Approved: Jan 21, 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 20, 1994 in Room 423-S of the Capitol.

All members were present except:
Rep. Tom Bishop, absent
Rep. Forrest Swall, excused

Committee staff present: Emalene Correll, Legislative Research Department
William Wolff, Legislative Research Department
Sue Hill, committee Secretary

Conferees appearing before the committee:
Sandra Strand, Legislative Coordinator, Kansans for Improvement of Nursing Homes
Joseph Kroll, Director, Bureau of Adult/Child Care, Department of Health and Environment
Marilyn Bradt, Council on Aging
Rosie Williams, President, Caring Connections, Inc.
Terri Roberts, Executive Director, Kansas State Nurses Association
Debbie Bird, Bock Associates
Diane Garner, Professor and Chair, Department of Social Work, Washburn University
Julie Walter, Executive Director, Clinton Hills, Area Agency on Aging, Manhattan, Kansas
Secretary Joanne Hurst, Department on Aging
Secretary Donna Whiteman, Department of SRS
Irene Hart, Area Agency on Aging, Wichita, Kansas (written only)
Patricia Kissick, Administrator, Mt. Hope Community Development, Inc. (written only)

Others appearing, see attached list.

The chair called the meeting to order stating if members wish to know who the prescreening assessors are in their District, there is a copy of the list, County by County, in the office of the Committee Chair. Ask Sue Hill if you wish to see the list.

Chair drew attention to Committee minutes for 1/18/1994, and stated if there are corrections call the secretary by 5:00 p.m. on 1/21/94, otherwise the minutes will be considered approved as written.

Chair requested those people giving testimony today please limit their remarks to 4 minutes in length since there are a number of conferees. It is important to leave time at the end of testimony, she noted, to allow time for questions by members and staff.

OPPONENTS TESTIMONY ON HB **HB 2581.**

Sandra Strand, Legislative Coordinator, Kansans for Improvement of Nursing Homes, (KINH) offered handout, (Attachment No.1), and stated a Task Force has been meeting since December 6, 1993 to study the Preadmission Assessment and Referral program, and numerous suggestions are forthcoming which will improve the implementation of this program. There is no denying there have been problems with implementation during the first year of existence of the program. With this study, and an independent study of the state long term care policy by nationally respected consultants beginning this week, KINH hopes the Legislature will wait until these studies are completed in order to review pertinent recommendations before making a final decision on the preadmission program. KINH supports the goals and purposes of preadmission assessment and referral. They oppose the repeal of this program before it has been adequate time to succeed. She asked that **HB 2581** be reported unfavorably.

Joseph Kroll, Director, Bureau of Adult and Child Care, Department of Health and Environment offered handout, (Attachment No.2). He noted his remarks will be neither for or against the passage of **HB 2581**, but he will try to protect the concept of prescreening. The ever-growing cost of long term care is an important issue that information on alternatives and prescreening efforts seek to address. This program is also a means to collect information on the needs of the elderly population. Issues related to the implementation of K.S.A. 39.966 must be dealt with, but it is important not to lose sight of the goals and original intent of the legislation this bill would repeal. The Department of SRS has responded aggressively trying to solve problems by establishing a task force to resolve concerns. The Department of Health and Environment believes the prescreening program can and will accomplish its goals. There are significant questions that we don't want lost, i.e., should there be an assurance in the nursing home process that the person interested in nursing home placement is making an informed decision; should the admission process provide key policy makers, including the legislature, with specific information on the needs of persons who are seeking placement in nursing homes so that the growing scarce dollars might be used in the most appropriate way; is there a shortage of community based services and if there is, where are the shortages and what kind of shortages are there; should the information distribution piece of **SB 182** be repealed? He stated, if **HB 2581** is passed and the statute repealed, what will Kansas do to deal with the current crisis with long term care? He hoped that the legislature would consider giving prescreening their continued support.

Marilyn Bradt, Kansas Coalition on Aging, (see Attachment No.3), reaffirmed the Council's support of the concept of preadmission assessment. Although there are concerns with problems that have occurred, and no doubt these problems being discussed are real, it is the opinion of the Coalition on Aging that these problems can and should be corrected. The program re-tooled, should be maintained. If it is the decision of this legislature to scrap the program, there must be an assurance that another, better designed program will replace it. The Kansas Coalition on Aging believes the most important component is a strong case management system that provides one on one counseling and directly assists clients to assemble a package of services to enable a client to remain in their own home whenever possible, and then follow through making sure services are being delivered appropriately.

Rosie Williams, President, Caring Connections, Inc., offered handout, (Attachment No.4). She stated she is a member of the task force who have been putting together recommendations to improve the preadmission screening process. She suggested solutions to some of the problems being discussed, i.e., perhaps had a task force been established earlier, a smoother implementation of the program probably would have occurred. There is already an improvement in the implementation of the program. If there are problems with assessors, ask those in the field who the good assessors are, and make them accountable. If there are problems with management/personnel, perhaps accountability and outside review of the managing organization needs to be put in place. Needs of the consumer and their caregivers have not changed and these needs will increase in the future. This program can succeed.

Terri Roberts, Executive Director, Kansas State Nurses Association offered handout,(Attachment No.5). She stated the Kansas State Nurses Association agrees the problem identified by others have been too many and gone on too long. They are disappointed that data regarding services availability has not been a priority and that the Area Agencies on Aging have not been informed about this as originally intended. Despite all the problems, it is their belief that the policy of preadmission screening is good public policy with merit and value. She encouraged deliberation by the Committee to find some common ground to modify the system. However, she said if no "common ground" can be found to salvage **HB 2581,** they would understand the decision of the Committee to repeal.

Debbie Bird, Bock Associates, (see Attachment No.6) stated the problems created for hospitals in implementing the prescreening program were due primarily to, i.e., faulty design, inconsistent and confusing directions to field staff, the absence of manuals for assessors, no quality assurance or follow-up functions in the program design. In July, 1993, the Department of SRS contracted with Bock Associates, a Minnesota based company with more experience with client screening than any other organization in the nation. Quickly, Bock identified problems and proposed major program enhancements to eliminate problems associated with the program. With these enhancements, plus recommended changes by the Department of SRS, profound results in the last few months have taken place. She detailed improvement procedures. The enhanced program has been in operation for three months. She urged members not to kill the program when it is finally beginning to work.

Diane Garner, Professor, Department of Social Work, Washburn University, stated she is also a member of the task force on preassessment. She detailed a study that tested hospital based preadmission screenings and evaluation of the impact of preadmission screenings on hospital based discharge planning and subsequent

discharges. She detailed the findings. (see Attachment No.7) The study began May 15, 1981, and ended May 15, 1982. She noted standardized preadmission screening has been in use in many states since the early 1980's and has been found to be beneficial in accessing and developing community based services in delaying or avoiding unnecessary institutional placement and slowing down the increase of costs for long term care. She drew attention to recommendations forthcoming from the task force, i.e., use of hospital based discharge planners in the preadmission screening process, setting time lines for training of assessors and for referral of clients found to need community based services to the Area Agencies on Aging within the same day the determination is made.

Julie Walter, Executive Director, Area Agency on Aging, Manhattan, Kansas. She supports the concept of preadmission referral. She is aware of problems with the program, however, she spoke of the positives, i.e., community based services are documented in a format that is consumer friendly. Area Agencies on Aging have worked very hard putting the resource guides together. The information component of a program as this is often overlooked, but has been proven to be a very important part of the program. She expressed concerns if **HB 2581** were to be repealed since the future will bring even more demands for the long term care services. She urged unfavorable consideration of **HB 2581.** (No written testimony provided.)

Joanne Hurst, Secretary of Department on Aging offered hand out (Attachment No.8) She stressed strong support to the concept of preadmission assessment and referral program is valid and that it is a needed component within a full comprehensive system of long term care. She drew attention to Dr. Rosemary Chapin who testified on preadmission assessment programs in other states. (She noted, Rep. Swall had distributed a document to members at a meeting in this Committee on January 19, 1994 compiled by Dr. Chapin.) Dr. Chapin stated in her paper that most states have had difficulty early-on in the implementation of these assessment programs. Secretary Hurst concurred. She spoke of the task force initiated and of the new recommendations that are just beginning to be implemented, and also noted, there hasn't been time to evaluate the success of improvement. A top priority of this task force became the referral component of the program. One problem was the lack of referrals between assessors and the Area Agencies on Aging. Improvements in the training process of the assessor is taking place. Additionally, training will include providing Area Agency on Aging staff with the necessary skills to complete the follow-up reports in a timely and efficient manner, will outline policy for self-referrals to Independent Living Centers. She opposes **HB 2581** because this legislation would scrap an important concept.

Donna Whiteman, Secretary of Department of SRS offered handouts, (Attachment No.9), a Reassessment and Referral Program Implementation Timeline Annual Report, and (Attachment No.10), Estimated savings due to preadmission screening programs. Secretary Whiteman directed attention to a chart indicating five year projections in offering services and the costs for those services. She noted she her remarks would be put in prospective with Dr. Chapin's handout received by members yesterday. She noted 60% of the funding comes from the federal government, 40% comes from the state. It is imperative the state continue the process of preassessment screening and referral. Without this program the state will need an even more increasing amount of funding to offer needed services. In the next 5 years the population eligible for nursing home will grow 51%, which equates to 20,000 more individuals needing to access services. It is imperative from a budget prospective that the state manages their long term care system better. All states who have done that, indicate preadmission screening is an essential component of being able to create a delivery system that is responsive in an ethical point of view for the consumer, and is responsible from an economic point of view for managing limited state dollars. In her view, if the state does not have preadmission screening, there will be a crisis. She drew attention to the recommendations of the task force in her handout.

Committee members asked numerous questions of several conferees. Budgetary concerns were discussed at length.

HEARINGS CLOSED ON **HB 2581.**

Chairperson Flower stated it appears there are many who agree the concept of this program is good, a program gone awry. She appointed a Sub-Committee requesting them to contact the appropriate people and try to work on solution,and bring recommendations back to Committee. The Sub-Committee appointed on **HB 2581** is Rep. Wells as Chair, with Rep. Neufeld and Rep. Sader also serving.

Chair inquired of Secretary Hurst in regard to a legislation request. It appears the legislation is related to the subject matter in **HB 2581**, and would there be any objection to taking the request to the Sub-Committee as a possible tool for them to work towards solving problems in **HB 25481**. Secretary Hurst agreed to do so.

Noted: (Attachment No. 11) is testimony provided by Ms. Patricia Kissick who testified as a proponent yesterday on **HB 25481**.

Noted: (Attachment No. 12) is written testimony from Irene Hart , Area Agency on Aging, Wichita, Kansas.

Chair adjourned the meeting at 3:14 p.m. The next meeting to be held January 24, 1994.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Jan. 20, 94

NAME	ORGANIZATION	ADDRESS
Marty Kennedy	DOB	Topeka
Dona Rose	SRS	Topeka
Joanne Quest	KDOA	Topeka
Dianne Garner	Washburn Univ.	Topeka
Dana Bird	Bock Assoc.	Topeka
Rosie Williams	Caring Connections	Topeka
Marilyn Bradt	KS Coalition on Aging	Lawrence
Sandy Strand	KINH	Lawrence
[illegible]	Citizen	[illegible]
Larry Pitman	KFMC	Topeka
[illegible]	KHCA	Topeka
Dona Frihart	KHCA	Topeka
Tom Bell	KHA	Topeka
Rick Guthrie	Health Midwest	KC
[illegible]	[illegible]	Topeka
Vicky Martin	KNOA	Topeka
Tom Young	AARP	Vassar
Harold Pitts	AARP-CCTF	Topeka
[illegible]	KDHE	Topeka
[illegible]	KDHE	Topeka
Annette Siebert	KAHA	Topeka
[illegible]	Wesley Towers Retirement Community	Hutchinson
Betty Jo Banks	KPNHHA	Topeka

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE _____

NAME	ORGANIZATION	ADDRESS
William D. Peterson	Hanglon Municipal Hosp-SWK KPNHAA	Herington
Sharon E. McCabe	KPNHAA	McPherson
[illegible]	KPNHAA	Topeka
Tari Roberts	KSNA	Topeka
TIM Hart	SRS	"
KEITH R LANDIS	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS	"
Julie Gavert Walter	N.C-Flt Area Agency on Aging	MANHATTAN
Michelle Clum	atty. Jon Small	Topeka
R Epps	SRS	"
Betty Smith Complexe	Intern Senator Brough	Lawrence
Karen DeVinney	Ks. Medical Services	Topeka
Joyce Sugnet	SRS	Topeka
Dona Whiteman	SRS	Topeka

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

TESTIMONY PRESENTED TO
THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING HB 2581

January 20, 1994

Madam Chair and Members of the Committee:

KINH has supported the concept of preadmission assessment and referral for nearly a decade. We still do, and for the same reasons we have expressed over the years:

1. The decision to enter a nursing home or to arrange such care for a frail relative has too often been an inappropriate one, made in haste and without full knowledge of the community-based alternatives.

2. There has not been a consistent process to inform consumers and their families about community resources, or to help them gain access to these resources.

3. There has been no reliable source of data on the need for or availability of community-based resources across the state. Consumers generally assert that if alternatives to nursing home care were available, they would be the overwhelming choice of those needing care.

4. Diverting from nursing home care those whose needs can be safely met in community settings would help to control increasing Medicaid costs.

There is no denying that there have been a number of implementation problems since the program went into effect a year ago. However, KINH believes that rather than repealing the preadmission statute, the more appropriate course of action is to evaluate the problems, identify needed changes, implement the changes, and continue to evaluate the program on a regular basis.

A 26-member task force has been meeting since December 6 to address specific implementation problems. We believe SRS should be given the opportunity to act on the task force's recommendations before any legislative changes are made.

In addition, an independent study of state long term care policy by nationally respected consultants began this week. KINH hopes this study will provide some helpful information for our state's long term care system. We also hope the legislature will wait until this study is completed, in order to review any pertinent recommendations before making a final decision on the preadmission program.

According to a 1986 study of 31 states participating in preadmission assessment programs, all the survey respondents believed that

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preadmission assessment and referral helped decrease the overall cost of long term care. Those reporting major problems implementing and maintaining their programs cited the following reasons:

1. Lack of funding.....50%
2. Lack of provider support:
   - nursing homes.....33%
   - home health-care agencies.....4%
   - physicians.....46%
   - hospitals.....46%
3. Lack of government support:
   - legislators.....17%
   - federal government.....17%
   - state government.....17%
   - local government.....0%
   - bureaucracy in general.....33%
4. Lack of family/client support:
   - family.....0%
   - client.....0%

(Iverson, Laura Himes and Polich, Cynthia, State Pre-Admission Screening Programs: Results of a National Inventory, Continuing Care Coordinator, June 1986, p. 31).

KINH's experience has been similar to the study results. Although we receive hundreds of calls each year from consumers complaining about state programs, we have not had a single consumer complaint about preadmission assessment. Most of the complaints we have heard were from assessors and former assesors who were frustrated with the contracting process.

Finally, Rosalie A. Kane, DSW and Robert L. Kane, MD, conclude in their overview of state programs:

> Preadmission screening seems so rational a concept that it is almost unobjectionable. The caveats, however, are that resources are needed to assist in diverting admissions and that such resources must be targeted well if saving money is the major objective.
>
> Finally, the logistical problems in doing prompt preadmission screening, including screening of persons in hospitals, are formidable. Programs must resist the temptation to become perfunctory and routine. (Long-Term Care: Principles, Programs, and Policies, New York, 1987, p. 313).

KINH supports the goals and purposes of preadmission assessment and referral. We oppose the repeal of this program before it has been given adequate opportunity to succeed. We ask the committee to report HB 2581 unfavorably.

Respectfully submitted,

Sandy Strand

Sandra Strand
Legislative Coordinator

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1-20-94
Attm #1-2
Pg 2 of 2

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Robert C. Harder, *Secretary*

TESTIMONY PRESENTED TO

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

HOUSE BILL 2581

House Bill 2581 repeals 1992 legislation authorizing the Secretary of Aging to compile and distribute comprehensive long term care resource information and the Secretary of SRS to establish a uniform needs assessment process for all persons seeking admission to a nursing facility.

These programs were the result of a collaborative effort by KDHE, SRS, and the Department on Aging to develop legislation that affirmatively addressed the need to change the focus of Kansas long term care. There is general consensus that Kansas is too reliant on institutional long term care and that non-institutional, or home-like services should become the focus of long term care in Kansas. The ever-growing cost of long term care is also an extremely important issue that information on alternatives and pre-screening efforts seek to address. In addition, pre-screening provides the means to collect information on the true needs of our state's elderly and to answer the question on why they seek nursing home placement. Issues related to the implementation of K.S.A. 39-966 must be dealt with, but we should not loose sight of the goal and intent of the legislation this bill would repeal.

There is a multitude of data that supports Kansas is too reliant on institutional care. Significant data is presented in the 1994 Long Term Care Action Committee's report to the Kansas Legislature. It is included in testimony by the Department of SRS and Department on Aging and need not be repeated here.

KDHE acknowledges that since its January 1, 1993 implementation, the pre-screening component has encountered considerable difficulty. The nursing home industry, other health care providers, and consumers are genuine in the concern they have expressed regarding the program. SRS has aggressively responded by establishing a task force to resolve concerns identified.

KDHE believes that a pre-screening program can and will accomplish its goals. SRS has worked with the task force mentioned above to identify and resolve implementation issues. We sincerely hope the legislature will consider giving a pre-screening program its continued support.

Presented by: Joseph F. Kroll, Director
Bureau of Adult and Child Care
January 20, 1994

PHW
1-20-94
Attm # 2

KANSAS COALITION ON AGING
1195 S.W. Buchanan
Topeka, KS 66604

TESTIMONY PRESENTED TO
THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE
CONCERNING HB 2581

January 20, 1994

Madam Chairperson and Members of the Committee:

I am Marilyn Bradt, speaking for the Kansas Coalition on Aging. KCOA has strongly supported pre-admission assessment from the beginning. We retain that support in our 1994 Legislative Program. That is not to say that we were not aware that implementation has had serious problems. We added to our general position of support for the concept of pre-admission assessment, that:

KCOA supports careful monitoring of pre-admission assessment to assure that it accomplishes the purposes of:
1) diverting from nursing home care those who can be cared for satisfactorily in other ways,
2) referring all assessed clients who choose community based care options to information and assistance providers,
3) providing adequate funding of information, counselling and case management services.

Clearly those goals have not been met in far too many instances. The assessment instrument, it would appear, is cumbersome and time consuming. Assessments have not been made in a timely way. The services of qualified persons such as hospital social workers have not been utilized. Referrals have not been sent on to community agencies best able to provide advice and counsel about alternatives. In short, we have no doubt that the problems cited by yesterday's conferees are real.

In KCOA's opinion, however, the problems can and certainly should be corrected. The program, retooled, should be maintained. Or if it is the decision of this legislature to scrap the program there must be an assurance that another, better designed, will be put in its place to achieve the goals that everyone seems to agree are laudable and desirable.

KCOA believes that the most important component of a successful program of this kind is a strong case management system that provides one on one counseling and directly assists clients to assemble a package of services that enables them to remain in

PHW
1-20-94
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their own home whenever possible and then follows through to assure that the services, once found, are being delivered appropriately. The assessment is simply a starting point that determines what the individual's needs are.

If Kansas is to turn around what has been historically a bias toward institutional care, demonstrated by the high percentage of the frail elderly who are cared for in the nursing home, we must take some positive steps to increase the number of in-home services available and to link up those services with those who need them. KCOA believes that pre-admission assessment is the first step.

PH&W
1-20-94
Attm # 3-2
pg 2 of 2

Caring Connections, Inc.
1020 SOUTH KANSAS AVENUE
TOPEKA, KANSAS 66612
PH. (913) 357-1333

TESTIMONY OPPOSING HB 2581
Rosie Williams, President Caring Connections, Inc.
January 20, 1994

Thank you Chairperson Flowers and members of the committee for giving me the opportunity to express my oposition to HB 2581.

I am Rosie Williams from Caring Connections, a small private case management firm located in Topeka. I am also a member of the task force who have been putting together recommedations to improve the pre-admission screening process.
There seems to be a consensus that the goals and intent of SB 182 were positive. I believe the PAS is a vital element to an overall long-term care program in Kansas and falls in line with national trends. The implementation of PAS has caused an outcry by many individuals in our state. I'd like to look at why objections are being made, however I do not think we should throw the baby out with the bath water to coin a phrase.

1. Confusion, delays and communication problems have been evident in this program. I believe the legislature must take some responsibility here with all due respect. This bill was a major change in the service delivery system in Kansas. The task force should have been in place early on, however, with the program taking effect January 1, 1993, there was no time for careful planning and program development to take place-it was time for implementation and we all jumped in! Just as in private business, the first few years will be given to program planning, goal-setting, program revisions, start-up costs, etc. The same applies (even more so) to government programs. Let's not set up our state agencies for failure and sit back one year later and echo the special interest groups who say "I told you that this program would fail"

Implementation problems? That is improving

Problems with policy or legislative intent? Policies have been changed and should continue as need arises.

Problems with management/personnel? This too can be dealt with without repealing the law. Accountability and outside review of the managing organization needs to be in place. Managers must have the educational back-ground not in clinical areas, but in management, as well as communication skills, public relations, and an unbiased approach to contract decisions and referral flow.

Problems with assessors? Ask those in the field who the good assessors are, make assessors accountable,

PH&W
1-20-94
Attm #4

Caring Connections, Inc.
1020 SOUTH KANSAS AVENUE
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TESTIMONY OPPOSING HB 2581
Rosie Williams

Problems with assessors?

Review why contracts were given to large provider organization with a poor track record over established individuals in the aging network.

Pre-admission screening is an important link in the overall long-term care continuum of services. It is an excellent way to get individuals connected to case managers and in turn, services. THE NEEDS OF THE CONSUMERS AND THEIR CAREGIVERS HAVE NOT CHANGED. They will increase in the coming years.

This program can succeed. If we do not meet this challenge, chances are the feds will meet it for us with even more stringent requirements.

Lets continue to deal with the root problems and hard issues presented today and have the courage to move forward with our LTC policy.

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1-20-94
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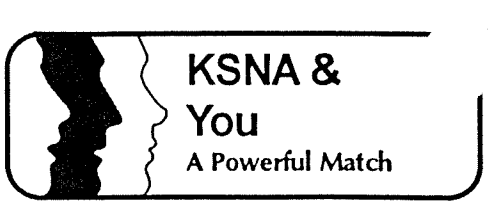
pg 2 of 2

KSNA
the voice of Nursing in Kansas



FOR MORE INFORMATION CONTACT:

Terri Roberts J.D., R.N.
Kansas State Nurses Association
(913) 233-8638

January 20, 1994

H.B. 2581 Repeal of Pre-Admission Assessment

Chairperson Flowers and members of the House Public Health and Welfare Committee, my name is Terri Roberts R.N., and I am the Executive Director of the Kansas State Nurses Association.

The issue of repealing Pre-Admission Screening that was implemented just one year ago is one that our members, as registered nurses has struggled with. KSNA was one of the organizations that supported S.B. 182. We supported the systematic screening, primarily for the benefit gained in collecting data about what community based services were not available, thus needing to be implemented in various parts of the state. We philosophically support that our clients deserve to be presented with the available options for maintaining their independence in their own homes, until that is no longer possible for them. Saving money was not the primary factor in our decision two years ago to support this concept.

The presentations yesterday were very helpful in identifying for you as the policy makers the multitude of problems that have characterized the implementation of this program to date.

We agree that the problems identified have been too many and gone on too long for many of the providers and any sense that there is merit or value to the process has been lost. This is unfortunate, but a reality.

KSNA too, is dissapointed that the data regarding services availability has not been a priority and that the triple A's have not been informed about this as originally intended.

In closing, we would like to say that despite the problems, we still believe, that the policy of pre-admission screening is good public policy, with merit and value. We encourage your deliberation to find some common ground in a modified system, however, if there is no "common ground" that can be found to salvage this endeavor, we would understand your decision to repeal.

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1-20-94
Attm #5

Bock Associates
partners in human service management

1525 S.W. Topeka Boulevard
Suite A
Topeka, Kansas 66612
913/233-1340
800/255-2625
FAX 800/255-7363

Madam Chair:

My name is Debbie Bird and I have worked with the preadmission screening and referral program since the passage of SB 182 in 1992. The first six months of the program, I worked for KFMC and the last six months I have been working for Bock Associates. I want to tell you first hand why I believe the program was not accomplishing its goals during the first nine months and why I am now convinced that it can acheive all its goals and do so without delaying for even one day the placement of persons into adult care homes when such placement is sought.

You have heard of the many problems created for the hospitals when the program was first implemented on Jan 1 of last year. Those problems were real, due primarily to a faulty design of the program, inconsistant and confusing directions to the field, the absence of manuals for assessors and no quality assurance or follow-up functions in the program design.

The result of these shortcomings was the assessment of over 10,000 persons, many of whom were not seeking nursing home placement with very few being informed of community-based services and almost no referrals of persons to Area Agencies for community services. In the midst of these problems, persons actually seeking nursing home placement were delayed in hospitals incuring non-reimbursable costs.

In July, SRS contracted with Bock Associate, a Minnesota based company with more experience with client screening projects than any other organization in the nation. As early as June 11, 1993, Bock Associates identified these problems and proposed major program enhancements to eliminate the problems associated with the program.

Those enhancements along with several enhancements identified by SRS were implemented on October 1, 1993, with profound results: Unnecessary assessments stopped, resulting in a 60 percent cost reduction for assessments; potential diversion rates went from 8 percent to 45 percent; turnaround time for determinations went from 8 days to 3.5 days; and finnaly, referrals to Area Agencies are now occuring with accelerating frequency.

To eliminate the delays in placement from hospitals, short term stay and emergency placement options permitted the hospitals to place individuals prior to receiving an assessment thereby eliminating any delays. Finally, as a result of recommendations from the PAR Task Force, as of January 15, 1994, hospitals are now permitted to conduct

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1-20-94
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these assessments and make determination on the spot using SRS criteria. **In other words, there should be no more delays in the placement of persons into nursing facilities by hospitals effective immediately.**

This program must be saved since it is now structured in such a fashion that beyond saving the state money, it now will inform senior citizens needing services that they have options for care other than in a nursing home. The problems the program created for the hospitals is eliminated, and for the first time since the program was started, it is actually accomplishing what was intended by the legislature.

The next major enhancement schedul ed for implementation is the referral portion of the program that not only identifies services for seniors in need, but more importantly it will permit the Area Agencies to create the database of community services that will be required to truly divert persons seeking NF care into less restrictive and far less costly services.

The enhanced program has only had three months of operation and has still produced the results I spoke of earlier, don"t kill it now when it is finally starting to work.

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Explanation of Graphs

1. Completed KPARIs: Quarters 3 and 4

During the third quarter, Bock Associates received 4,742 KPARIs, compared to 2,836 KPARIs received in the fourth quarter. Therefore, there was a 40 percent reduction in the total number of KPARIs completed on a statewide basis.

2. Completed KPARIs: Quarter 4

During the fourth quarter, Bock Associates received a total of 3,791 referrals. Of the 3,791 referrals, 2,836 were full KPARIs (2,198 plus 638 SRS referrals), resulting in a determination and client decision on placement preference, and 955 were short-term stay (SHT) or emergency referrals (EMG).

3. Age Distribution: Quarter 4

This graph illustrates the distribution of ages across five age groups. The difference between the total number of individuals (n=3,581) and the total number of referrals (n=3,791) is due to the fact that both KPARIs and SHTs were completed for some individuals. The average age of an individual for whom a KPARI was completed was 78.9 years of age.

4. KPARIs Completed Statewide

This graph presents the total volume of KPARIs completed by location, during the last half of 1993. Please note that the drastic reduction in the total volume of KPARIs in October coincides with the implementation of the new program model. It appears that, after implementation of the new program model, the number of KPARIs that are completed in individuals' homes, nursing facilities and other locations are returning to previous levels, while the number of KPARIs completed in hospitals is still dramatically less. Although the number of KPARIs completed in nursing facilities has returned to previous levels, Bock Associates believes that the return in the number of KPARIs completed in nursing facilities to previous levels is due to the influx of EMG/SHT admissions, rather than to a return to previous practices. Bock Associates believes that the reduction in the number of KPARIs completed in hospitals is due to the elimination of inappropriate KPARIs.

5. Percent of Clients Choosing NF Placement

Based on 3,236 KPARIs completed in the third quarter and 2,198 KPARIs completed in the fourth quarter, this graph presents the percentage of individuals who chose nursing facility placement by location. As a result of the new program model, based on the total number of KPARIs completed in the third and fourth quarters, more than 50 percent of the individuals who were applying for admission to nursing facilities indicated that they were interested in community-based service alternatives (potential diversions), as of December 1993. Please note that the total number of actual diversions will be less than the number of potential diversions, based on the placement selected.

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The following are three financial scenarios for every 2,000 applicants (quarterly volume) to a nursing facility, if 50 percent become potential diversions:

* If 75 percent of potential diversions become actual diversions, the State of Kansas will save $5,175,000 (750 x 6,900 average difference in annual nursing facility and community-based service costs) per quarter, or a total of $20,700,000 on an annual basis.

* If 50 percent of potential diversions become actual diversions, the State of Kansas will save $3,450,000 (500 x 6,900 average difference in annual nursing facility and community-based service costs) per quarter, or a total of $13,800,000 on an annual basis.

* If 25 percent of potential diversions become actual diversions, the State of Kansas will save $1,725,000 (250 x 6,900 average difference in annual nursing facility and community-based service costs) per quarter, or a total of $6,900,000 on an annual basis.

The decrease in the total number of individuals who chose community-based service alternatives, beginning in October 1993, is dramatic and may be attributed to the improved methods for completing KPARIs and explaining available community-based service alternatives.

6. Timeliness Performance

Based on data from the first and fourth quarters of 1993, this graph illustrates both the average time that it takes for an assessor to complete a KPARI and the average time for the contractor to complete the review, determination and notification processes.

7. Total Contractor Program Costs

Based on data from SRS (excluding an estimate of December's KPARI costs), this graph presents both the KPARI and contractor administrative costs during 1993. Since the Kansas PAR Program is funded at 75 percent federal financial participation (FFP), the cost to the State of Kansas is represented by the line that runs across the graph.

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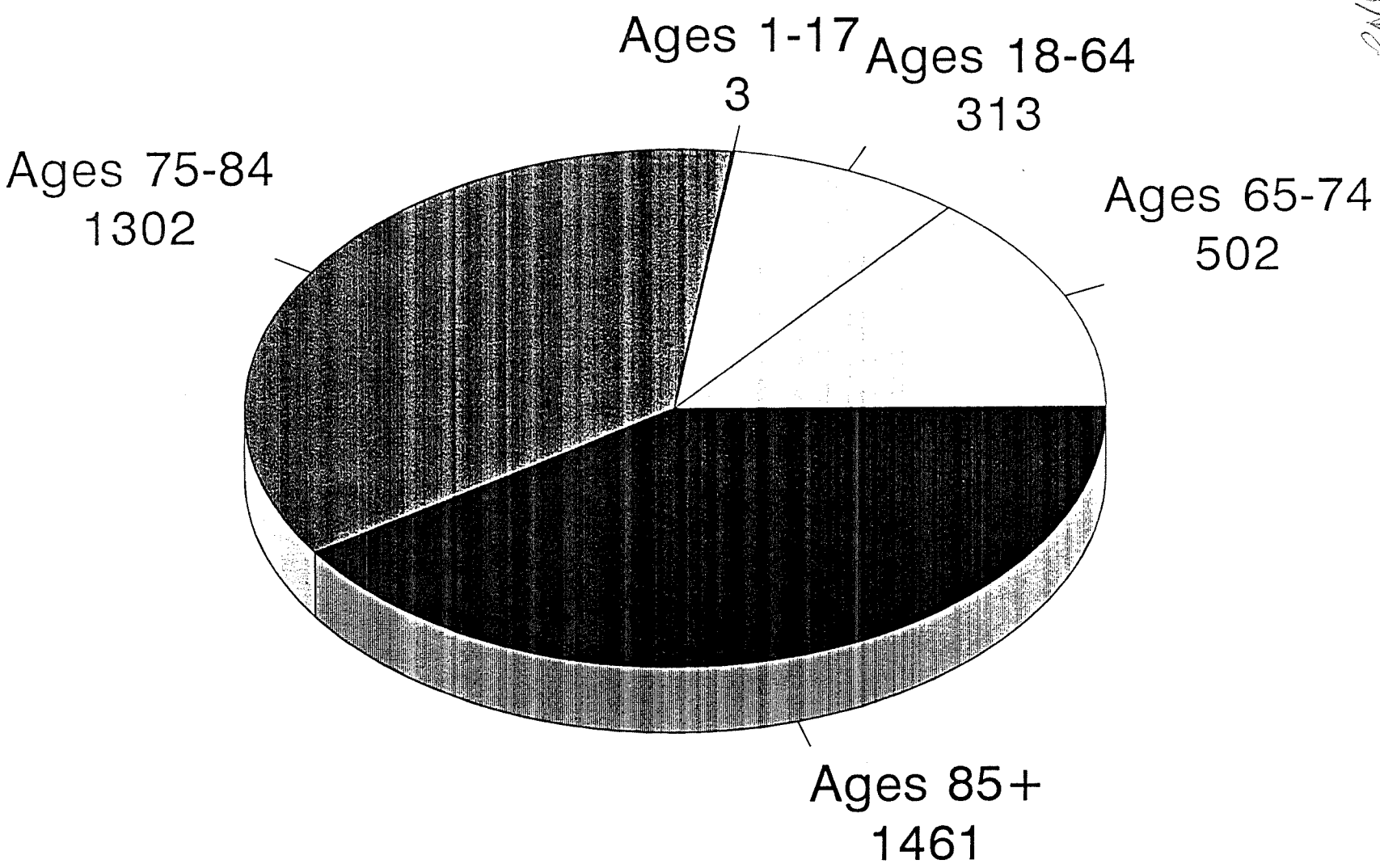
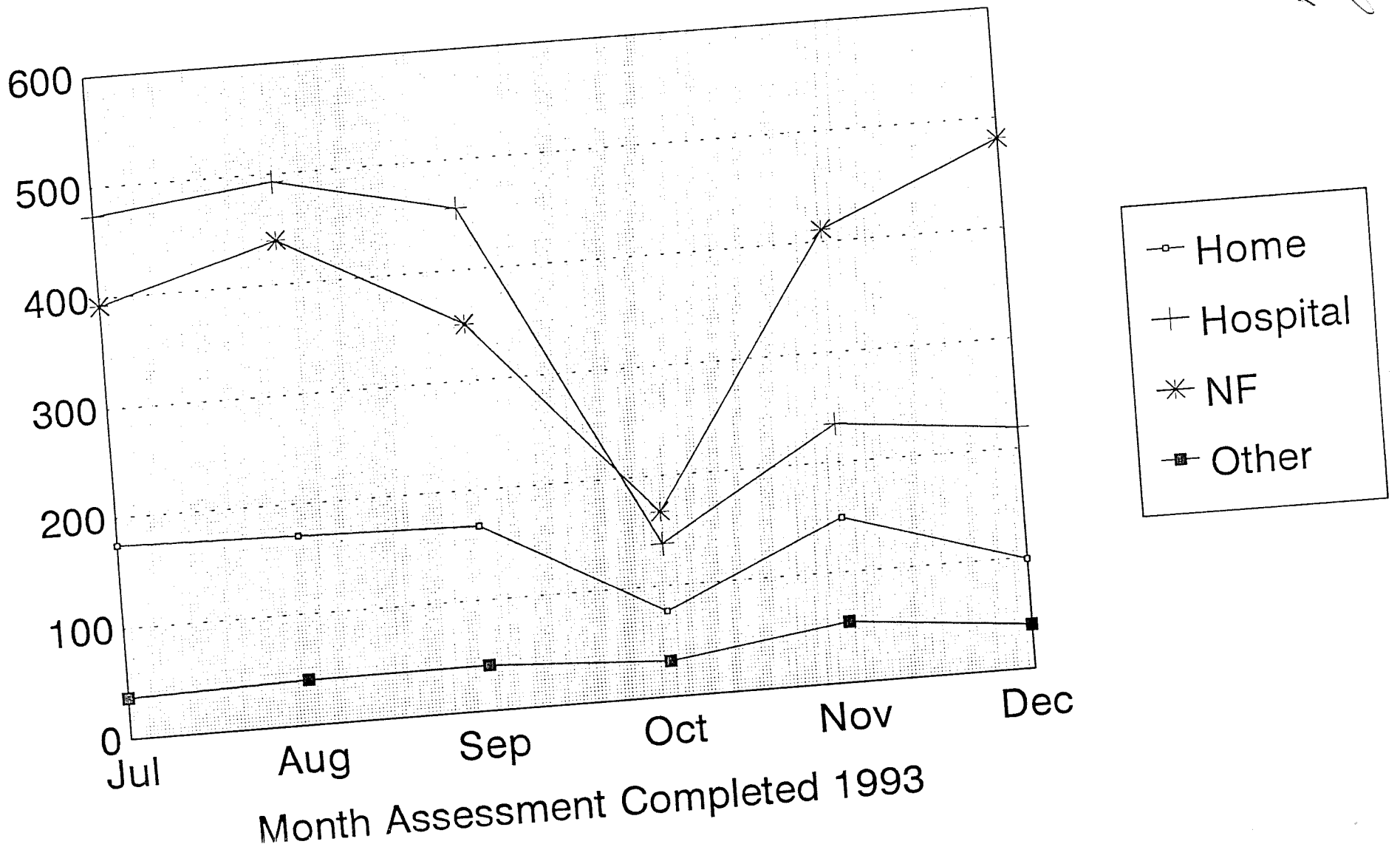
Age Distribution: Quarter 4



N=3,581

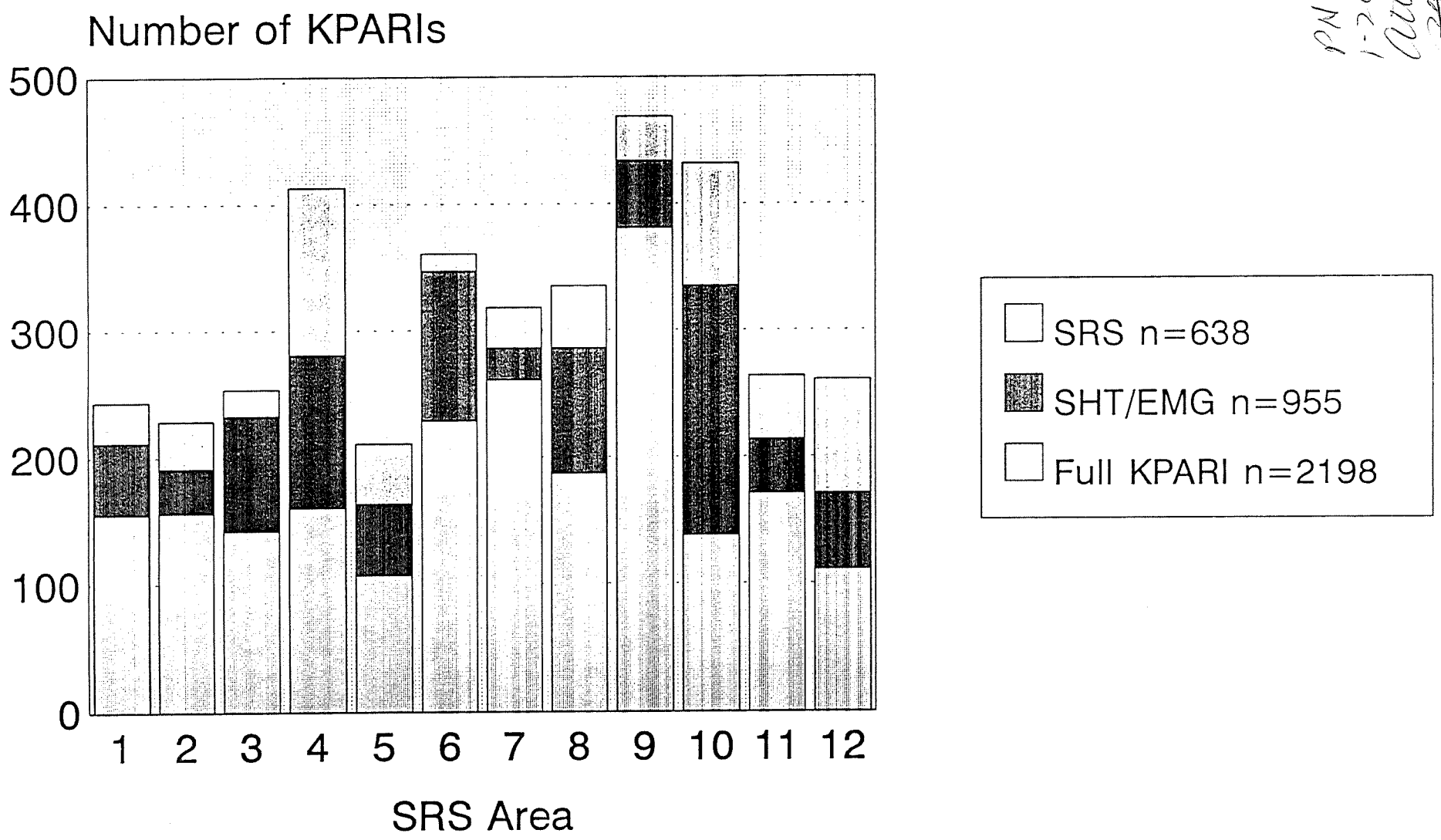
KPARIs Completed Statewide

By Assessment Location Type



Completed KPARIs: Quarter 4

By Type of Assessments



SRS Office Legend

1	=	Lawerence
2	=	Manhatten
3	=	Salina
4	=	Hays
5	=	Kansas City
6	=	Olathe
7	=	Topeka
8	=	Emporia
9	=	Chanute
10	=	Whicita
11	=	Hutchinson
12	=	Garden City

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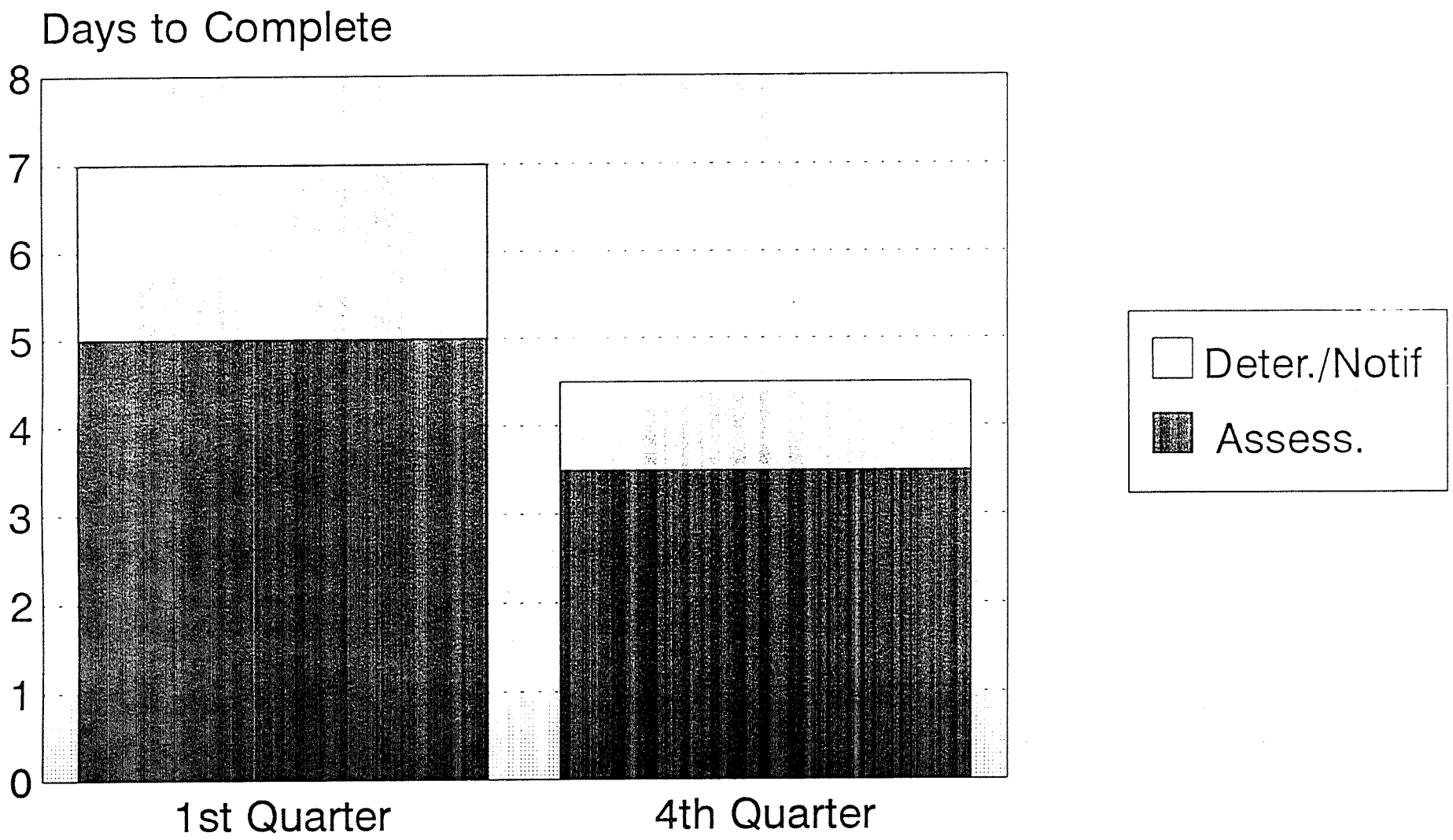
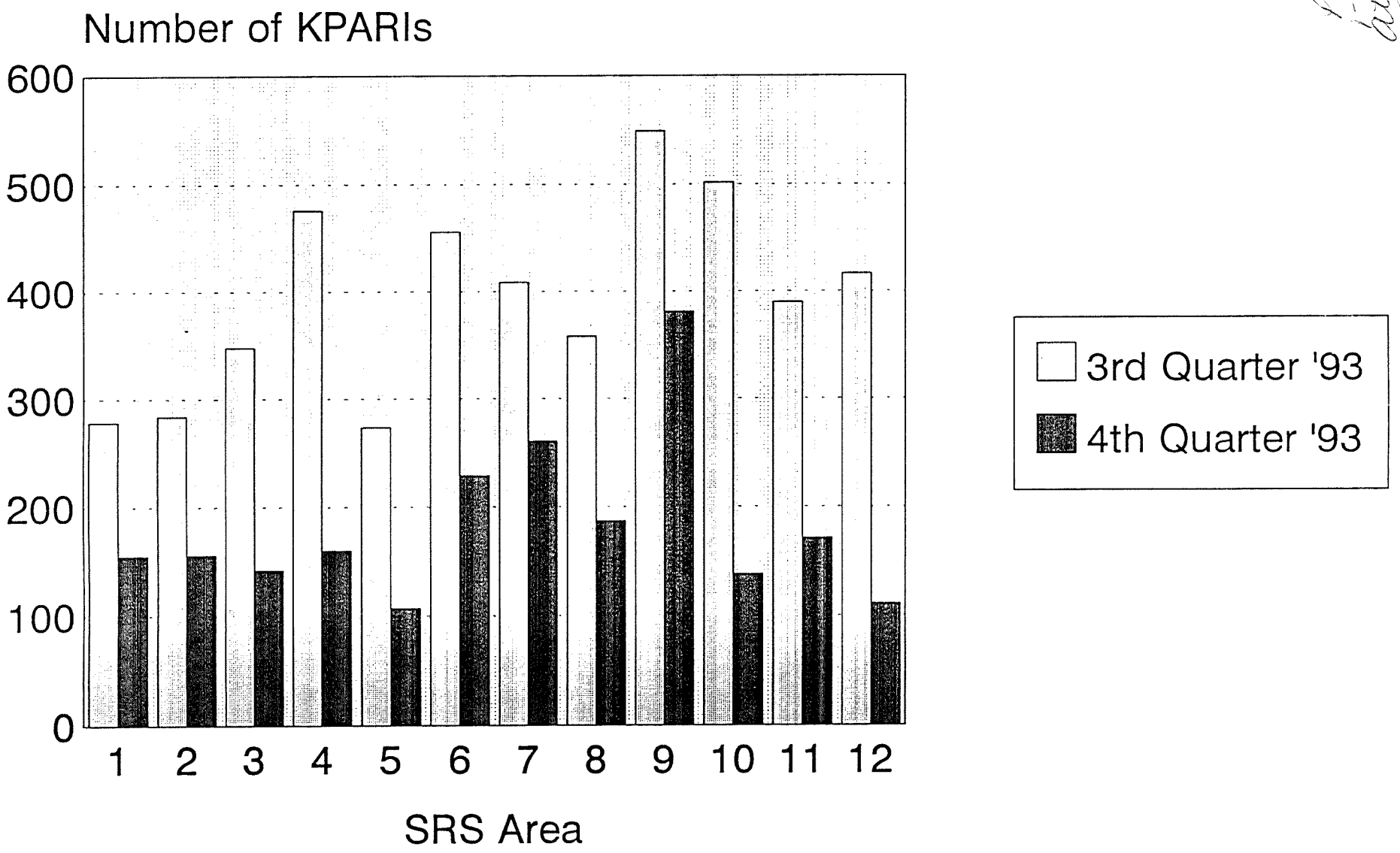
Timeliness Performance

Comparing 1st Quarter to 4th Quarter '93



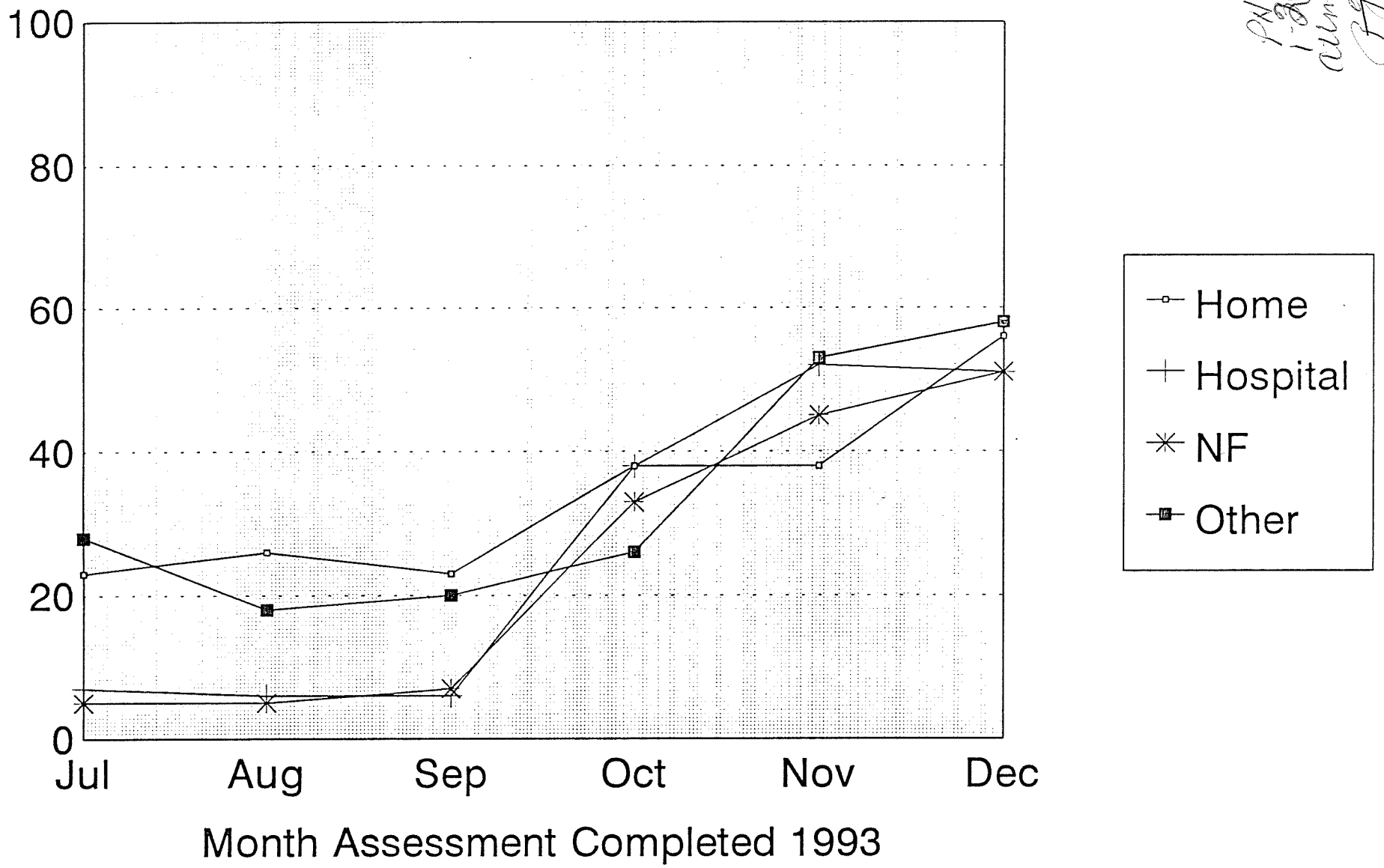
Completed KPARIs: Quarters 3 and 4

By SRS Area



Percent of Clients Choosing Community Based Services

Kansas Statewide Totals
By Assessment Location Type



HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE
STATE OF KANSAS
THURSDAY, JANUARY 20, 1994

Subject: House Bill 2581, KSA 39-966

Testimony prepared by: Dianne Garner, Professor and Chair, Department of Social Work, Washburn University and member, Kansas Nursing Facility Preadmission Assessment and Referral Program Task Force

I began working with preadmission screening in 1981 as Director of the Department of Social Work at St. Vincent Medical Center, a 750 bed acute care general hospital in Little Rock, Arkansas. At that time I was also a doctoral candidate and beginning work on my dissertation entitled *Utilization of Long-term Health Care.*

In its 1981 legislative session, the State of Arkansas passed Act 380 mandating the development and implementation of a comprehensive long-term care assessment system as a part of developing a coordinated and accessible network of long-term care and related community based services. In cooperation with the State Office of Long-term Care and the State Department of Aging, the Department of Social Work at St. Vincent Medical Center volunteered to participate in testing hospital based preadmission screening and to evaluate the impact of preadmission screening on hospital based discharge planning and subsequent discharges. Given the size of the hospital, it was possible to select both control and experimental units for concomitant comparison purposes. The preadmission screening process, including the use of a standardized instrument, was implemented on one general surgical unit, one oncology unit, one general medical unit, one orthopedic unit and one cardiology unit. The usual process of discharge planning, involving a narrative assessment, was followed on comparable units: one general surgical unit, one oncology unit, one general medical unit, one orthopedic unit and one cardiology unit. All hospital units selected experienced a high utilization of patients 65 years of age and older. On all hospital units, discharge planning was the responsibility of social workers with Masters' degrees who, in addition to assessment, were responsible for explaining all post-hospital care options and arranging for post-hospital placements or services.

Participants in both the experimental units and the control units were compared by demographic variables such as age, sex, race, and marital status to insure the validity of comparisons. Evaluation of the discharge planning processes included comparisons of length of time to complete the assessment, the average number of interviews conducted as part of the discharge planning process, the average length of stay of patients in both groups and the number of actual discharge delays related to the two different discharge planning processes. Evaluation of outcomes included patient/family satisfaction with the discharge planning process, the actual post-discharge services received and patient/family satisfaction with post-discharge services.

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The study began on May 15, 1981 and ended on May 15, 1982 with results tabulated at three month intervals and included a total of 453 patients. Of the 453 patients studies, 230 were discharged from experimental units and 223 were discharged from control units.

Findings:

1. Screening using a standardized instrument took an average of thirty minutes less time per client with the length of time steadily decreasing over time and leveling out during the final quarter and involved an average of one less interview per client. There was a reduction in subsequent interviews and phone calls to obtained information missed using the standardized instrument even among experienced MSW discharge planners.

2. Completeness of information regarding patients was greater using the standardized instrument throughout the study as was ease of access to information by other health care professionals.

3. The average length of stay of patients who were assessed using the instrument was reduced by half a day by the termination of the study.

4. Discharge delays among the two groups of patients were comparable with the primary reason for discharge delays being the lack of an available bed in a nursing facility. No discharge delays were found to be related to the use of a screening instrument.

5. Patient/family satisfaction with the discharge planning process was greater during the first two quarters using narrative assessment and was the same during the last two quarters of the study.

6. There was no difference in patient/family satisfaction with post-hospital services between the two groups.

7. There were slightly fewer nursing home placements (3) using the standardized preadmission assessment screen. Utilization of home health care services and other community based services was slightly elevated using an assessment instrument process.

8. In both groups only one-third of the patients whose physician recommended nursing home placement went immediately to a nursing home post-discharge. Two-thirds went home with community based services.

Standardized preadmission screening has been in use in many states beginning in the early 1980's and has been found to be of benefit in accessing and developing community based services, in delaying or avoiding unnecessary institutional placement, and in slowing down the increase of expenditures for long-term care. Process and outcome differences have been found to be greater over time as problems are addressed and people become more familiar with procedures. In addition, the increased thoroughness of assessments can be predicted to be greater when assessors are other than experienced, professional discharge planners It is still true, however, that the United States institutionalizes its elderly at the highest rate in the world and Kansas ranks in the upper range in terms of its rate of institutionalization

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of elderly citizens.

The Kansas Nursing Facility Preadmission Assessment and Referral Program Task Force has met regularly and will be making recommendations regarding the process currently used for preadmission screening in Kansas. Recommendations include the use of hospital based discharge planners in the preadmission screening process and setting time lines for training of assessors and for referral of all clients found to need community based services to the Areas Agencies on Aging within the same day the determination is made. The task force has included representatives from hospitals, nursing facilities, community based service organizations, consumers, universities, and State agencies. In my opinion there has been no pressure on task force members to comply with State agency recommendations, but rather there has been a desire on the part of members to assist in rectifying current problems by offering viable solutions. I strongly oppose House Bill 2581 and support preadmission screening as ultimately of benefit to the elderly citizens of Kansas as well as a mechanism to assist in slowing the rate of increase in the cost of long-term care in Kansas.

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Testimony on HB 2581
by
Joanne E. Hurst
Secretary of Aging
before the
House Public Health & Welfare Committee
January 14, 1994

Chairperson Flower and members of the committee:

I appreciate the opportunity to present testimony in opposition to House Bill No. 2581. I realize that you heard a great deal of testimony yesterday in support of this bill, and that preadmission assessment and referral in Kansas is in some difficulty. However, I believe strongly that the concept of preadmission assessment and referral is valid and that it is a needed component within a full comprehensive system of long term care.

Yesterday, in the Senate Public Health and Welfare Committee, Dr. Rosemary Chapin testified on preadmission assessment in other states. You received a copy of that testimony yesterday afternoon as well. In her testimony, Dr. Chapin spoke to the issue of most states having difficulty when they implemented preadmission assessment. She spoke of it as a bumpy start. I think that both Secretary Whiteman and I would concur that Kansas has experienced just that type of start in the implementation of its preadmission assessment and referral program.

Preadmission Assessment & Referral Task Force

In October, the House and Senate Committees on Public Health and Welfare directed Secretary Whiteman to initiate a task force to fix some of the problems which had been identified in the preadmission assessment and referral program. Secretary Whiteman asked me to co-chair that task force and over the last two months we have had several meetings in which strong remedial recommendations have been developed. These recommendations are just beginning to be implemented.

The top priority of the Task Force became the referral component of preadmission assessment and referral. The Legislative Post Audit report on Examining Potential Duplication and Overlap in Programs for Kansas' Aging Population (October, 1993) identified problems with the implementation of the law. One problem was the lack of referrals between assessors and Area Agencies on Aging:

> To ensure that elderly individuals are not falling through the cracks, the Department of Social and Rehabilitation Services should ensure that the results of the pre-admission screenings are being sent to the area agencies on aging on a consistent basis.

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The Preadmission Assessment and Referral Task Force discussed this issue as its top priority on January 10. The Task Force recommended we provide training for the community based assessor and Area Agency on Aging staff on or before March 1, 1994. The training will emphasize to assessors the importance of reporting timely referrals to the Area Agency on Aging and how this component of the program "fits into" the overall assessment and referral process. The training will emphasize for the Area Agency on Aging staff the importance of timely follow-up with consumers to ensure access to needed services. Additionally, the training will include providing Area Agency on Aging staff with the necessary skills to complete the follow-up report in a timely and efficient manner. The training will also outline a policy for self-referrals to the Independent Living Centers.

We believe that this recommendation will repair the problem cited in the Post Audit report. With this follow up the program can succeed.

Explore Your Options

One of the key features of K.S.A. 39-966 is the mandate for the creation of a comprehensive listing of long term care resources available to assist individuals meeting their care needs. The resource guide is a valuable asset to individuals and agencies in learning the variety of services available and having the names, addresses, and telephone numbers to contact these services.

In addition, and a very important feature, K.S.A. 39-966 requires that the resource guide be distributed by all nursing homes, hospitals, and physicians.

These two very important features of K.S.A. 39-966 certainly provide much support for the attainment of the valuable underlying concepts and goals of preadmission assessment and referral.

Conclusion

Rep. Flower and members of the committee, I speak today in opposition to HB 2581 because the bill would scrap an important concept. We supported the original intent of the preadmission assessment and referral law (K.S.A. 93-966) because people need information about alternatives to nursing home care. The implementation problems with this statute have been significant; but, we believe that these problems are surmountable.

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KANSAS NURSING FACILITY PREADMISSION ASSESSMENT AND REFERRAL PROGRAM IMPLEMENTATION TIMELINE

December 31, 1993
Annual Report, Addendum A

May, 1992 - SB 182 passed and authorized in statue preadmission assessment and referral program.

June, 1992 - Approval to recruit program manager is obtained.

July, 1992 - Implementation task force meets to determine options for program administration.

September, 1992 - Approval from Department of Administration to amend an existing PASARR contract with the Kansas Foundation for Medical Care (KFMC) to include administrative components of preadmission assessment and referral.

October, 1992 - Program manager is hired. Regulations are drafted and submitted.

November, 1992 - Assessment instrument and training plans developed. Recruitment of assessors is initiated.

December, 1992 - Initial training provided to nursing facilities, hospitals, community based assessors and SRS staff.
Program operating procedures are finalized.

January, 1993 - Program operation begins.

February, 1993 - Request for Proposal (RFP) process begins.

March, 1993 - RFP is issued. Management reports are defined and development begins.

April, 1993 - RFP bidding process is closed. KFMC, Bock Associates, First Mental Health of Nashville, and Mental Health Consortium have submitted bids.

May, 1993 - Bock Associates is awarded contract based on best technical proposal. Administration of the program is to be transferred effective July 1, 1994.

June, 1993 - Protests by unsuccessful bidders are submitted, delaying transfer and development of program operation.

July, 1993 - Bock Associates assumes administration of the program.
Contracts with community based assessors and hospitals have to be completed with Bock.
Program operation continues under procedures developed by KFMC to allow time for development of enhancements.

August, 1993 - Program enhancements are submitted to SRS by Bock Associates for program operation effective October 1, 1994.

September, 1993 - Policy and procedure revisions are made based on program enhancements. Training for assessors, nursing facilities, and SRS staff is developed and delivered.

October, 1993 - Program enhancements including prior authorization criteria are implemented.

November, 1993 - Preliminary data from implementation of program enhancements indicates dramatic improvement in cost-efficiency of program operation.
Management reports are designed and developed.

December, 1993 - Task Force is implemented and meets to address the critical administrative and operational issues facing the program.

January, 1994 - Recommendations of the task force are delivered.
First management reports are provided by Bock Associates.

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Addendum B

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

DATE: December 29, 1993

TO: Governor Joan Finney
State Legislators

FROM: Donna Whiteman Donna Whiteman

SUBJECT: Kansas Nursing Facility Preadmission Assessment and Referral Program
1993 Annual Report

Enclosed for your review is the 1993 Kansas Nursing Facility Preadmission Assessment and Referral Program Annual Report. This report is provided in compliance with K.S.A. 1992 Supp. 39-966. The information is based on the first year of program operation. An addendum to this annual report will be provided on January 10, 1994 as comprehensive third and fourth quarter data become available. SRS continues to work with Bock Associates and the Area Agencies on Aging to strengthen the follow-up on referrals to community based service component of the program. Doing so, will provide "length of diversion" data which to date has not been available. This information should be available by March 31, 1994.

If you have any questions regarding the information within the report please do not hesitate to let me know.

DLW/DHB/wjd

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915 SW HARRISON STREET, TOPEKA, KANSAS 66612

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
DIVISION OF INCOME SUPPORT AND MEDICAL SERVICES

Secretary Donna L. Whiteman
Commissioner Robert L. Epps

KANSAS NURSING FACILITY PREADMISSION ASSESSMENT AND REFERRAL PROGRAM ANNUAL REPORT - 1993

December 31, 1993

****

SRS Mission Statement

"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

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pg 3 of 49.

I. INTRODUCTION

This annual report on the Kansas Nursing Facility Preadmission Assessment and Referral program is provided in accordance with K.S.A. 1992 Supp. 39-966, (Senate Bill No. 182). Subsection (g) of the statute directs the Secretary of Social and Rehabilitation Services (SRS) to "report to the governor and to the legislature on or before December 31, 1993, and each year thereafter on or before such date, an analysis of the information collected under this section that identifies the need for home and community based services and such other information relating to the administration of this section as the secretary deems appropriate." The following provides information for the program's first year of operation.

II. BACKGROUND

SRS values providing Kansans with options for health care services within available resources. The overwhelming choice of care settings among frail, vulnerable adults is their home. And yet, in fiscal year 1991 over 90% of Kansas public long term care (LTC) expenditures were for nursing facility care. The current Kansas revenue system cannot continue to support this trend.

Because of this apparent contradiction between expenditures and desires of frail vulnerable adults, the interagency LTC Action Committee included in their 1992 recommendations to the Kansas legislature, development and implementation of a Preadmission Assessment and Referral program. (Sub. HB 2566) As a result of the 1992 legislative session, a nursing facility preadmission assessment and referral program was authorized in SB 182, new section (2). The legislation provided program responsibility for both SRS and the Kansas Department on Aging (KDOA). SRS would be responsible for the regulation and administration of the program. KDOA would be responsible for development of comprehensive resource guidebooks which identify available community based services specific to geographical regions of the state.

Prior to implementation of this program, only 22% of Medicaid clients seeking admission to nursing facilities were provided an assessment of their needs when faced with decisions regarding long term care. For private pay individuals the percentage was even smaller. Only those private pay admissions to nursing facilities directly from hospitals received information about alternative services. The amount and extent of information received through discharge planning was inconsistent and varied greatly between hospitals. In either situation, whether Medicaid or private pay, individuals were not aware of available alternatives to institutional care which met their needs. National statistics indicate that the average private pay nursing facility resident converts to Medicaid within 2 1/2 years. The LTC Action Committee felt it critical that all Kansans seeking admission to a Medicaid-certified nursing facility be provided with assessment and referral services.

The program authorized late in May, 1992 was implemented on January 4, 1993.

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GOALS OF THE NURSING FACILITY PREADMISSION ASSESSMENT AND REFERRAL PROGRAM INCLUDED:

1. Compliance with mandated federal preadmissioin assessment and annual resident review, PASARR, requirements for nursing facility preadmission screening.

   Note: PASARR is a screening process which identified potential mental illness and/or mental retardation among applicants seeking admission to Medicaid-certified nursing facilities. In situations where mental illness and/or mental retardation is suspected, a second (Level II) screening is required to determine the need for specialized services which address the mental illness or mental retardation diagnosis.

2. Provide all persons seeking admission to nursing facilities with information regarding community-based alternatives to meet their LTC needs identified through the assessment process.

3. Increase access to community-based LTC services in all geographical areas of Kansas.

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

5. Reduce Medicaid expenditures for institutional LTC services by developing and expanding utilization of cost-effective community-based alternatives.

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

III. PROGRAM OPERATION

The program design and implementation process began in July, 1992 (See Addendum A, Timeline). Department of Administration, Division of Purchasing, allowed SRS to amend an existing PASARR contract with the Kansas Foundation for Medical Care (KFMC) to include implementation of the new preadmission assessment and referral program through June 30, 1993. Approval included a stipulation that a competitive request for proposal (RFP) would be issued and awarded prior to July 1, 1993 and would include administration of both state and federal preadmission screening requirements.

This complex federal and state mandated program touches virtually every aspect of the LTC industry including consumers, families, physicians, hospitals, nursing homes, SRS and Area Agency on Aging (AAA) local offices, and three state agencies (SRS, KDOA and Kansas Department on Health and Environment, KDHE). The implementation date of January 1, 1993 provided less than six months for program development. As a result, implementation problems surfaced during the first six months of program operation.

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Attm #9-5
pg 5 of 49

- Limited number of assessors in rural areas of the state.
- Heavy telephone and fax traffic caused delays in KFMC processing time.
- Unclear instructions/training for nursing facilities and hospitals.
- Field testing the assessment instrument for reliability and validity.

As these problems were identified and resolutions sought during the first three months of program operation, the RFP was issued and the negotiation process began. Two in-state and two out-of-state proposals were submitted. Kansas Statutes Annotated 75-3740(a) directs that the lowest responsible bidder be awarded the contract, when consideration of conformity with specifications, terms of delivery, and other conditions imposed in the RFP is given. KSA 75-3740(b) directs that only in the case of identical bids, is the in-state bidder selected over the bidder from out-of-state.

On May 26, 1993, less than five months into program operation, the administrative contractor changed. Bock Associates, a Minnesota firm with extensive background in PASARR, was awarded the contract effective July 1, 1993. Bock Associates has provided PASARR and Preadmission Assessment administrative services in eight other states including Alabama, Arkansas, California, Illinois, Georgia, North Dakota, Louisiana and Ohio. This decision was based on a technical proposal which targeted strengthening the program, streamlining processes, increasing effectiveness and decreasing overall costs of the program within the agency's limited resources.

The transition period between July 1, 1993 and September 30, 1993 presented new problems for Bock Associates in addition to those recognized early in program operation. Community based providers of assessment services were required to submit new verification and documentation for continued contracts with Bock; nursing facilities did not have adequate documentation of compliance with PASARR during survey process; and problems with internal procedures and personnel issues surfaced as Bock established their Kansas office.

The new problems, attributed to short transition timeframes provided Bock Associates as a result of protests filed by unsuccessful bidders, complicated problem resolution. Without adequate lead time, Bock Associates could not implement program enhancements identified in their RFP. Instead, SRS directed Bock Associates to continue program operation as established by KFMC for three months to allow for the development of policy and procedures to implement the program changes.

Throughout the first six months of the program, SRS sought input and feedback on the overall program management through a Continuing Quality Improvement (CQI) team. (See Attachment A) Based on their input and the recommendations of the Legislative Post Audit (LPA) study to continue the program with necessary changes, and utilizing the technical proposal by Bock Associates, the following program enhancements were implemented on October 1, 1993: (See Attachment B)

1. All assessment and referral services must be prior authorized by Bock Associates utilizing a toll-free telephone number.

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pg 6 of 9

2. Completion of assessment and referral services may be delayed for hospitalized patients whose health care and service needs can more accurately and/or more appropriately be determined at a later date.

3. Adopt a standardized criteria for determining appropriate level of care to be applied to all assessors.

4. Follow-up and documentation of access to community-based services for those individuals who choose the community based option.

5. The uniform assessment instrument has been modified to facilitate data entry; provide optional financial information; and delete unnecessary data elements. Incorporate proven and reliable data format from other states.

6. Improve the PASARR delivery system to ensure compliance with federal regulations by revising the Level II screening instrument.

7. Establish an average rate for assessment and referral reimbursement based on accessibility and geographical area.

While implementation of these enhancements is ongoing, preliminary data indicates these changes will improve cost-effectiveness of the program and overall service delivery.

On October 21, 1993, a public hearing was conducted by a joint meeting of the Committee's on Public Health and Welfare. Nearly all testimony was provided by hospital and nursing home industry representatives and associations. The testimony presented indicated changes needed to be made in program operation. As a result, Secretary Whiteman and Secretary Hurst, KDOA, were ask to convene a task force (See Attachment C) to address the critical issues facing the program. The task force met twice in December and will meet three times in January, 1994. The task force will provide recommendations and a timeframe for resolution of the critical issues to the House and Senate Committee's on Public Health and Welfare early in the 1994 Legislative Session.

V. FINDINGS

DETAIL:	JANUARY - JUNE, 1993	JULY - SEPTEMBER, 1993	OCTOBER - DECEMBER, 1993*
A. Total number reimbursed Level I assessments	8,045	4,852	2,361
B. Total number of Level II assessments	798	278	174
C. Monthly average number of Level I assessments	1,341	1,617	787

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D. Monthly average number of Level II assessments	133	93	75
E. Area of highest frequency of completed Level I assessments	Chanute (13%)	Chanute	Chanute
F. Average age of individual assessed	77	78	78
G. Average cost/Level I Assessment	$74.34	$75.00	$70.00
H. Average cost/Level II Assessment	$223.20	$176.26	$125.00***
I. Average completion time for Level I assessment (working days)	8	4.5	2.7
J. Average completion time for Level II assessment	16	9	9
K. Total number of available assessors (Individuals) (See Attachment D)	796	796	198
L. Most requested, least available community based services (See Attachment E)	Adult Day Care, Attendant Care, Respite Care (See Attachment I)	To be provided 3-31-94	To be provided 3-31-94
M. Percentage of time recommended services were not available	13%	To be provided 3-31-94	To be provided 3-31-94
N. Diversion Percentage**	7.5%	14.5%	45%
O. Length of Diversion	Available 3-31-94	Available 3-31-94	Available 3-31-94

* Data through December 31, 1993.

Diversion Formula
**Any individual actively seeking nursing facility placement, who, as a result of receiving information through the preadmission assessment and referral process, chooses to remain in the community and pursue community based service alternatives.
***A temporary six week increase to $210.00 is being paid through January 31, 1994 to allow for review of Level II assessment performance time.

Attm #9-8, PHFW 1-20-94

VI. SUMMARY

This program provides a critical coordinating function with other SRS initiatives to shift Kansans' overreliance on institutional care to a system which provides for individual choice of a wide array of services and care settings. The 1993 LPA study examining potential duplication and overlap in programs for Kansas' Aging Population recognized that all four comparison states have utilized a prescreening program to shift to a community based service delivery system. In the 1992 report, Long Term Care for the Elderly, developed by the School of Social Welfare, University of Kansas, the following is noted in relationship to preadmission assessment and referral:

> "A strong gatekeeping function is needed at the point people are considering admission to a nursing facility, or ideally at an earlier point before financial, and informal care resources are depleted. Many states have combined preadmission screening with statewide case management to help elderly people develop viable community alternatives for their care. This is crucial if a less costly community system for long term care is to ultimately result. Of course, community based long term services must be developed before they can be accessed."

The Kansas Preadmission Assessment and Referral program is designed to achieve those items noted in the report. Through effective program operation, individuals are provided information regarding their health care needs and LTC service options, referrals to needed services including case management, and data is gathered and analyzed identifying what services are needed in each geographical area of the state.

While program implementation and operation have not been smooth during the first year, complaints have not come from consumers. The strongest critics of the program have been the nursing facility and hospital industry and associations.

SRS recognizes the urgent and critical need to resolve the implementation problems. The task force will be addressing the following issues:

Ensuring Access on Referrals
Cost Analysis of Program Operation
Refining the Assessment Tool
Availability and Access to Assessors
Assessment Process and Exemptions
Contractor Administrative Concerns
Consensus and Training Needs
Early Intervention Proposal

PH&W
1-20-94
Attm #9-9

As of January 3, 1994 the following recommendations have been made by the task force:

Refining the Assessment Tool:

Continue to utilize the KPARI as the uniform assessment instrument for preadmission assessment and referral services by all providers of the assessment. Delegate the responsibility of refining the tool to a subcommittee of the Continuing Quality Improvement (CQI) team. The subcommittee will provide a draft of the revised instrument by March 1, 1994 to members of the task force. The final revised instrument will be implemented April 1, 1994. Specific areas which require review and revision include question one and thirty-seven.

Ensuring Access on Referrals:

Allow all hospitals, obtaining prior authorization, to provide assessment and referral services as a part of the hospital discharge planning process. Hospitals would utilize the common assessment instrument for the program and apply SRS established nursing facility level of care criteria. Hospitals would ensure that only appropriate qualified staff would provide assessments. As a part of the discharge planning process, reimbursement would not be available. Hospitals would provide copies of the assessment and outcome determinations to the program contractor. Hospitals would be responsible for advising admitting nursing facilities of the outcome determination and compliance with PASARR. Hospitals would be subject to the same quality assurance standards as other assessors land monitored by the program contractor. Hospitals may continue to utilize the emergency planned brief stay nursing facility admission procedures currently in place.

The remaining task force recommendations will be available by January 31, 1994. Through the recommendations of the task force and CQI team, these problems can be addressed and resolutions implemented by the end of calendar year 1994. Additional client demographic information, cost-effectiveness of program operation, and other assessment data will be forthcoming. This additional information will be submitted as an addendum to the annual report.

VII. ATTACHMENTS

A. CQI Membership List
B. October 1, 1993 Program Enhancement Chart
C. Task Force Membership List
D. November 2, 1993 Assessor List
E. Recommended/Least Available Community Based Services by Area

DLW/DHB/wjd

PH&W
1-20-94
Item #9-10
~~9~~ 10 of 49

Attachment A

CONTINUOUS QUALITY IMPROVEMENT TEAM LIST

Ms. Dona Booe
Division of Medical Services
Room 628 South
Docking State Office Building
915 SW Harrison
Topeka, KS 66612-1570

Ms. Debbie Bird
Bock Associates
1525 SW Topeka Blvd, Suite A
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Ms. Victoria Martin
Aging Network Specialist
Kansas Department of Aging
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Topeka, KS 66612-1570

Ms. Pat Maben, Director
Department of Health and Environment
Landon State Office Building
900 SW Jackson, Suite 1001
Topeka, KS 66612-1572

Ms. Annette Siebert, Director
Government and Legal Affairs
Kansas Association of Homes for the Aging
700 SW Harrison, Suite 1106
Topeka, KS 66603-3759

Mr. John Kiefhaber, Executive Director
Kansas Health Care Association
221 SW 33rd
Topeka, KS 66611

Ms. Jane Ford
Kansas Hospital Association
1263 South Topeka Blvd.
Topeka, KS 66612

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Ms. Sandra Strand, Legislative Coordinator
Kansans for the Improvement of Nursing Homes,Inc.
913 Tennessee, Suite #2
Lawrence, KS 66044

Ms. Shirley Hitt
Kansas Home Care Association
Douglas County Visiting Nurses Association
336 Missouri, Lower Level
Lawrence, KS 66044

Ms. Karin Rexroad, Executive Director
Reno County Department on Aging
206 West 1st
Hutchinson, KS 67501

Ms.Julie Govert Walter, Director
North Central/Flint Hills AAA
437 Houston
Manhattan, KS 66502

Ms. Marci Urbanek
Hays Area SRS Office
1105 East 30th St.
Hays, KS 67601

Ms. Mary Transue
Lawrence Area SRS Office
1901 Delaware - Box 590
Lawrence, KS 66046

Ms. Diane Vaughn
Wichita SRS Office
3244 East Douglas
Wichita, KS 67201

Ms. Karen Thornton
Topeka SRS Office
235 Kansas, Box 1424
Topeka, KS 66601

Ms. Ellen Elliston, Director
Social Work Department
St.Francis Regional Medical Center
929 North Street
Wichita, KS 67214

Mr. Jeffrey Tarrant, Administrator
Mitchell County Hospital
400 West 8th
Beloit, KS 67420

PH rec'd 1-20-94 Action #9-12 pg 9-42

Ms. Monica Flask
Halstead Hospital
328 Poplar
Halstead, KS 67056

Ms. Gina McDonald
Topeka Independent Living Resource Center
3258 SW Topeka Blvd
Topeka, KS 66611

Ms. Linda Johnson, Supervisor
St. Luke's Hospital
4401 Warnall Road
Kansas City, MO 64111

Ms. Rosie Williams
1020 South Kansas Avenue
Topeka, KS 66612

Ms. Elaine Duffens
3750 SW Belle Avenue
Topeka, KS 67420

Ms. Leslie Burkholder
Memorial Hospital
511 10th St.
Abilene, KS 67410

Ms. Joyce Gordon-Raske
c/o Advanced Medical Consultants
P. O. Box 194
Riverton, KS 66770

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1-20-94
attn: 9-13

Pg 13 of 49

KANSAS NURSING FACILITY (NF) PREADMISSION ASSESSMENT AND REFERRAL PROGRAM
RECOMMENDED PROGRAM ENHANCEMENTS
EFFECTIVE OCTOBER 1, 1993

Program Issues #1	o Enhancement(s) and -Fiscal Impact	Anticipated Outcomes	Potential o Barriers/-Solutions
o Inappropriate assessments being completed. These include assessments performed on persons not seeking NF care, and for persons who have received assessment services previously.	o Require all assessments be authorized by Bock Associates before completion. A toll free "800" number will be utilized. - $112,000 cost savings annually. (16,000 assessments x $70 x 10%)	o 10% to 20% reduction in number of assessments completed for reimbursement. o Elimination of service duplication. o Assures consumer is actually seeking NF care. o Ensures consumer choice of providers.	o Paradigm of nonconsumer control "seeking" NF care (i.e., Physician orders NF care). o Decreased reimbursement potential for Level I assessors. - Program intent was to provide this service only to persons seeking NF care. - Substantial time-savings result by elimination of inappropriate assessments.

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Item #9-14

KANSAS NURSING FACILITY (NF) PREADMISSION ASSESSMENT AND REFERRAL PROGRAM
RECOMMENDED PROGRAM ENHANCEMENTS
EFFECTIVE OCTOBER 1, 1993

Program Issues #2	o Enhancement(s) and -Fiscal Impact	Anticipated Outcomes	Potential o Barriers/-Solutions
o Assessment and referral services completed on hospitalized patients following an acute care episode may be more effective when fully completed upon stabilization of medical/functional condition.	o Revise the uniform assessment instrument to include a segment which determines if the individual is NF appropriate by utilizing a toll free "800" number. Bock Associates will recommend completion of the assessment and referral upon stabilization of consumer condition. The telephone assessment will include all information necessary to determine if a diversion from NF care is possible immediately. - $130,000 savings. (16,000 x 58% x 20% x $70). 58% reflects total number of persons assessed in hospitals.	o 20% reduction in number of assessments completed for full reimbursement. o Reduces the potential for discharge delays from hospitals. o Allows time for practical consideration of community-based service options for individuals and families. o Statewide consistency in service delivery of Preadmission Assessment & Referral. o Compliance with federal PASARR regulations.	o Legislation as written allows hospitals with conflict of interest to provide assessments. - Amend statute to clarify hospitals with NF licensure or skilled nursing wings cannot provide assessment. o NF's may resist post-admission assessments and consider it duplicative with the MDS+ (Case Mix) assessment. - NF staff are not required to complete the assessment. Data on the uniform assessment instrument will be consistent with MDS+ data and will be utilized in conjuction to trigger referral component of assessment process.

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KANSAS NURSING FACILITY (NF) PREADMISSION ASSESSMENT AND REFERRAL PROGRAM
RECOMMENDED PROGRAM ENHANCEMENTS
EFFECTIVE OCTOBER 1, 1993

Program Issues #3	o Enhancement(s) and -Fiscal Impact	Anticipated Outcomes	Potential o Barriers/-Solutions
o Criteria establishing appropriateness for NF level of care is not consistent with other SRS Long-Term Care (LTC) program eligibility requirements.	o Adopt standardized NF level of care to be Level III, Score 10. (Based on 3 ADL and 2 IADL limitations and point systems, hospitalization and age.) o Eliminate Income Eligible (IE) annual redeterminations from the assessment process. o SRS Area/Local office assessors will not refer HCBS/NF and/or IE assessments to private based assessors. - $9,000 administrative cost savings annually.	o 5% increase in the number of medicaid individuals found to be inappropriate for NF level of care. o 2% savings in administrative costs of program operation. o Eliminates duplication of service. -(5000 SRS assessments x $1.80 admin cost per assessment).	o Loss of centralized control over NF level-of-care determination process. - Training and detailed manual instructions coupled with a quality assurance (QA) review process will insure consistency in determinations. o Slight decrease in numbers of persons found NF eligible. o Slight increase in level of care needs for NF resident population.

PH&W 1-20-94 Attm. #9-1[illegible] Pg. 16 of 49

KANSAS NURSING FACILITY (NF) PREADMISSION ASSESSMENT AND REFERRAL PROGRAM
RECOMMENDED PROGRAM ENHANCEMENTS
EFFECTIVE OCTOBER 1, 1993

Program Issues #4	o Enhancement(s) and -Fiscal Impact	Anticipated Outcomes	Potential o Barriers/-Solutions
o Inadequate follow-up on referral component of program. Persons choosing community-based alternative receive inconsistent referral and follow-up services. o Diversion statistics do not provide complete information.	o Bock Associates will ensure follow-up on referral process and access to community-based services by adding staff dedicated to follow-up and quality review functions. - Funding for additional staff is within the existing contract	o Improved statistical validity of diversion rates. o Increased detail regarding availability of community-based alternatives. o Enhanced quality assurance system for providers of assessment. o Strengthens opportunities for consumer education and choice. o Strengthens coordination of service delivery between KDOA & SRS programs.	o Potential for decrease in current reported diversion rate, as current assessment instrument reflects consumer choice at the time of assessment. - Measurement of choice of LTC option and subsequent receipt of CBS services will provide a valid and defendable database for future funding considerations. - Improved resource management for development of community-based services. o 100% of consumers will not be available for follow-up data.

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KANSAS NURSING FACILITY (NF) PREADMISSION ASSESSMENT AND REFERRAL PROGRAM
RECOMMENDED PROGRAM ENHANCEMENTS
EFFECTIVE OCTOBER 1, 1993

Program Issues #5	o Enhancement(s) and -Fiscal Impact	Anticipated Outcomes	Potential o Barriers/-Solutions
o Insufficient uniform assessment instrument. Reliability of the instrument is inadequate. Data collection is cumbersome. No financial information section is available.	o Modify assessment instrument to facilitate data entry; provide for consumer choice for optional financial information; and delete unnecessary data elements. (See Attachment E1) - Cost of developing a new instrument and providing the training are included in the current contract with Bock Associates.	o Enhanced information assists in improved referral proces. o Increased flexibility for creating detailed management reports. o Encourages other agencies to utilize instrument. o Facilitates development of direct data entry by assessors. o Provides for more cost-effective service delivery by reducing assessment time. o Consistent with MDS+ data collection.	o Require retraining of current assessor pool. - Current assessors have asked for additional training. The new instrument includes recommendations made by assessors. o Requires waiver amendment. - A full 3 months of management information utilizing the new instrument will be available for the annual report to the legislature.

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KANSAS NURSING FACILITY (NF) PREADMISSION ASSESSMENT AND REFERRAL PROGRAM
RECOMMENDED PROGRAM ENHANCEMENTS
EFFECTIVE OCTOBER 1, 1993

Program Issues #6	o Enhancement(s) and -Fiscal Impact	Anticipated Outcomes	Potential o Barriers/-Solutions
o Compliance with federal PASARR regulations continues to be unmet.	o Revise Level II PASARR Screening instrument to be compatible with the Level I assessment instrument. - $154,000 cost savings Annually: (30% x #513,000). o Utilize Community Mental Health Centers (CMHC) as providers of Level II assessment through providers of the Mental Health Consortium. - Failure to comply with federal PASARR regulations may result in loss of FFP.	o 30% reduction in time needed to complete Level II assessments. o Reduce potential for duplication of services. o Ensure compliance with federal PASARR regulations.	o Reduction in number of available Level II providers. - CMHC's are the primary provider of Level II assessments currently and promotes consistency with mental health reform policies.

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Attachment #9-19

KANSAS NURSING FACILITY (NF) PREADMISSION ASSESSMENT AND REFERRAL PROGRAM
RECOMMENDED PROGRAM ENHANCEMENTS
EFFECTIVE OCTOBER 1, 1993

Program Issues #7	o Enhancement(s) and -Fiscal Impact	Anticipated Outcomes	Potential o Barriers/-Solutions
o Inconsistent reimbursement rates for assessment services among providers, from $25 to $100.	o Bock Associates will negotiate using a modified RFP approach with potential providers of assessment utilizing cost-effective quality assurance criteria. - Cost savings of $80,000 annually. (16,000 x $5.00).	o Ensure maintenance of statewide access to to service. o 25% reduction in reimbursement rates. o Increased quality control of providers of assessment. o Facilitates communication processes between SRS, Bock Associates, and subcontractors.	o Reduction in number of Level I assessors. - Improved quality of assessments and creates a dedicated provider group without decreasing access to services. o Lower reimbursement rates to current providers. - Only providers of the highest quality and efficiency will provide the service.

* Total Cost Savings of $485,000 Annually.

DRR:wjd
Revised 10/21/93

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Attn: # P.20
Pg. 20 of 49

Attachment C

KANSAS NURSING FACILITY PREADMISSION ASSESSMENT AND REFERRAL TASK FORCE MEMBERSHIP LIST

December 20, 1993

Secretary Donna L. Whiteman, SRS, Co-chair
Secretary Joanne E. Hurst, Kansas Department on Aging, Co-chair

Robert L. Epps, Commissioner Income Support/Medical Services, SRS
George Vega, Commissioner Mental Health and Retardation Services, SRS
Gary Nelson, Hutchinson Area Director, SRS
Warren Bock, Chief Executive Officer, Bock Associates
Mike Nunamaker, Memorial Hospital, Manhattan
Joe Engelken, Onaga Community Hospital, Onaga
Dean Edson, United Methodist Homes, Inc., Topeka
David Slack, Aging Resource Institute, Topeka
Julie Steward, Consumer, Lawrence
Rosie Williams, Caring Connections, Topeka
Julie Govert Walter, AAA Director, K4A President, Manhattan
Patricia Maben, RN, Kansas Department of Health and Environment
Ed Lewis, Southview Homecare, Louisburg
John Holzhuter, Director Catholic Social Services, Topeka
Melvin Potts, Consumer, Pittsburg
Ruth Lyon, Consumer, Independence
Ty Petty, Stormont Vail Regional Medical Center, Topeka
Lyndon Drew, Kansas Department on Aging, Topeka
Mike Donnelly, Independent Living Center, Topeka
Dianne Garner, Washburn University, Topeka
Sandra Strand, Kansans for Improvement of Nursing Homes, Lawrence
Rhonda Montgomery, University of Kansas, Lawrence
Michelle Crozier, Consumer, Shawnee
Sandra Medinger, Johnson County AAA, Olathe

Dona Booe, CBLTC Program Manager, SRS (Staff)
Wilda Davison, Secretary, SRS (Staff)

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1-20-94
Attm # 9-21
Pg 31 of 49

Novem[illegible], 1993

APPROVED CONTRACTORS BY KANSAS COUNTY

County: ALLEN

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell
Neosho Memorial Hospital	352	Nancy Castelluci

County: ANDERSON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Elaine Duffens	942	Elaine Duffens

County: ATCHISON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens
Jefferson Cty Mem'l Hosp.	943	Robert Hixson
Northeast KS Multi-Cty HD	991	Patricia Scott

County: BARBER

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Harper Co Hospital District #5	310	Vernon Minnis
Rita White	313	Rita White

County: BARTON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade

PN+CW
1-20-94
attm 9.22
pg. 22 of 49

County: BOURBON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell

County: BROWN

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens
Northeast KS Multi-Cty HD	991	Patricia Scott

County: BUTLER

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell Kan	353	Jamia Cantrell
Hospice Inc.	941	Nadine Penner
Mary Corrigan	321	Mary Corrigan

County: CHASE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Elaine Duffens	942	Elaine Duffens

County: CHAUTAUQUA

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell

PKW
1-20-94
Attm# 9-23
pg 23 of 49

County: CHEROKEE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell

County: CHEYENNE

Organization/Individual	Contractor ID#	Contact
Cheyenne County Hospital	936	Susan Roelfs
Citizens Medical Center **	934	Lisbeth Bell

County: CLARK

Organization/Individual	Contractor ID#	Contact
Minneola District Hospital	365	Lisa Freeborn
Southwest Home Care	367	Becky Richardson

County: CLAY

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Clay County Hospital *	980	John Wiebe
Sherry Provost	987	Sherry Provost

County: CLOUD

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
St. Joseph Hospital	986	Rose Koerber
Sherry Provost	987	Sherry Provost
Steve Proctor	988	Steve Proctor

PN&W
1-20-94
Attn #9-24
pg. 24g 49.

County: COFFEY

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell Kan	353	Jamia Cantrell
Elaine Duffens	942	Elaine Duffens

County: COMANCHE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts, Inc. **	350	Elaine Wade

County: COWLEY

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell Kan	353	Jamia Cantrell
Hospice Inc.	941	Nadine Penner
Mary Corrigan	321	Mary Corrigan

County: CRAWFORD

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell

County: DECATUR

Organization/Individual	Contractor ID#	Contact
Decatur County Home Health *	937	Dean Aldridge
Joy Haney	939	Joy Haney

County: DICKINSON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elanie Wade
Elaine Duffins	942	Elaine Duffins
Memorial Hospital	981	Leslie Burkholder

PH+W 1-20-94 attn 9-25

pg. 25 of 49

County: DONIPHAN

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens

County: DOUGLAS

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens
Jefferson Cty Mem'l Hosp	943	Robert Hixson
Lawrence-Douglas Cty HD	940	Wynona Floyd
Midland Psychiatric Associates	911	Tom Flanagan
University of Kansas Medical Ctr.	940	Diane Lee

County: EDWARDS

Organization/Individual	Contractor ID#	Contact
Edwards Cty Hospital	361	Judi McKenney
Hodgeman Co. Hospital	362	Roger Salsbury

County: ELK

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell

County: ELLIS

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Hodgeman Cty Health Center	362	Roger Salisbury

P H&W
1-20-94
Attm #9-26
pg 26 of 49

County: ELLSWORTH

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Ellsworth Cty Hosp *	984	Roger Pearson
Helen Reeves	989	Helen Reeves

County: FINNEY

Organization/Individual	Contractor ID#	Contact
Hodgeman Co. Hospital	362	Roger Salsbury
St. Catherine Hospital	366	Marla Linenberger
Satanta District Hospital	364	T.G. Lee

County: FORD

Organization/Individual	Contractor ID#	Contact
Edwards Co. Hospital	361	Judi McKinney
Hodgeman Co. Health Center	362	Roger Salisbury
Southwest Home Care	367	Becky Richardson
Western Plains Regional Hospital *	372	Vonda Sanders

County: FRANKLIN

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens

County: GEARY

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens

9-27

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County: GOVE

Organization/Individual	Contractor ID#	Contact
Hodgeman Cty Health Center	362	Roger Salisbury

County: GRAHAM

Organization/Individual	Contractor ID#	Contact
Graham County Hospital	932	Rebecca Perry

County: GRANT

Organization/Individual	Contractor ID#	Contact
Satanta District Hospital	364	T.G. Lee
Teresa Follis	314	Teresa Follis

County: GRAY

Organization/Individual	Contractor ID#	Contact
Hodgeman Co. Hospital	362	Roger Salisbury
Satanta District Hospital	364	T.G. Lee
Southwest Home Care	367	Becky Richardson

County: GREELEY

Organization/Individual	Contractor ID#	Contact
Greeley County Hospital *	370	Cindy Schneider
Hamilton Cty Hospital *	368	Diedra Piper

County: GREENWOOD

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell
Elaine Duffens	942	Elaine Duffens

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County: HAMILTON

Organization/Individual	Contractor ID#	Contact
Greeley Co. Hospital	370	Cindy Schneider
Hamilton Cty Hospital	368	Diedra Piper

County: HARPER

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Harper Hospital District #5	310	Vernon Minnis
Hospice Inc.	941	Nadine Penner
Rita White	313	Rita White

County: HARVEY

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Hesston Medical Center	320	Cheryl Erb
Mary Corrigan	321	Mary Corrigan

County: HASKELL

Organization/Individual	Contractor ID#	Contact
Martha Schlenker	306	Martha Schlenker
Satanta District Hospital	364	T.G. Lee
Southwest Home Care	367	Becky Richardson

County: HODGEMAN

Organization/Individual	Contractor ID#	Contact
Edwards Co. Hospital	361	Judi McKinney
Hodgeman County Health Center	362	Roger Salisbury
Southwest Home Care	367	Becky Richardson

9-29

pg 29 of 49

County: JACKSON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens
Jefferson Cty Mem'l Hosp	943	Robert Hixson
Northeast KS Multi-Cty HD	991	Patricia Scott

County: JEFFERSON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens
Jefferson Cty Mem'l Hosp	943	Robert Hixson

County: JEWELL

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Caring Connections	944	Rosie Williams
Ruth Caldwell	992	Ruth Caldwell
Steve Proctor	988	Steve Proctor

County: JOHNSON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens
Midland Psychiatric Associates	911	Tom Flanagan
Overland Park Regional Med.Ctr.		

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1-20-94
attm # 9-30

County: KEARNY

Organization/Individual	Contractor ID#	Contact
Greeley Co. Hospital	370	Cindy Schneider
Kearny County Hospital	360	Barabara Woodrow

County: KINGMAN

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Harper Hospital District #5	310	Vernon Minnis
Hospice Inc.	946	Nadine Penner
Kingman Community Hospital	311	Gayle Easley
Mary Corrigan	321	Mary Corrigan

County: KIOWA

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Edwards Co. Hospital	361	Judi McKinney

County: LABETTE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell

County: LANE

Organization/Individual	Contractor ID#	Contact
Hodgeman Cty Health Center	263	Roger Salisbury

PH&W
1-20-94
Attm #9-31

County: LEAVENWORTH

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens
Jefferson Cty Mem'l Hosp	943	Robert Hixson
Midland Psychiatric Associates	911	Tom Flanagan

County: LINCOLN

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Ellsworth Cty Hospital *	984	Roger Pearson
Helen Reeves	989	Helen Reeves
Lincoln Cty Hospital	982	Jolene Yager

County: LINN

Organization/Individual	Contractor ID#	Contact
Advanced Medical Center, Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell

County: LOGAN

Organization/Individual	Contractor ID#	Contact
Wichita County Hospital **	369	Bertie Evans

County: LYON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens

P H+C
1-20-94
Attm # 9-32

32
49

County: MARION

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants Inc	350	Elaine Wade
Salem Hospital Inc. *	380	Glenda Miller

County: MARSHALL

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants Inc	350	Elaine Wade
Community Memorial Hospital/HHA	990	Lucille Papes
Elaine Duffens	942	Elaine Duffens

County: MCPHERSON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants Inc	350	Elaine Wade
Hesston Medical Office	320	Cheryl Erb

County: MEADE

Organization/Individual	Contractor ID#	Contact
Martha Schlenker	306	Martha Schlenker
Satanta District Hospital	364	T.G. Lee
Southwest Home Care	367	Becky Richardson

County: MIAMI

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Midland Psychiatric Associates	911	Tom Flanagan

PNrcW
1-20-94
Attm # 9.33

Pg 33 of 49

County: MITCHELL

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Ruth Caldwell	992	Ruth Caldwell
Caring Connections	944	Rosie Williams
Steve Proctor	988	Steve Proctor

County: MONTGOMERY

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell
Wilson Cty Hospital	951	Deanna Pittman

County: MORRIS

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens

County: MORTON

Organization/Individual	Contractor ID#	Contact
Martha Schlenker	306	Martha Schlenker
Morton County Hospital *	307	Glen Wood

County: NEMAHA

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Caring Connections	944	Rosie Williams
Community Memorial Hospital	990	Lucille Papes
Elaine Duffens	942	Elaine Duffens

PH & W
1-20-94
Attm #9-34
pg. 34 of 49

County: NEOSHO

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell
Neosho Memorial Hospital	352	Nancy Castellucci
Wilson Cty Hospital	351	Deanna Pittman

County: NESS

Organization/Individual	Contractor ID#	Contact
Hodgeman Cty Health Center	362	Roger Salisbury
Ness County Hospital District #2	960	Pamela Pavlu

County: NORTON

Organization/Individual	Contractor ID#	Contact
Graham County Hospital	532	Rebecca Perry
Phillips Cty Hospital	935	Penelope Moffatt

County: OSAGE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens

County: OSBORNE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Elizabeth Hill	938	Elizabeth Hill
Phillips County Hospital **	935	Penelope Moffatt
Steve Proctor **	988	Steve Proctor

PKnW
1-20-94
atlm #9-35

Pg. 35 of 49

County: OTTAWA

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Elaine Duffens	942	Elaine Duffens
Steve Proctor	988	Steve Proctor

County: PAWNEE

Organization/Individual	Contractor ID#	Contact
Edwards Co. Hospital	361	Judi McKinney
Hodgeman Cty Health Center	362	Roger Salisbury

County: PHILLIPS

Organization/Individual	Contractor ID#	Contact
Elizabeth Hill	938	Elizabeth Hill
Graham Cty Hospital	932	Rebecca Perry
Phillips County Hospital	935	Penelope Moffatt

County: POTTAWATOMIE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens

County: PRATT

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Kingman Community Hospital	311	Gayle Easley

County: RAWLINS

Organization/Individual	Contractor ID#	Contact
Cheyenne County Hospital	936	Susan Roelfs
Rawlins County Hospital	931	Don Kessen

PX/rcw
1-20-94
attm # 9-36
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County: RENO

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Judi Emerson	315	Judi Emerson
Kingman Community Hospital	311	Gayle Easley
Mary Corrigan	321	Mary Corrigan

County: REPUBLIC

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Caring Connections	944	Rosie Williams
Ruth Caldwell	992	Ruth Caldwell
Steve Proctor	988	Steve Proctor

County: RICE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Judi Emerson	315	Judi Emerson
Rice County Health Department *	312	Jane Yates

County: RILEY

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens
Memorial Hospital	983	Lynne Stitz
Sherry Provost	987	Sherry Provost

County: ROOKS

Organization/Individual	Contractor ID#	Contact
Graham County Hospital	932	Rebecca Perry
Phillips County Hospital	935	Penelope Moffatt

PKW 1-20-94 Attm #9-37

pg 378/49

County: RI

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Hodgeman Cty Health Center	362	Roger Salisbury

County: RUSSE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Consultants	350	Elaine Wade
Helen Reeves	989	Helen Reeves
Ellsworth Cty Hospital •	984	Roger Pearson

County: SALIN

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
St. Johns Regional Health Center	985	Lindi Farenthold

County: SCOTT

Organization/Individual	Contractor ID#	Contact
Greeley Co. Hospital	370	Cindy Schneider
Scott County Hospital	363	Carol Forbish

County: SEDGWICK

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Hospice Inc.	946	Nadine Penner
Kingman Community Hospital	311	Gayle Easley
Mary Corrigan	321	Mary Corrigan

PN & W
1-20-94
Attn # 9-38
pg 387 of 49.

County: SEWARD

Organization/Individual	Contractor ID#	Contact
Martha Schlenker	306	Martha Schlenker
Satanta District Hospital	364	T.G. Lee
Southwest Home Care	367	Becky Richardson

County: SHAWNEE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Conections	944	Rosie Williams
Elaine Duffens	942	Elaine Duffens
Jefferson Cty Mem'l Hosp	943	Robert Hixson

County: SHERIDAN

Organization/Individual	Contractor ID#	Contact
Graham County Hospital	932	Rebecca Perry
Sheridan County Hospital	933	Janice Brown

County: SHERMAN

Organization/Individual	Contractor ID#	Contact
Cheyenne County Hospital	936	Susan Roelfs

County: SMITH

Organization/Individual	Contractor ID#	Contact
Caring Connections	944	Rosie Williams
Smith County Health Department	930	Elizabeth Hill
Phillips County Hospital	935	Penelope Moffatt
Ruth Caldwell	992	Ruth Caldwell

County: STAFFORD

PKwC 1-20-94 Attm #9-39

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Edwards Co. Hospital	361	Judi McKinney

Pg 39 of 49

County: STANTON

Organization/Individual	Contractor ID#	Contact
Hamilton Cty Hospital	368	Diedra Piper
Teresa Follis	314	Teresa Follis

County: STEVENS

Organization/Individual	Contractor ID#	Contact
Martha Schlenker	306	Martha Schlenker
Satanta District Hospital	364	T.G. Lee
Southwest Home Care	367	Becky Richardson

County: SUMNER

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Hospice Inc.	946	Nadine Penner
Harper Hospital District #5	310	Vernon Minnis
Mary Corrigan	321	Mary Corrigan
Rita White	313	Rita White

County: THOMAS

Organization/Individual	Contractor ID#	Contact
Cheyenne County Hospital	936	Susan Roelfs
Citizen's Medical Center	934	Lisbeth Bell

County: TREGO

Organization/Individual	Contractor ID#	Contact
Graham County Hospital	932	Rebecca Perry
Hodgeman Cty Health Center	362	Roger Salisbury

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1-20-94
Attm # 9-40
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County: WABAUNSEE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Caring Connections	944	Rosie Wiliams
Elaine Duffens	942	Elaine Duffens

County: WALLACE

Organization/Individual	Contractor ID#	Contact
Greeley County Hospital *	370	Cindy Schneider

County: WASHINGTON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Community Memorial Hospital	990	Lucille Papes
Sherry Provost	987	Sherry Provost

County: WICHITA

Organization/Individual	Contractor ID#	Contact
Greeley County Hospital *	370	Cindy Schneider
Wichita County Hospital	369	Bertie Evans

County: WILSON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell
Wilson County Hospital	351	Deanna Pittman

County: WOODSON

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Cantrell-Kan	353	Jamia Cantrell

PNW
1-20-94
Attn: 9-41

pg. 44 of 49

County: WYANDOTTE

Organization/Individual	Contractor ID#	Contact
Advanced Medical Cnslts Inc.	350	Elaine Wade
Elaine Duffens	942	Elaine Duffens
Midland Psychiatric Associates	911	Tom Flanagan

* Indicates contract offered but not returned
** Indicates contract returned, considering additional counties

VETERAN'S HOSPITALS ONLY

Organization/Individual	Contractor ID#	Contact
VA Medical Center, Kansas City	901	Joseph Mcglon
VA Medical Center, Leavenworth	902	James Runyon
VA Medical Center, Wichitia	903	Barbara Fretwell
VA Medical Center, Topeka	904	Rosemary Gosser

STATE HOSPITALS ONLY

Organization/Individual	Contractor ID#	Contact
Larnard State Hospital	800	John Adams
Osawatomie State Hospital	801	Martha Town
Topeka State Hospital	802	Mary Schell
Rainbow MHC	803	?

P&W
1-20-94
Attm # 9.42
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Attachment E

KANSAS NURSING FACILITY PREADMISSION ASSESSMENT AND REFERRAL PROGRAM
1993 ANNUAL REPORT

MOST REQUESTED/LEAST AVAILABLE
COMMUNITY BASED SERVICES
BY SRS MANAGEMENT AREA

As of June 30, 1993

Area Office:	CH	EM	GC	HA	HU	KC	LA	MA	OL	SA	TO	WI
Type of Service:												
NF Care												
Adult Day Care	X		X		X	X	X	X		X	X	
Home Delv. Meals												
Attendant Care					X	X						X
Homemaker												
Congregate Meals												
Home Health Care												
Transportation												X
Case Management												
Respite Care		X							X			
Hospice Service												
Mental Health Care												
Tele. Reassurance												
Minor Home Repair				X					X			
Chore Service	X		X	X								
Durable Med. Equip.												
Assisted Living		X					X	X		X	X	

PH&W
1-20-94
Attm # 9-43

pg. 43 of 49

KANSAS NURSING FACILITY PREADMISSION ASSESSMENT AND REFERRAL PROGRAM TASK FORCE

ISSUE PRIORITY LIST
(Revised as a Result of the December 20, 1993 Task Force Meeting)

January 3, 1994

Priority # 1 - **ENSURING ACCESS ON REFERRALS** -January 10, 1994

- Review and strengthen the follow-up on the referral process.
- Define the role of the AAA in the referral process.
- Incorporate and utilize the AAA Case Managers effectively in service delivery.

Priority #2 - **COST ANALYSIS OF PROGRAM OPERATION** -January 18, 1994

- Rate of growth of LTC Expenditures.
- Legislative Post Audit (LPA) comparison of states.
- Define LTC expenditures in terms of federal and state mandates.
- Data on current NF caseload size.
- Program benefits vs. program costs.

Priority #3 - **REFINING THE ASSESSMENT TOOL** -December 20, 1993

- Review the wording of questions to assure "choice" is not biased.
- Assure assessment instrument questions reflect the impact of mental status at the time of completion. (Does the assessment instrument take into account "crisis" situation and it's impact on the response to questions?)
- Standardization of forms.
- Confidentiality.

Priority #4 - **AVAILABILITY AND ACCESS TO ASSESSORS** -December 20, 1993

- Utilize available and existing resources to reduce duplication of service delivery.
- Chart by county the availability of locally based assessors.
- Confidentiality.

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1-20-94
Attm #9-44
pg 44 & 49

Priority #5 - **ASSESSMENT PROCESS AND EXEMPTIONS** -January 3, 1994

- Review paperwork involved and eliminate any unnecessary duplication.
- Flow chart the process and identify a streamlined process.
- Timeliness of outcome determinations and accountability for fiscal impact.
- Common entry point.
- Medicaid reimbursement for emergency admissions.
- Review the assessor instruction manual.

Priority #6 - **CONTRACTOR ADMINISTRATIVE CONCERNS** -January 18, 1994

- Accountability for delays and fiscal impact.
- Timeliness of response on outcome determination.
- Status and review of quality assurance plan.

Priority #7 - **CONSENSUS AND TRAINING NEEDS** -January 3, 1994

- Emphasis on program goals.
- Define "choice" and "community services", consumer empowerment.
- Program/process alternatives.
- Confidentiality.

Priority #8 - **EARLY INTERVENTION PROPOSAL** - January 10, 1994

- Avoid crisis intervention.
- Identify target population.
- Confidentiality.

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PH&W
1-20-94
Attn # 9-45
pg. 45 of 49

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
KANSAS NURSING FACILITY PREADMISSION ASSESSMENT AND REFERRAL PROGRAM

ATTACHMENT C
January 13, 1994

TASK FORCE RECOMMENDATIONS - ISSUE PRIORITY LIST

Priority #1: Ensuring Access on Referrals

Bock Associates in coordination with KDOA and SRS, must provide training for the community based assessors and AAA Information and Referral (I&R) staff on or before March 1, 1994. The training will emphasize to assessors the importance of timely referrals to the AAA and how this component of the program "fits into" the overall assessment and referral process. The training will emphasize for the AAA I&R staff the importance of timely follow-up with consumers to ensure access to needed services. Additionally, the training must include providing I&R staff with the necessary skills to complete the follow-up report in a timely and efficient manner. A component of the training must provide assessors with information and procedures for consumers to make self-referrals to independent living centers as appropriate.

Priority #2: Cost Analysis of Program Operation

Discussed by the task for on January 18, 1994. The decision was made by the members to make no formal recommendation regarding this issue.

Priority #3: Refining the Assessment Tool

Continue to utilize the Kansas Preadmission Assessment and Referral Instrument (KPARI) as the uniform assessment instrument for preadmission assessment and referral services by all providers of assessments. Delegate the responsibility of refining the tool to a subcommittee of the Continuing Quality Improvement (CQI) team. The subcommittee will provide a draft of the revised instrument by March 1, 1994 to members of the task force. The final revised instrument will be implemented April 1, 1994. Specific areas which require review and revision include questions one and thirty-seven.

Priority #4: Availability and Access to Assessors

Allow all hospitals, obtaining prior authorization, to provide assessment and referral services as a part of the hospital discharge planning process. Hospitals would determine appropriate level of care needs by utilizing the common assessment instrument for the program and apply SRS established nursing facility level of care criteria. Hospitals would ensure that only appropriate qualified staff would provide assessments. As a part of the discharge planning process, reimbursement would not be available. Hospitals would provide copies of the assessment and outcome determinations to the program contractor. Hospitals would be responsible for advising admitting nursing facilities of the outcome determination and compliance with PASARR. Hospitals would be subject to the same quality assurance standards as other assessors and monitored by the program contractor. Hospitals may continue to utilize the emergency planned brief stay nursing facility admission procedures currently in place.

P&A&W
1-20-94
Attachment 9-46
Pg. 46 of 49

Priority #5: Assessment Process and Exemptions

Continue to refine the process as outlined on the program flowchart. Reduce total processing time, including outcome determinations and written notification, to a maximum of three working days. Utilize the current assessment tool as the means to complete assessments and collect data. Provide that these refinements occur within the next calendar year through effective training and data processing.

Define, through regulation, that medicaid reimbursement for nursing facility care will be available for emergency admissions from the date of admission until the individual is found inappropriate for nursing facility level of care up to a maximum of thirteen calendar days. Target an implementation date of September 1, 1994. Ensure "post-admission" assessments for emergency admissions are prioritized for completion by the contractor within 10 working days of nursing facility placement as defined by regulation. Include in regulation a definition of "emergency admission".

Define through regulation that "post-admission" assessments for individuals admitted to nursing facilities as "planned brief stays" be provided only when the individuals length of stay has exceeded 30 calendar days. Target an implementation date of September 1, 1994. Ensure that follow-up on community based services is provided by the Area Agency on Aging within 30 days of admission by copy of the "three page" assessment submitted by assessors.

Priority #6: Contractor Administrative Concerns

By April 1, 1994, 100% of assessments for individuals choosing community based services, will be referred by assessors to the appropriate Area Agency on Aging within an established timeframe of twenty-four hours or less following completion of the outcome determination by the contractor.

Area Agencies on Aging will be required to provide initial contact to individuals having received assessment services within three working days. Additionally, the procedures and timeframes established by the contractor for follow-up reporting by the Area Agencies on Aging will be followed.

Priority #7: Consensus and Training Needs

Continue to support the following as goals to be achieved through the program:

* Compliance with mandated federal Preadmission Assessment and Annual Resident Review, (PASARR), requirements for nursing facility preadmission screenings.

* Provide all persons seeking admission to nursing facilities with information regarding community-based alternatives to meet their long term care (LTC) needs identified through the assessment process.

* Increase access to community-based LTC services in all geographical areas in Kansas.

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1-20-94
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* Create a comprehensive data base that identifies the availability of community based services statewide.

* Reduce medicaid expenditures for institutional LTC services by developing and expanding utilization of cost-effective community-based alternatives.

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

Support and implement the recommendations of this task force and the Continuing Quality Improvement (CQI) team to address problem resolution. Direct SRS and Bock Associates to develop effective quality training for nursing facilities, hospital discharge planners, SRS and AAA staff, and community based assessors. Ensure delivery of the training before March 31, 1994, including a plan which addresses ongoing training needs.

Priority #8: Early Intervention Proposal

Kansas Department on Aging will create a community services information dissemination program by utilizing pharmacists, physicians and others as appropriate.

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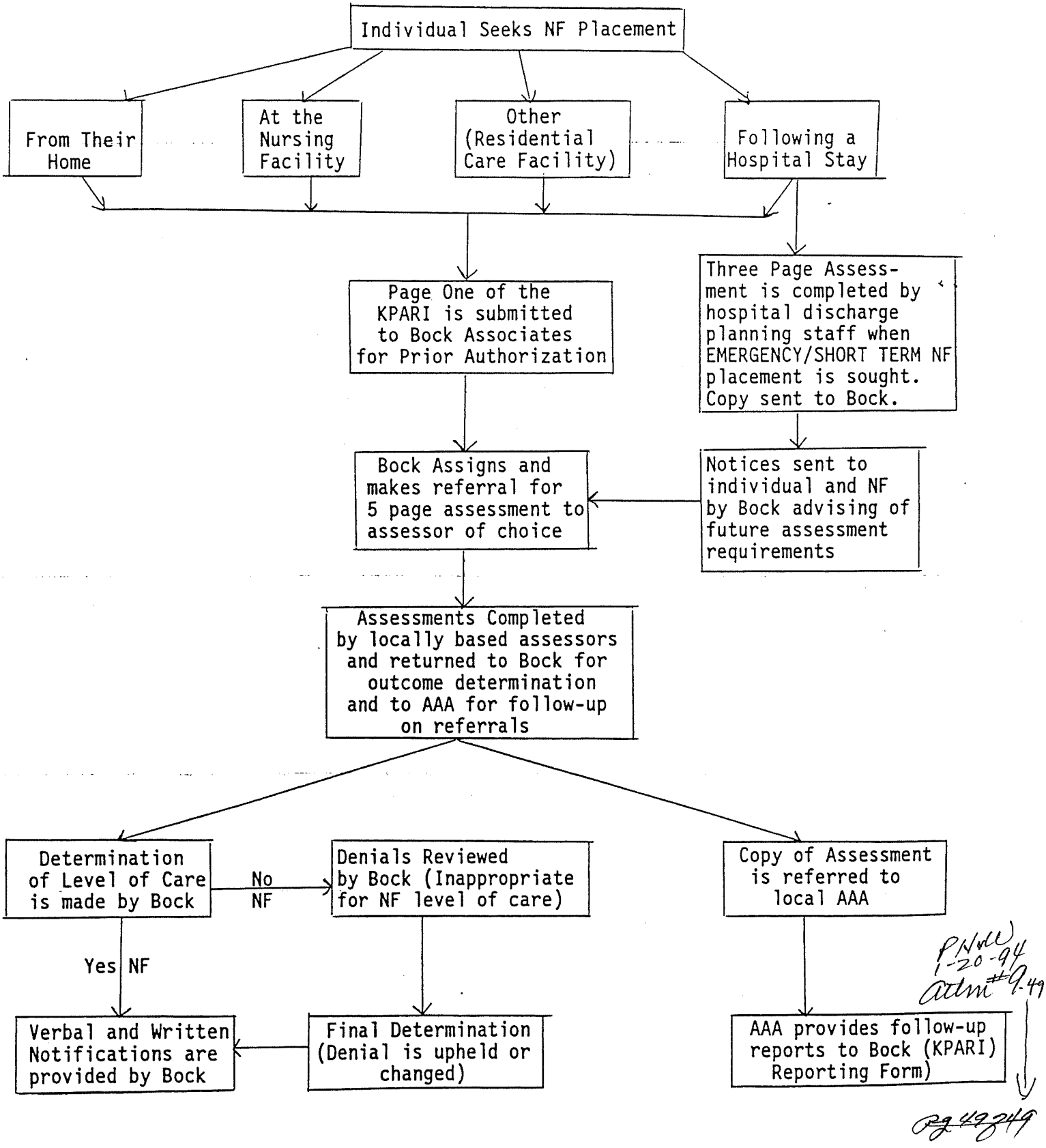
KANSAS NURSING FACILITY PREADMISSION ASSESSMENT AND REFERRAL PROGRAM
LEVEL I FLOW CHART
DECEMBER 1993



PNW 1-20-94 admn #9-49

pg 49 of 49

	July 94	Aug 94	Sept 94	Oct 94	Nov 94	Dec 94	Jan 95	Feb 95	Mar 95	Apr 95	May 95	June 95	FY95 Total
Total assessments (reimbursed and in-kind)													
Level I	900	900	900	900	900	900	900	900	900	900	900	900	10,800
Level II	97	97	97	97	97	97	97	97	97	97	97	97	1,166
Potential diversion rate	0.450	0.450	0.450	0.450	0.450	0.450	0.450	0.450	0.450	0.450	0.450	0.450	
Estimated monthly no. diverted	405	405	405	405	405	405	405	405	405	405	405	405	4,860
Est. % diverted persons on XIX and not otherwise screened	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	
Estimated no. diverted this mo. who will be on XIX during yr	162	162	162	162	162	162	162	162	162	162	162	162	1,944
Cumulative # XIX diversions minus # later entering NFs	1,308	1,296	1,296	1,296	1,296	1,296	1,296	1,296	1,296	1,296	1,296	1,296	1,296
Est. XIX expenditures avoided per person per month	$801	$801	$801	$801	$801	$801	$801	$801	$801	$801	$801	$801	
Total XIX expenditures avoided per month	$1,048,035	$1,038,420	$1,038,420	$1,038,420	$1,038,420	$1,038,420	$1,038,420	$1,038,420	$1,038,420	$1,038,420	$1,038,420	$1,038,420	$12,470,655
Monthly Contractor Costs	$145,852	$145,852	$145,852	$145,852	$145,852	$145,852	$145,852	$145,852	$145,852	$145,852	$145,852	$145,852	$1,750,224
Estimated net savings	$902,183	$892,568	$892,568	$892,568	$892,568	$892,568	$892,568	$892,568	$892,568	$892,568	$892,568	$892,568	$10,720,431

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1-20-94
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P&W
1-20-94
Attm #10

Estimated Savings due to Nursing Facility Preadmission Screening Program

	July 93	Aug 93	Sept 93	Oct 93	Nov 93	Dec 93	Jan 94	Feb 94	Mar 94	Apr 94	May 94	June 94	FY94 Total
Total assessments (reimbursed and in–kind)													
Level I	2,313	4,286	1,824	656	854	889	900	900	900	900	900	900	16,222
Level II	90	86	77	57	98	52	90	90	90	90	90	90	1,000
Potential diversion rate	0.075	0.075	0.075	0.220	0.457	0.488	0.450	0.450	0.450	0.450	0.450	0.450	
Estimated monthly no. diverted	173	321	137	144	390	434	405	405	405	405	405	405	4,030
Est. % diverted persons on XIX and not otherwise screened	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	0.400	
Estimated no. diverted this mo. who will be on XIX during yr	69	129	55	58	156	174	162	162	162	162	162	162	1,613
Cumulative # XIX diversions minus # later entering NFs	309	438	453	471	587	721	843	965	1,058	1,091	1,198	1,302	1,302
Est. XIX expenditures avoided per person per month	$698	$698	$698	$698	$698	$698	$698	$698	$698	$698	$698	$698	
Total XIX expenditures avoided per month	$215,682	$305,724	$316,194	$328,758	$409,726	$503,258	$588,414	$673,570	$738,484	$761,518	$836,204	$908,796	$6,586,328
Monthly Contractor Costs	$134,561	$155,129	$151,154	$93,160	$95,656	$136,616	$144,556	$144,556	$144,556	$144,556	$144,556	$144,556	$1,633,612
Estimated net savings	$81,121	$150,595	$165,040	$235,598	$314,070	$366,642	$443,858	$529,014	$593,928	$616,962	$691,648	$764,240	$4,952,716

Notes

Above data represents actual number of assessments and contractor expenditures through December.
Other data are estimates. Actual data on year–to–date diversions and duration of diversions will be available March 31, 1994.

Potential diversion rate is the number of individuals seeking nursing facility placement as an immediate placement consideration, who as a result of information received during the assessment and referral process, change their ming\ds and choose to pursue community–based services.

Until better data are available, costs avoided are based on eight months of avoided costs; therefore cost avoidance levels out by FY95.

Patricia J. Kissick
Box 5, 204 N. Thomas
Mt. Hope, Ks. 67108

Jan 20, 94

OPE COMMUNITY DEVELOPMENT INC.
"Making Living Longer Better"

Box 308, 704 E. Main
Mt. Hope, KS 67108

(316) 667-2431

January 14, 1994

Rep. Russell Mills
Room 556 N.
State Capitol
Topeka, KS 66612

Dear Representative Mills,

I am Patricia Kissick, Administrator of Mt. Hope Community Development, Inc., facilities in Mt. Hope, Kansas, which includes Mt. Hope Nursing Center. I have not had the opportunity to meet you yet but hope to do so in the near future.

I am chairperson of the Kansas Association of Homes for the Aging and I am frequently in Topeka so perhaps we can meet soon to discuss aging issues.

I have enclosed a report "Kansas Seniors and Their Families" that our association has compiled and a brochure to show you the services we provide in Mt. Hope. You are welcome to stop by our facilities for a tour and visit. Give me a call if you are interested.

I am writing to express a concern about the prescreening program for nursing home placement and ask that you contact members of the House Public Health & Welfare Committee and ask them to support repeal of prescreening (HB2581).

Out of forty-one prescreens in 1993 we only had one resident that did not enter our home and her prescreen was done to determine if she needed active mental health care. SRS was already screening Medicaid Admissions and no private resident is going to enter a nursing home unless all other options have been tried. We always explore all alternatives with our residents. If they are admitted from the hospital the hospital social worker has explored options with them. Prescreening is a serious obstacle for an elder person

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Attm #11

trying to access the system and they can only do it with assistance of the nursing homes, Area Agencys on Aging, hospitals or SRS. When families contact the nursing homes for admission, we make the arrangements for them.

We also have a difficult time getting copies of the prescreens from Bock for our charts. We provide a wide range of services and try to place people in the least restrictive environment. I just feel the $6 million spent on prescreening is wasted and could be used better for services such as case management.

I also question why state tax dollars were awarded to a company from outside the state to perform the prescreening.

Thank you for your interest in this matter which concerns the elderly and all tax payers of Kansas.

Sincerely,

Patricia J. Kissick

Patricia J. Kissick, MA,RNC
Administrator

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1-20-94
Attm # 11-2
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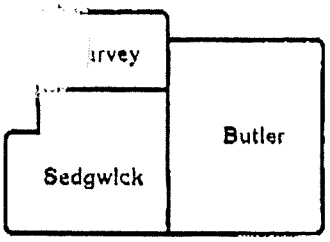

Central Plains Area Agency on Aging

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Administration — 316-383-7298
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TESTIMONY IN OPPOSITION TO HB2581

Two years ago, I testified before this Committee, in support of pre-admission screening. I did so for the following reasons:

1. A comprehensive assessment provides older persons and their families with objective information which can then be used for appropriate care planning. The information may be used to confirm the difficult choice of nursing home care, or may facilitate use of community-based care which enables living in a home environment. By providing such an assessment at a specific event (when considering nursing home placement), we can be assured everyone has access to an objective assessment. There is no other point in the continuum of care where such an assessment can be guaranteed.

2. I believe that a properly run Pre-Admission Screening Program will divert some persons from nursing home placement. As an example, we receive calls from frantic adult children who, when visiting their elderly parents from out-of-town, find their parents have become more frail. Since the children mostly return to their homes within a few days, they see nursing home placement as the only alternative for their parent. In this example, a comprehensive assessment and referral to case management for community-based care might indeed divert nursing home placement.

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3. I believe that a standard assessment performed uniformly statewide would yield data regarding needs and gaps in the community-based care system. Accurate data could give an indication of the need, for example, for sliding fee scale respite care, assisted living units, or transportation for care. We could then develop resources to meet specific needs.

4. I believe that two specific programs were critical to the success of a pre-admission screening effort. The first was a statewide case management program which could assist older persons and their families in developing and implementing community-based care plans. (It's not enough to simply divert someone from nursing home care; they often need help in arranging appropriate community-based care).

The second program was to be an organized, thorough and comprehensive initiative to provide awareness of and information about community-based services. Many times, services which maintain community living can be assessed by informed family and friends; such self-help activities reduce the need for case manager involvement.

The Pre-Admission Screening Program was implemented, along with case management and information dissemination. I feel, personally, that pre-admission screening in Kansas has been poorly implemented. However, I do believe the problems can be and are being corrected and the reasons for its implementation remain as valid now as they did two years ago.

I appreciate your consideration of this written testimony as I am unable to attend today's hearing. Please let me know if I can answer any questions or provide additional information.

Sincerely,

Irene Hart

Irene Hart
Director

P.H.C.W
1-20-94
Attn: #12-2