Approved: 1-27-94
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on January 19, 1994 in Room 526-S of the Capitol.

All members were present except:

Committee staff present:
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Joanne E. Hurst, Secretary, Kansas Department on Aging
Rosemary K. Chapin, KU School of Social Welfare

Others attending: See attached list

Continuation of Preadmission Assessment & Referral Task Force Report

Joanne E. Hurst, Secretary, KDA, appeared before the Committee with written testimony on changes that would be implemented by the Kansas Department on Aging and Area Agency on Aging offices that the Preadmission Assessment and Referral Task Force recommended be made. Those changes in order of priority are: Ensuring Access on Referrals, Assessment Process and Exemptions, and Early Intervention. Secretary Hurst noted such changes would improve the probability of success for the preadmission assessment and referral program. (Attachment 1)

In answer to a member's comment regarding duplication being avoided if area agencies were handling this process, Secretary Hurst noted that the state and SRS have made an investment in the present process, and KDA has been supportive of SRS initiatives, however, with proper planning area agencies could manage the program. It was noted that 88 counties currently have implemented the Senior Care Act, with 6 more counties coming on and 11 counties not covered because of problems with developing community based services in those rural counties. Concern was also expressed for the need of assessors to be from the same community in which they're doing the assessing.

Secretary Whiteman noted that they needed to look at tightening up the referral issue, because right now they depend upon the assessors if they make the referral, and Bock Associates indicated that they will if necessary reduce what they're paying the assessor if they're not making that referral. She indicated that the broader issue is that as soon as Bock Associates receives the assessment, they should be able to refer that information to AAA offices which may also impact the need for additional staff.

In answer to a member's question on staffing and moving from institutional to community based care in the next three to five years, Secretary Hurst agreed they are under staffed at this point and that those additional staff members that would be needed could also provide other functions within the agency.

In answer to a member's question as to who is providing the data collection function and assessing the needs based on information collected, Secretary Whiteman noted that Bock Associates is obtaining that information which is part of their contract.

Rosemary K. Chapin, KU School of Social Welfare, appeared before the Committee and submitted written testimony on preadmission assessment and referral. Ms. Chapin talked about what policy analysists at the national level have to say about how states can build an effective long term care system, experience of other states with preadmission assessment, the importance of preadmission assessment and referral in the Kansas long term care system, and population projections of older adult Kansans. (Attachment 2) Committee discussion related to impacting state dollars and the annual increase of nursing home cost, and Ms. Chapin noted that it reinforces the need for targeting preadmission assessment and linkage.

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for January 20, 1994.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH & WELFARE DATE: 1-19-94

NAME	ADDRESS	COMPANY/ORGANIZATION
Rosemary Chapin	Schl of Soc Welfare KU	KU
Lynda Dunn	Topeka	KDCL
Joanne Hurst	Topeka	KDOA
John Conard	Lecompton	AARP
Shari L. McCabe	McPherson	KPNHAA
William D. Pike	Topeka	Heights Medical Hosp KPNHAA
RICH GUTHRIE	KC	Health Midwest
Larry Pitman	Topeka	KEMC
Michelle Dunn	Topeka	atty. Jon Small

Testimony on Preadmission Assessment & Referral

Task Force

before the
Senate Public Health & Welfare Committee

by
Joanne E. Hurst, Secretary
Kansas Department on Aging

January 13, 1994

Senator Praeger and members of the Senate Public Health & Welfare Committee, I appreciate the opportunity to join with Sec. Whiteman this morning to report on the progress of the Preadmission Assessment & Referral Task Force. We have come up with recommended changes, which will improve the probability of success for the preadmission assessment and referral program.

I want to speak to the recommendations which will be implemented by the Kansas Department on Aging.

Priority #1 -Ensuring Access On Referrals

First, we selected "Ensuring Access on Referrals" as the #1 priority. The Legislative Division of Post Audit recommended in its October, 1993 report on Examining Potential Duplication and Overlap in Programs for Kansas' Aging Population:

> 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.

Bock Associates testified on October 21 before this committee that one of the program changes would be a "Feedback Loop on Placement":

> All Level I screens that indicate the individual is interested in HCBS [home and community based services], will be forwarded to the local AAA [Area Agency on Aging] office.

Bock Associates subsequently mailed to all Level I Contracts the attached memo on January 4, 1994. Note that the memo states:

> It is imperative that these KPARIs [the preadmission assessments] be sent immediately to the AAA office so that caseworkers can contact the individual and develop a case management plan to deliver necessary services to the individual when they need them--which is now.

Senate PH&W
Attachment #1
1-19-94

When the Task Force met on January 10 to discuss Priority #1, the members agreed to recommend further training to ensure a good linkage between assessment and referral. The Task Force recommended:

> Bock Associates, in coordination with KDOA and SRS, must provide training for the community based assessors and AAA I&R [information and referral] staff on or before February 15, 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.

We all agree that referral is essential to follow up on assessments. Otherwise, the program will fail. The Kansas Department on Aging and the Area Agencies on Aging have agreed to do our part in accepting referrals and in providing the necessary follow up to link people with community based services.

Priority #5 - Assessment Process and Exemptions

The Task Force also discussed on January 10 priority #5 - Assessment Process and Exemptions. The pre-admission assessment and referral statute allows an exemption for people who move to a nursing facility for less than 30 days and in an emergency situation. Bock Associates have developed a three page assessment for hospitals to use for people with these exemptions.

The Task Force recommended that we ensure that a follow-up on community based services be provided by the Area Agency on Aging. The Kansas Department on Aging and the Area Agencies on Aging have accepted the responsibility for follow up on the people who will leave nursing facilities after a brief stay. We believe that it is important to build a linkage with community based services for these people so that rehospitalization and reinstitutionalization is avoided or delayed.

Priority # 8 - Early Intervention

The Task Force also discussed on January 10 priority #8 - early intervention. Preadmission assessment and referral services often occur too late in the decision making process. We agree that earlier intervention can complement preadmission assessment and referral services to improve the success rate in diverting people from nursing home care. The Task Force recommends that the Department on Aging improve information and referral services by building a partnership with pharmacists, physicians, and other health professionals. The intent of this recommendation is to create linkages between the aging and health networks so that

people who see a pharmacist or a physician about a long term care need can easily find their way to appropriate services long before they turn to nursing home care.

Conclusion

The Task Force has been productive in tackling the implementation issues identified in the Legislative Post Audit report and in the October 21st hearing. We believe that the recommended changes can make a better program as authorized in SB 182 in 1992.

Bock Associates
partners in human service management

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MEMORANDUM

TO: Level I Contractors

FROM: Debbie Bird

DATE: 4 January 1994

RE: Completion of Level I Screens

FOR YOUR IMMEDIATE ATTENTION AND DISSEMINATION TO ALL ASSESSOR STAFF.

I want to explain a very important aspect of the *Kansas Preadmission Assessment and Referral Program*, to each of you.

The compelling objective--the very heart and soul--of the program, is to ensure that people considering nursing facility services are making an informed choice when selecting long-term care services. An informed choice can only occur when people, or their representatives, understand all of the long-term care service options available to them within a timely basis. Please be thorough with your description and discussion of all choices available to them.

Moreover, it is an essential part of your task, and in fact a part of your contract, that the assessor provide a copy of the AAA resource book to each individual and/or their family who have expressed an interest in community based services. Further, please remember to forward the KPARI to the local AAA office for each individual who indicates in item 40, that he/she may be interested in services other than a nursing facility. If you transmit the KPARI to Bock Associates via facsimile, then you may forward the original to the AAA office. If you mail/deliver the original to Bock Associates, then you must make a photocopy to be sent to the AAA office. It is imperative that these KPARIs be sent <u>immediately</u> to the AAA office so that caseworkers can contact the individual and develop a case management plan to deliver necessary services to the individual when they need them--which is now. Holding KPARIs to be sent in a batch is not acceptable.

Again, this link in the system is critical and is only as successful as each of you are committed to this most basic tenant of the program. Bock Associates will be working closely with the AAA offices to identify problems and/or delays in this area. Please ensure that this task is completed successfully in the spirit of the program. We do not want to delay or withhold payment for failure to comply with this most important aspect of this program.

(over)

Other program reminders are:

* Assessors are expected to call the referral contact person and make an appointment to complete the KPARI. Please be on-time for your appointment and upon arrival, seek out the contact person for assistance in completing the KPARI.

  Identification badges, letters of introduction and procedures for identifying yourself are being prepared and will be forwarded to you under separate cover.

* There is no reimbursement for KPARIs completed without prior authorization from Bock Associates. Please refer all requests for KPARIs to our Topeka office.

* If you accept a KPARI assignment from Bock Associates, it is due back into the Topeka office within 72 hours. We would prefer not to invoke penalty deductions for late KPARIs. Please do not transmit KPARIs to our office in St. Paul.

* Please ensure that the individual or their legal representative is signing the KPARI on page 5. As instructed on page 2 of the manual, "either have the statement signed by the individual or her/his guardian/legal representative or have the statement marked by the individual and signed by a witness".

* Remember, you must notify Bock Associates whenever a KPARI is aborted due to death, cancellation of a request for a screen, lack of cooperation or any other reason the KPARI cannot be completed.

Finally, I am excited about the program changes implemented on 1 October 1993, and the improvement in the quality of the KPARIs being completed by assessors. As we prepare for a tough legislative session, any positive comments or thoughts you may have on the new program would be welcomed in our office prior to 14 January 1993. Please keep up the good work and make whatever adjustments are necessary to comply with the guidelines in this memo.

cc: Secretary Donna Whiteman
Secretary Joanne Hurst
Commissioner Robert Epps
Ms. Dona Booe, SRS-DMS
Dr. Warren H. Bock

Rosemary K. Chapin
KU School of Social Welfare
The University of Kansas
Lawrence, Kansas
January 13, 1994

TESTIMONY CONCERNING

PRE-ADMISSION ASSESSMENT AND REFERRAL

Introduction

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

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

Senate PH&W
Attachment #2
1-19-94

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

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

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

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

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

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

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

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

Pre-Admission Assessment/Screening in Other States

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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APPENDIX

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

Figure 1

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

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

* See Chart 1 for graphic illustration.
Source: Population projections from the State of Kansas Division of the Budget based on 1990 Census.

Chart 1

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