cost effective, and who would prefer it, into community based services. If we do not, state long term care costs will most certainly escalate even more sharply than they already have. Kansas most certainly can not wait for national long term care reform. We

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rank fifth in the nation in the percentage of our population 85 and over. Yet Kansas has not put in place the necessary infrastructure to build an effective long term care system or to implement national long term care reform should it come. I urge you to give long term care your careful consideration and to continue your efforts to develop a humane, and cost effective system.

Thank you.

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- Population projections from State of Kansas Division of the Budget based on 1990 census information indicate that population groups 65+ will increase substantially between 1990 and 1995. Table 1 illustrates the projected number and percent of increase for persons aged 65 and over in three age groups.

Figure 1

Projections for
Percent of Increase for Older Adults Kansans
Between 1990 and 1995*

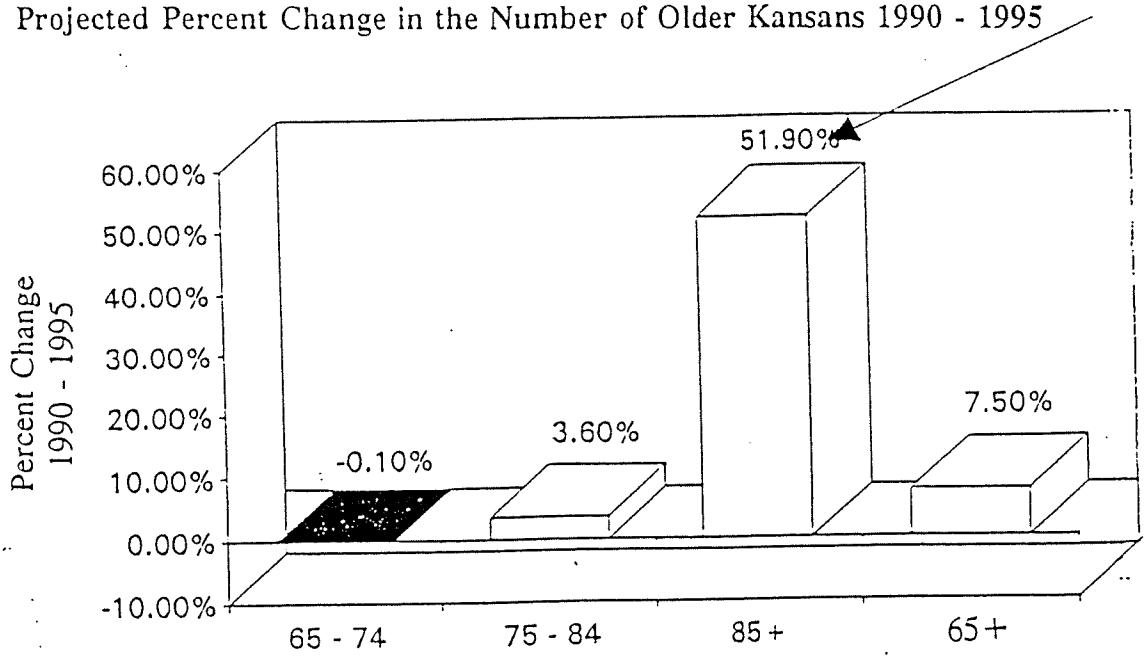
Age Group	Increase Number Between 1990 and 1995	Percent of Increase Between 1990 and 1995
65 - 74	-191	-0.1%
75 - 84	4,204	3.6%
85+	21,723	51.9%
Total	25,736	7.5%

* See Chart 1 for graphic illustration.

Source: Population projections from the State of Kansas Division of the Budget based on 1990 Census.

Chart 1

Projected Percent Change in the Number of Older Kansans 1990 - 1995



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