Approved: 3-30-94
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 March 16, 1994 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:
Mack Smith, Executive Secretary, Kansas State Board of Mortuary Arts
Pamela Scott, Executive Director, Kansas Funeral Directors and Embalmers Association
Joanne Hurst, Secretary, Kansas Department on Aging
Donna L. Whiteman, Secretary, SRS
Jim Sund, Johnson County Commission on Aging
Ellen Elliston, Director of Patient Support, St. Francis Regional Medical Center, Wichita
Sandra Strand, Legislative Coordinator, Kansans for Improvement of Nursing Homes, Inc.
Monica Flask, President, Society for Social Work Administrators in Health Care
Rosie Williams, President, Caring Connections

Others attending: See attached list

Hearing on HB 2772 - Mortuary arts; defining terms, setting penalties
Mack Smith, KSBMA, appeared before the Committee in support of **HB 2772** and noted that passage of the bill would clarify three sections that relate to: (1) the supervision of student and apprentice embalmers by licensed embalmers during the embalming process - student embalmers would require direct personal supervision, while actions of apprentice embalmers would be under the full responsibility of a licensed embalmer, (2) criminal penalty provision, and (3) update the definition of funeral establishments, embalming preparation rooms and allow licensure for funeral establishments without a preparation room and for separate embalming establishments. (Attachment 1)

During Committee discussion, Mr. Smith noted that currently a funeral establishment must have a preparation room while a branch establishment does not have to have one. It was noted by staff that the criminal penalty changes do use the terminology of the sentencing guidelines, but the bill would increase the penalties in the current statutes.

Pam Scott, KFDA, addressed the Committee in support of **HB 2772** which she noted would better define the degree of supervision a funeral director must exert over a student embalmer, as well as updating the definition of funeral establishments and removing the requirement that a funeral establishment be equipped with a preparation room. (Attachment 2)

Hearing on HB 2786 - Durable power of attorney for health care decisions
Pam Scott, KFDA, addressed the Committee in support of **HB 2786** which would allow an individual to authorize an agent to make health care decisions including those concerning disposition of their body upon death. An amendment was added in the House Committee that would not only provide the funeral director with immunity from liability when following the directions of a durable power of attorney for health care decisions, but to anyone acting in good faith in accordance with the terms of the document. (Attachment 3) During Committee discussion, it was noted that the Kansas Bar Association approved the language in the amendment.

Hearing and Brief on Sub. for HB 2581 - Establishing the client assessment, referral and evaluation

The bill would repeal K.S.A. 39-966, the statute enacted in 1992 that creates a preadmission assessment and referral program under which each area agency on aging is required to compile comprehensive resource information on long-term care resources, and various individuals and entities are required to make such materials available to persons seeking long-term care or admission to an adult care home or discharge from a hospital. The bill also requires that, on and after January 1, 1993, no person is to be admitted to an adult care home that participates in the Medicaid program unless such person has received assessment and referral services as defined in the statute and provided under the administrative direction of the Secretary of SRS. The bill would replace the

long-term care assessment and referral program currently being implemented with a new program to be known as client assessment, referral and evaluation or "CARE." Prior to January 1, 1995, assessment and referral services for persons who are required by federal law to have such services prior to admission to an adult care home are to be provided by the Secretary of SRS unless the individual is a medical care facility patient, in which case the service is to be provided by the medical care facility for those considering becoming a resident of an adult care home. After January 1, 1995, the Secretary on Aging, assisted by area agencies on aging, is to provide the assessment services and the preparation of CARE data forms for persons required by federal law to be assessed prior to admission to an adult care home. The bill also creates a nine-member voluntary oversight council.

Joanne Hurst, Secretary, Department on Aging, addressed the Committee with recommendations for **Sub. for HB 2581** and noted that the bill is intended to be an assessment of medicaid and PASARR populations during FY 1995, and that the current language would not include the medicaid population because there is no federal requirement that this population have an assessment before entering a nursing facility. Secretary Hurst offered an amendment to clarify that the bill would require an assessment of these two populations in FY 1995, as well as other clarifying amendments which she noted would result in her support of the proposed legislation. (Attachment 4)

Staff noted that the federal mandated PASARR screening specifically screens for the need of mental health services regardless if that person is medicaid related or not. The reference in the bill to require federal assessment and referral services would not be the same as PASARR.

Secretary Whiteman noted that currently everybody who is going to enter a nursing home has to receive a PASARR test, and SRS combines preadmission screening with PASARR which is a Level I screening. If there is any indication that individual has mental health problems, then they go into Level II screening. SRS basically combines the two and receives a 75% federal match on the PASARR. In answer to a member's question regarding language on page 2, line 28, the phrase, "preceding admission to the adult care home or within 10 days subsequent to admission to the adult care home...," Secretary Whiteman noted that language needed to be deleted from the bill otherwise they would be out of conformity with PASARR and jeopardize federal money.

Donna L. Whiteman, Secretary, SRS, addressed the Committee with a number of concerns and recommendations on **Sub. for HB 2581** as noted in her written testimony. Recommendations of the Kansas Nursing Facility Preadmission Assessment and Referral Task Force as well as a Level I Assessment form are attached. Secretary Whiteman also called attention to the estimated fiscal impact of the bill and recommendations from Robert L. Mollica, National Academy for State Health Policy, Portland, Maine. (Attachment 5)

In answer to a member's question if the recommendations offered were also offered in the House Public Health and Welfare Committee when they worked the bill, Secretary Whiteman noted there was not an opportunity to offer them, and that once it passed the House, those individuals involved had more opportunity to consider changes.

Jim Sund, Johnson County Commission on Aging, and Ellen Elliston, St. Francis Regional Medical Center, Wichita, both addressed the Committee and submitted written testimony in support of the bill. (Attachments 6 and 7)
Sandra Strand, KINH, expressed her support for the bill but noted two concerns about the CARE data form and two definitions which needed to be clarified or corrected as reference in her written testimony. (Attachment 8)

Monica Flask, Social Work Administrators in Health Care, addressed the Committee in support of **Sub. for HB 2581** and noted that the CARE program is a significant improvement and a one page data form is sufficient if there are two purposes to that form -- one is PASARR screening, which can be a few questions, and secondly to submit resource information which will tell what kind of services would have prevented nursing home admissions. Ms.
Flask asked the Committee to consider those people who are clients of hospice and home-health agencies to be treated the same as those who are patients in a medical care facility. Another recommendation was to consider avoiding something that would create a huge obstacle for people with emergency situations. That is a concern she had if the 10 day waiting period is eliminated. (Attachment 9)

Rosie Williams, President, Caring Connections, appeared in opposition to **Sub. for HB 2581** and noted that the bill was drafted before the task force recommendations were presented and that the proposed legislation is trying to "fix" some problem areas that have already been addressed. (Attachment 10)

The Chair announced that the hearing on **Sub. for HB 2581** will be continued on Friday, March 18, 1994.

The meeting was adjourned at 11:00 a.m.
The next meeting is scheduled for March 17, 1994.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH & WELFARE DATE: 3-16-94

NAME	ADDRESS	COMPANY/ORGANIZATION
Mary Ellen Conlee	Wichita	St Francis Reg. Med Cntr
Marilyn Bradt	Lawrence	KCOA
~~Sandy Strand~~	Lawrence	KINH
Donna Whiteman	Topeka	SRS
Rosie Williams	"	Family Connections
Millie Walter	"	EDS
Mara Boeer	Lawrence	intern
Harold Pitts	Topeka	AARP-CCTF
Kay LeMay	Topeka	JAAA
Kathy Reardon	Topeka	Ks. Assn. for the Medically Underserved
Rich Guthrie	KC	Kaiser Midwest
W. Gross	"	Shawnee Mission Med Ctr
Vicky Martin	Topeka	KDOR
Robert Emmart	Wichita	St Francis Regional Med Ctr
Wanda C. Pumphrey	Newton	St. Francis Regional Med Ctr.
Lyndon Dunn	Topeka	KDOH
Katie Ryle	"	CCTF (AARP)
phyllis fast	"	Atty. Gen.
Mary Jane Stattelman	"	AG
ELAINE OYFFENS	TOPEKA	PRIVATE ASSESSOR
John Kiefhaber	Topeka	Ks. Health Care Assn.
Joyce Koci	Topeka	KDHE
Jan Nellie Sund	Herrian	Self

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH & WELFARE DATE: 3/16/94

NAME	ADDRESS	COMPANY/ORGANIZATION
Joann Quest	Topeka/Lawrence	KDOT
Robert Hagen	LSOB	KDHE
Ellen Piekalkiewicz	Topeka/Lawrence	Assoc. of CMHCs

The Kansas State Board of Mortuary Arts

CREATED AUG. 1, 1907

700 S.W. JACKSON ST., SUITE 904
TOPEKA, KANSAS 66603-3758
(913) 296-3980

March 16, 1994

Senator Sandy Praeger, Chairperson
Senate Committee on Public Health and Welfare
Statehouse, Room 128-South
Topeka, Kansas 66612

Madam Chair and Members of the Committee:

My name is Mack Smith, and I am the executive secretary to the Kansas State Board of Mortuary Arts. Thank you for the opportunity to appear before you today to ask for your support of House Bill 2772.

The passage of HB 2772 would clarify the supervision of student and apprentice embalmers by licensed embalmers during the embalming process. Student embalmers would require direct personal supervision (actual physical presence), while actions of apprentice embalmers would be under the full responsibility (not necessarily physical presence) of a licensed embalmer.

The word "Kansas" has been deleted in line 38 of page 1 and line 2 of page 2. Apprentice embalmers may service their apprenticeships in states other than Kansas (such as Missouri, Nebraska or Oklahoma). A city such as Kansas City is an example of where this could occur. If a Kansas licensed embalmer does not happen to be employed at that particular funeral home, then a license embalmer from that state is acceptable to the board.

Section 2 (found on page 2 of the bill, lines 5-19) and 4 (found on page 3, lines 27-37) converts the language concerning criminal violation of embalming and funeral establishment statutes to that contained in the Kansas Sentencing Guidelines Act of July 1, 1993.

Section 3 of the bill updates the definition of funeral establishments, embalming preparation rooms and would allow licensure for funeral establishments without a preparation room (page 2, lines 30-36) and for separate Embalming establishments (page 3, lines 18027 in section (5), (c)).

Again, thank you madam chair for the opportunity to testify today. I would be glad to attempt to answer any questions of the committee and ask for your support of the bill as amended!

Respectfully submitted,

Mack Smith, Executive Secretary
Kansas State Board of Mortuary Arts

MS:tab

Senate PH&W
attachment #1
3-16-94

THE KANSAS FUNERAL DIRECTORS AND EMBALMERS ASSOCIATION, INC.

EXECUTIVE OFFICE — 1200 KANSAS AVENUE, P.O. BOX 1904
TOPEKA, KANSAS 66601
PHONE 913-232-7789 FAX 913-232-7791

AFFILIATED WITH N.F.D.A.

TESTIMONY PRESENTED TO

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

ON

HOUSE BILL NO. 2772

Madam Chair and members of the committee, my name is Pamela Scott, executive director of the Kansas Funeral Directors and Embalmers Association (KFDA). I appear before you today in support of House Bill No. 2772.

The KFDA supports the amendments to K.S.A. 65-1703, which better define the degree of supervision a funeral director must exert over a student embalmer and apprentice embalmer. The amendments will remove any confusion our membership may have concerning the degree of supervision they must exert over student and apprentice embalmers.

The amendments to K.S.A. 65-1713a in the bill update the definition of funeral establishment and remove the requirement that a funeral establishment be equipped with a preparation room. A new definition of embalming establishment is added to cover those entities just performing embalming services. This will allow the board to issue a license covering just embalming services which it currently can not do.

The KFDA fully supports the amendments requested by the State Board of Mortuary Arts, and urges you to adopt them. Thank you for the opportunity to appear before you today.

Senate PH&W
Attachment #2
3-16-94

THE KANSAS FUNERAL DIRECTORS AND EMBALMERS ASSOCIATION, INC.

EXECUTIVE OFFICE — 1200 KANSAS AVENUE, P.O. BOX 1904
TOPEKA, KANSAS 66601
PHONE 913-232-7789 FAX 913-232-7791

AFFILIATED WITH N.F.D.A.

TESTIMONY PRESENTED TO

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

ON

HOUSE BILL NO. 2786

Madam Chair and members of the committee, I am Pamela Scott, executive director of the Kansas Funeral Directors and Embalmers Association (KFDA). The KFDA represents over 250 funeral establishments in the state of Kansas. I am here to urge your support of House Bill No. 2786.

House Bill No. 2786 amends Kansas law pertaining to durable power of attorneys for health care decisions. That law allows an individual to authorize an agent to make health care decisions including those concerning disposition of their body upon their death. In the bill as originally written the KFDA requested an amendment to K.S.A. 58-629 to provide the funeral director with immunity from liability when following the directions of a durable power of attorney for health care decisions. The Kansas Bar Association testified before the House Public Welfare Committee and suggested that the amendment be rewritten to apply not only to funeral directors, but to anyone acting in good faith in accordance with the terms of the document. A similar good faith reliance exception currently exists in the uniform durable power of attorney laws. As a result, we redrafted the present language found in the bill which passed the House on a vote of 124-0.

The proposed amendment addresses a problem funeral directors are experiencing when the directions concerning disposition of the body made by the agent differ from the wishes of the family. Of particular concern to funeral directors are those situations where the agent directs that a body be disposed of by cremation and the family doesn't want the body to be cremated. The problem lies in that the cremation process is irreversible and there is no remedy once it is completed. When a disagreement arises concerning where a body is to be

Senate PH&W
Attachment #3
2-16-94

buried, a remedy is available because the body can be disinterred and reburied in another location.

Traditionally in Kansas the family makes the final decision concerning disposition of the body upon death. There are two Kansas cases addressing who has control over disposition of the body. In Nelson v. Schoonover, 89 Kan 779(1913) the court held that a husband's instructions concerning burial should be followed even though his deceased wife left burial instructions in her will. The Court in Cordts v. Cordts 154 Kan 354(1941), a case involving a disagreement as to final arrangements, stated "each case must be considered in equity on its own merits." giving importance to the decedent's wishes, but also considering the rights and feelings of the surviving family, with preference to those who were "closely affiliated with and devoted to the decedent in her lifetime."

Time is often of the essence in cases concerning health care decisions. A person acting according to the terms of a durable power of attorney for health care decisions should be able to rely in good faith on the validity of the document without liability. The law as presently written does not have such a good faith exception to liability.

There are funeral directors from various parts of the state who, upon the advise of counsel, will not accept a case where there is a durable power of attorney involved and the agent for the deceased is requesting cremation unless the family also consents to the cremation. Funeral directors are concerned of possible litigation and liability. There is a trend nationwide toward litigation in this area.

The KFDA is not challenging the legality of a properly executed durable power of attorney. It is merely asking for some protection against liability in the event the provisions of the durable power of attorney are followed. Immunity will discourage litigation in this area.

Thank you for this opportunity to appear before you today. We ask for your support of House Bill No. 2786.

Testimony on Sub. for HB 2581
by the
Kansas Department on Aging

before the
Senate Public Health & Welfare Committee
March 16, 1994

Sen. Praeger and members of the Committee, I speak today in support of Sub. for HB 2581 because it preserves the concept of preadmission assessment and referral. The bill as amended by the House creates a new program called CARE, which will assess people before they enter a nursing home. The substitute bill authorizes administration of the program by SRS for six months until January 1, 1995, when KDOA assumes administration of the program.

Ambiguous Language

Although we agree with the intent of the House substitute, we believe that there are ambiguities in the language.

First, we understand the intent of the bill to be an assessment of medicaid and PASARR populations during FY 1995. The current language would not include the medicaid population because there is no federal requirement that this population have an assessment before entering a nursing facility. We have attached an amendment which should clarify that the bill would require an assessment of these two populations in FY 1995.

Second, we understand the intent of the bill to apply to nursing facilities only; therefore, we have attached an amendment which would substitute the words "nursing facility" for "adult care home" every time it appears in the bill. Adult care home is a broader term which includes boarding care homes.

Other Amendments

Besides the clarification of these ambiguities, we support amendments about the composition of the oversight committee, the development of the data form, and the penalty clause for nursing facilities offered today by SRS and KDHE.

In addition, we believe that the 10 day exception clause in Sec. 1(e)(3) would make us out of compliance with the PASARR requirements. We, therefore, have attached an amendment to this section.

Finally, we request the authority to issue rules and regulations to implement the act.

Conclusion

With these clarifying amendments, we support the House substitute

Senate PHEW
Attachment #4
3-16-94

and will work to successfully implement its provisions.

Amendments

New Sec. 1(e)(1) Prior to January 1, 1995, assessment and referral services for ~~persons who are required by federal law to have such services prior to admission to an adult care home~~ medicaid-eligible people who are considering becoming a resident of a nursing facility and for people who are required by federal law to complete the preadmission screening and annual resident review (PASARR) shall be provided by the secretary of social and rehabilitation services except that such services shall be provided by a medical care facility to a patient of the medical care facility who is considering becoming a resident of ~~an adult care home~~ a nursing facility upon discharge from the medical care facility.

(2) On and after January 1, 1995, the secretary of aging, with the assistance of area agencies on aging, shall provide for assessment services and the preparation of the client assessment, referral and evaluation (CARE) data forms for individuals who are medicaid-eligible people who are considering becoming a resident of a nursing facility or who are required by federal law to complete the preadmission screening and annual resident review (PASARR) ~~to be admitted to adult care homes where such assessment services are required prior to admission to an adult care home to comply with federal law~~, except that such assessment services shall be provided by a medical care facility to a patient of the medical care facility who is considering becoming a resident of a nursing facility ~~an adult care home~~ upon discharge from the medical care facility.

(3) On and after July 1, 1995, each individual ~~who is admitted to an adult care home and who is not required by federal law to receive assessment services prior to admission to the adult care home~~, preceding admission to a nursing facility ~~the adult care home or within 10 days subsequent to admission to the adult care home~~, shall receive assessment services. Assessment services under this paragraph shall be provided by the secretary of aging with the assistance of area agencies on aging except that ~~(A)~~ such assessment services shall be provided by a medical care facility to a patient of the medical care facility who is considering becoming a resident of a nursing facility ~~an adult care home~~ upon discharge from the medical care facility and ~~(B) if the assessment services have not been provided prior to admission to the adult care home, the adult care home shall request that an area agency on aging serving the geographic area in which the adult care home is located provide the assessment services within 10 days after admission of the resident to the adult care home~~.

New Section. The secretary shall adopt rules and regulations to govern such matters as the secretary deems necessary for the administration of this act.

Senate Public Health & Welfare
Attachment # 5
3-16-94

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

Senate Public Health and Welfare Committee
Testimony on Substitute House Bill 2581

March 16, 1994

****

The 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."

****

Members of the committee, I thank you for the opportunity to present you with this testimony.

Nursing facility preadmission assessment and referral services is the cornerstone of a consumer preferred and cost effective community based long term care system. The recent study completed by the National Academy for State Health Policy supports the need for a strong preadmission assessment and referral program identifying it as critical to any effective long term care system. As task force recommendations are implemented, the existing program will enhance or achieve the following:

- o Provide individuals with information, referrals and access to community based services.
- o Create a statewide comprehensive resource data base.
- o Prevent unnecessary or avoidable nursing facility placements.
- o Reduce financial risk for nursing facilities.
- o Eliminate unnecessary short term stay assessments.
- o Refine the assessment tool eliminating unnecessary information.
- o Provide quality training.
- o Develop early intervention programs.

SRS concerns about specific provisions of Substitute House Bill 2581 include:

o All consumers of LTC services, both private pay and medicaid are entitled to information and access to services. Exempting private pay consumers results in substantial fiscal impact to the state. (See Attachment A)

o While assessors need to work closely with hospitals, hospital staff should not be able to approve nursing facility level of care. Regardless of the skill and dedication of hospital discharge planners, the incentives to discharge people as quickly as possible are strong. Nursing homes are the path of least resistance particularly if the system for arranging community care is complicated and fragmented. Financial incentives are intensified when hospitals own nursing facilities.

o **Page One, Line 22, 25 and 39; Page Two, Line 2:** The definition of assessments appears to be inconsistent or contradictory. The differences in the definitions should be reconciled and address the feasibility of directing an agency to perform assessments as defined on a one page instrument. Level II PASARR screenings and Annual Resident Reviews are more than forty pages in length alone. For purposes of flexibility, a uniform assessment instrument should not be limited by statute. Funding of the CARE program is dependent upon federal financial participation (FFP) related to PASARR. The agency responsible for delivery of service and federal fiscal responsibility should develop the uniform assessment instrument.

o **Page One, Line 41:** Federal regulations for medicaid reimbursement for nursing facility services is dependent upon appropriate placement based on level of care needs. A single page assessment form will not accomplish this eligibility factor. Additional resources will be necessary in SRS field offices to provide "post-admission" level of care determinations for medicaid nursing facility applicants. (See Attachment A)

o **Page Two, Line 8:** Clarify that prior to January 1, 1995, assessments continue to use the current program procedures for Medicaid applicants to nursing facilities while private pay admission "assessments" are limited to Level I PASARR screenings.

o **Page Two, Line 10:** Throughout the bill reference to adult care homes should be changed to nursing facilities. Without this change applicants to board and care homes and other community based residential settings will be required to have CARE services.

o **Page Two, Line 15:** Based on the National Academy for State Health Policy Consultant's report, there are strong incentives for administration of the preadmission assessment program to remain with the agency responsible for authorizing home and community based services. **Maximizing the efficiency of potential diversions through the preadmission assessment program is lost when administered by** an agency **without fiscal responsibility for the medicaid nursing facility budget.**

Page Two, Line 25: All persons, both private pay and medicaid, without exception, are required by federal law to receive PASARR Level I screening and if necessary PASARR Level II screenings **PRIOR** to admission to a nursing facility. There are no other federal eligibility regulations applicable prior to admission.

Federal Register Volume 57, No. 230
483.106 Basic Rule

(a) Requirement. The State PASARR program must require (1) Preadmission screening of all individuals with mental illness or mental retardation who apply as new admissions to Medicaid NF's on or after January 1, 1989.

Page Three, Line 16 and 26: Any voluntary oversight council should include equitable representation from the provider community. As written, this bill does not include membership of private individuals who provide community based services.

SRS is committed to the continued refinement of the existing program with attention to concerns presented by consumers, providers and others involved with the administration and day to day operations of the program.

Donna L. Whiteman
Secretary

5-4

ESTIMATED IMPACT OF SUBSTITUTE HB 2581, THE CARE PROGRAM

	First half FY95 7/94 thru 12/94	Second half FY95 1/95 thru 6/95	Total FY 95 7/94 thru 6/95	Total FY 96 7/95 thru 6/96
Est. Medicaid Savings under KPAR	$799,274	$5,472,164	$6,271,438	$10,246,124
Est. Medicaid Savings under CARE	$34,319	$1,332,344	$1,366,663	$2,222,444
Difference (Medicaid Savings Lost)	($764,955)	($4,139,820)	($4,904,775)	($8,023,680)
SGF	($313,632)	($1,697,326)	($2,010,958)	($3,289,709)

Notes

This chart excludes Medicaid savings due to persons diverted prior to FY95. Those savings will remain regardless of passage of new legislation.

The estimated cumulative Medicaid savings of the current pre-screening program (KPAR) is $4.9 million ($2 m. SGF) for FY94 and $10.7 million ($4.4 m. SGF) for FY95.

This chart does not include additional staff which SRS would need under the CARE program to perform level of care determinations prior to a Medicaid eligible entering a nursing facility. This function is currently accomplished through the KPAR screen. It is estimated that an additional seven Social Worker I's and one clerical staff would be needed at a cost of $299,000 ($157,000 SGF).

National Academy for State Health Policy

50 Monument Square, Suite 501, Portland, Maine 04101
207-874-6524 FAX: 207-874-6527

March 8, 1994

Joanne E. Hurst, Secretary
Department of Aging
915 S.W. Harrison
Topeka, Kansas, 66612

Donna Whiteman, Secretary
Social and Rehabilitative Services
915 S.W. Harrison
Topeka, Kansas 66612

Dear Secretary Hurst and Secretary Whiteman:

Our preliminary report on the Kansas long term care system will be submitted shortly, but I wanted to highlight some of our findings and recommendations concerning the preadmission assessment and referral program. Though the program has been beset with controversy, we believe that assessment for nursing home admission is a critical part of an effective long term care system. There are many incentives for people to be placed in a nursing home when they may also be served in the community. Regardless of the skill and dedication of hospital discharge planners, the incentives to discharge people as quickly as possible are strong. Nursing homes are the path of least resistance particularly if the system for arranging community care is complicated and fragmented. Financial incentives are intensified when hospitals also own nursing homes.

While assessors need to work closely with hospitals, hospital staff should not be able to approve nursing home admission. All nursing home assessments are completed by Area Agencies on Aging in the Indiana system and Massachusetts is moving away from hospital delegation by having their Home Care Corporations (most are AAAs) monitor hospital assessments and approvals.

We agree that the present system has not worked as well as it might. We believe there are three ingredients for a successful nursing home diversion program: an appropriate array of housing and community services programs, adequate funding and an integrated system that can assess a person's needs and directly access services needed to meet those needs in the most appropriate and cost effective manner.

One of the problems is structural - the location of assessors. Under the present arrangement, assessors are independent of the resources needed to serve

people in the community. Referrals are not being made to SRS and AAAs. Further, a system based on referrals between agencies and programs requires extensive coordination to overcome fragmentation and delays in the process. We will recommend that the assessment function be located in the same agency that has control of the services which people will need to return to or remain in the community. We will propose several options for creating single entry points that would address this issue.

The existing assessment and referral program has been designed to measure a person's eligibility for nursing home admission rather than to promote their access to community services through a triage function. If the assessment function were performed by staff who could also authorize, rather than refer to, services, it would enhance the program's ability to initiate services faster and to offer real alternatives to admission.

Two other issues raised by the bill are assessment for private pay applicants and the length of the form. People who pay for nursing home care from their own resources tend to spend down to Medicaid eligibility levels once their resources are exhausted. Studies have found the average spend down period is about 4-6 months. Once admitted, it is difficult to re-establish appropriate housing in the community. If private pay admissions do not receive an assessment and people who could be served in the community are admitted, the cost to Medicaid increases. One alternative to assessing all private pay applicants might be to assess those who are likely to spend down.

The length of the assessment form has also been an issue. Assessing to see if a person meets the level of care criteria can be done on a brief form, however, obtaining enough information to determine whether home and community based services are appropriate and developing a care plan requires additional information. Whether this added data is included in the assessment form or a second supplemental assessment makes little difference. Since assessors are making significant financial decisions on behalf of Kansas, state policy should ensure that they collect enough information to make these financial commitments. Determining the most appropriate form to use and manner of collecting information might better be left to a state agency to determine.

In closing, I believe it is premature to make wholesale revisions in the preadmission assessment and referral program in isolation. Changes should be made in the context of broader revisions that reflect the State's policy goals to reduce the reliance on institutional services. While we recommend that the functions be performed in a single entry model, it will take time to develop such a model. During the transition, the current contractor can perform a valuable training, quality control and data collection function.

I hope these comments are useful to you as HB 2581 moves through the legislature.

Sincerely,

Robert L. Mollica

The Wichita Eagle
BUSINESS & FARM
SUNDAY March 13, 1994

5-7

LONG-TERM CARE IN KANSAS

In 1990, there were an average of 53.3 nursing home beds per 1,000 people 65 and older in the United States. Kansas ranked No. 1 in the country that year, with 30,383 nursing home beds, or 88.6 beds per 1,000 senior citizens. By 1992, the number of beds in Kansas had fallen to 27,664, or 79 per 1,000.

Here is a snapshot of long-term care for the elderly in Kansas (1992 numbers, unless otherwise noted):

DEMOGRAPHICS

Population aged 65 and older: 14% (U.S. 12.7%)

Population aged 85 and older: 1.8% (U.S. 1.3%)

LICENSED NURSING HOMES

(provides 24-hour licensed nursing care)

Total number of homes: 417

Total number of beds: 27,664

Avg. number of beds per home: 66.3

Avg. occupancy rate: 89.9%

✳ **Number of beds per 1,000 people 65 and older:** 79 *(U.S. 53.1)*

✳ **Number of beds per 1,000 people 85 and older:** 603.9 *(U.S. 501.7)*

✳ **Medicaid patients per 1,000 population (1991):** 7.36 *(U.S. 5.8)*

Medicaid expenditures per 1,000 population (1991): $64,321 *(U.S. $81,317)*

LICENSED RESIDENTIAL CARE

(provides care by certified nurse's aides)

Number of residential care facilities: 187

Number of beds: 1,694

Avg. number of beds per facility: 9.1

✳ **Number of beds per 1,000 people 65 and older:** 4.84 *(U.S. 17.6)*

LICENSED HOME HEALTH CARE AGENCIES

(provides in-home care by licensed nurses)

Number of agencies: 228

Number of agencies per 1,000 people 65 and older: 0.65 *(U.S. 0.28)*

✳ **Medicaid home health patients per 1,000 population (1990):** 1.59 *(U.S. 3.1)*

✳ **Medicaid home health expenditures per 1,000 population (1991):** $4,939 *(U.S. $15,930)*

Sources: State Nursing Home Bed Survey, Institute for Health & Aging, University of California, San Francisco; U.S. Bureau of the Census.

Recommendations of the Kansas Nursing Facility Preadmission Assessment and Referral Task Force

Secretary Donna Whiteman, SRS, co-chair
Secretary Joanne Hurst, Dept. on Aging, co-chair

At the direction of the Joint Committee on Health Care, the Kansas Nursing Facility Preadmission and Assessment and Referral Task Force has reviewed the program's operation and prioritized the critical issues affecting its operation. Members of the committee included consumers of long term care services, hospital and nursing facility administrators, representatives from the area Agencies on Aging, the participating state agencies and the contracting firm.

The Task Force met five times during December and January to discuss the critical implementation issues facing the program.

A Jan. 18 meeting addressed the topics of cost analysis of program operation and contractor issues. With the exception of those two issues, the task force recommendations are as follows:

2/94

5-9

• 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 task force on Jan. 18. The committee reviewed the current program and made no formal recommendation.

5-10

• 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 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 to members of the task force. The final revised instrument will be implemented April 1. Specific areas which require review and revision include questions one and thirty-seven.

5-11

- **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.

5-12

• 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 authorized 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 13 calendar days. Target an implementation date of Sept. 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 Sept. 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.

5-13

- **Priority #6: Contractor Administrative Concerns**

By April 1, 100% of assessments for individuals choosing community based services will be referred to the Area Agencies on Aging by assessors within an established timeframe of 24 hours following completion of the outcome determination. 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.

5-19

- **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.
* 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, 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.

Kansas Nursing Facility Preadmission and Referral Program
Level I Assessment Instrument

SECTION I: SOCIODEMOGRAPHIC INFORMATION

Name: _____ _____ _____
Last First Middle initial

Address: _____ City: _____ Zip: _____

Phone: _____ County: _____ State: _____

Date of birth: ____/____/____ SSN: _____

Gender: ☐ Male ☐ Female Marital status: ☐ Married ☐ Single ☐ Widowed

1. **Have you or anyone decided you need to move to a nursing facility?**
   ☐ No If "No," stop here. Complete item 10 below and refer the individual to the local SRS or AAA office.
   ☐ Yes If "Yes", who, check all that apply: ☐ Client ☐ Family ☐ Physician ☐ Other

2. **What is the individual's current location?** ☐ Home ☐ Hospital ☐ Nursing facility ☐ Other (*specify*): _____

3. **Have you considered living in a nursing facility?** ☐ Yes ☐ No

4. **Have you or anyone helped you to find information about a nursing facility?**
   ☐ No
   ☐ Yes If "Yes", check all that apply: ☐ AAA ☐ Nursing facility ☐ SRS ☐ Family/Friend ☐ Physician ☐ Other

5. **Have you tried to find information on services that would allow you to continue to live at home?** ☐ Yes ☐ No

6. **Would you be interested in having someone tell you about the services that may be available to you?**
   ☐ Yes ☐ No ☐ Not sure

7. Assessor preference #1: _____ #2: _____

8. **Individual's representative:** ☐ Family/Friend ☐ Legal/Medical representative ☐ None ☐ Guardian ☐ Durable power of attorney ☐ Self

   Name: _____ Home phone: ( ) _____

   Address: _____ Work phone: ( ) _____
   Street

   City: _____ State: _____ Zip: _____

   Please fax notification to: _____ Fax phone: ( ) _____

9. **To schedule an appointment contact:**

   Name: _____ Home phone: ( ) _____

   At: _____ Work phone: ( ) _____

10. **Signature:** _____ Date: _____

11. SRS/AAA/Hospital: _____ Number: _____

    Contact person: _____ Work phone: ( ) _____

    ☐ Referral for screen ☐ SRS ~~HCBS~~ Level of Care, determination is: _____

    ☐ Hospital KPARI determination is: _____

Client's initials _____

#5-15

SECTION II: FUNCTIONAL STATUS

12. Activities of Daily Living *(mark one level for each item)*	Independent	Minimal assistance	Moderate assistance	Total assistance
Eating (act of cutting food, bringing food to mouth, chewing and swallowing)				
Bathing (bathing body, including back, and shampooing hair)				
Dressing (setting out clothing and dressing entire body, including necessary prosthesis/orthosis)				
Toilet use (use of toilet, urinal, bedpan, including cleansing self after elimination and adjusting clothing, assist to toilet)				
Bowel management (intentional control of bowel movements, including use of agents necessary for bowel control)				
Bladder management (intentional control of urinary bladder, including use of agents necessary for bladder control)				
Transfer (transferring to and from bed, chair or wheelchair, including coming to a standing position)				
Locomotion: ☐ **Walking** ☐ **Wheelchair** ☐ **Bed Fast** (includes walking, once in a standing position, and using a wheelchair indoors)				

13. **Instrumental Activities of Daily Living** *(as compared to same age peers living in the community)*:

	Independent	Minimal assistance	Moderate assistance	Total assistance
Meal preparation				
Medication administration				
Telephone use				
Housekeeping				
Shopping				
Handling finances				
Transportation use				

14. How many times have you been hospitalized in the last six months? *(mark one)*
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

15. *Please indicate which of the following best describes your social support needs (mark one):*
- ☐ Not needed
- ☐ Support is strong - continue indefinitely
- ☐ Support is weak - continue indefinitely
- ☐ Support is strong/weak - cannot continue
- ☐ Needed, but does not exist

16. **Communication:**

Comprehension: *(mark one)*
- ☐ Able to understand directions
- ☐ Can follow directions with minimal prompting/repetition
- ☐ Has difficulty following directions; needs constant prompting
- ☐ Unable to follow simple directions

Expression: *(mark one)*
- ☐ Expresses needs clearly
- ☐ Expresses needs slowly or requires minimal prompting
- ☐ Expresses needs with difficulty and requires much prompting
- ☐ Unable to express needs

Primary Mode of Communication: *(mark one)*
- ☐ Speech
  - ☐ English
  - ☐ Other (specify): _____
- ☐ Writing
- ☐ Gestures/sounds
- ☐ Sign language
- ☐ Communication device
- ☐ Unable to communicate

Client's initials _____

5-16

SECTION II: FUNCTIONAL STATUS (*continued*)

17. **Current health conditions** *(mark all that is observed and/or documented and describe current health conditions):*

- ☐ Blood disorders
- ☐ Cardiovascular disorders
- ☐ Circulatory disorders
- ☐ Comatose
- ☐ Continence disorders
- ☐ Digestive disorders
- ☐ Endocrine disorders
- ☐ Fractures/injuries
- ☐ Musculoskeletal disorders
- ☐ Neoplasms
- ☐ Nutritional disorders
- ☐ Neurological disorders
- ☐ Physical disability
- ☐ Respiratory disorders
- ☐ Sensory impairment
- ☐ Skin disorders
- ☐ Terminal illness
- ☐ Other (specify):
- ☐ None

_____

_____

18. *Please indicate whether the individual has any of the following physician-diagnosed conditions (mark all that apply):*

- ☐ Alzheimer's disease
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Comatose
- ☐ Delirium
- ☐ Dementia/OBS
- ☐ Functions at brain stem
- ☐ Huntington's
- ☐ Parkinson's
- ☐ Terminally ill
- ☐ Ventilator dependent
- ☐ None of the above
- ☐ Other (*specify*): _____

SECTION III: MH/MR SCREEN

19. Has the individual been diagnosed as having a major mental disorder that is listed in the *DSM-III-R*?
☐ Yes ☐ No

20. *Please indicate whether a mental disorder has negatively impacted the individual in any of the following areas (mark all that apply):*
- ☐ Interpersonal functioning
- ☐ Concentration, persistence and pace
- ☐ Adaptation to change
- ☐ Not applicable

21. *Based on treatment history, please indicate whether the individual has experienced any of the following within the last two years (mark all that apply):*
- ☐ Use of psychotropic medication for behavior control
- ☐ Inpatient psychiatric treatment
- ☐ An episode of significant disruption
- ☐ Not applicable

22. Does the individual display a disturbance in orientation, affect or mood that is not attributable to dementia?
☐ Yes ☐ No

23. Has the individual been diagnosed as having mental retardation prior to the age of 22?
☐ Yes ☐ No

24. Has this individual been diagnosed with a related condition or developmental disability, prior to the age of 22, that is likely to continue indefinitely?
☐ Yes ☐ No

25. Is there any presenting evidence (behavioral/cognitive) that may indicate that the individual has mental retardation/ related condition or developmental disabilities? ☐ Yes ☐ No

26. *Please indicate whether the individual has a substantial functional limitation, due to mental retardation, in any of the following areas of major life activity (mark all that apply):*
- ☐ Self-care
- ☐ Language
- ☐ Mobility
- ☐ Learning
- ☐ Independent living
- ☐ No functional limitations

27. Has the individual been referred from an agency that serves individuals with mental retardation?
☐ Yes ☐ No

I am interested in seeking nursing facility services and authorize the release of information, as necessary, to make nursing facility eligibility and/or placement determinations.

28. Individual's signature: _____ Date: _____

Form completed by: _____ Date: _____

SECTION IV: SUPPORT INFORMATION

29. *Who lives with you (mark all that apply):*

- ☐ Minor children
- ☐ Adult children
- ☐ Spouse
- ☐ Other relative
- ☐ Friends
- ☐ Non-related paid helper
- ☐ Lives in adult care home setting
- ☐ No one
- ☐ Not answered

30. *Please indicate whether or not the individual's dwelling has the following amenities/features (mark all that apply):*

- ☐ Electricity
- ☐ Fans/air conditioner
- ☐ Flush toilet
- ☐ Laundry facilities
- ☐ Piped hot water
- ☐ Refrigerator/stove/microwave
- ☐ Telephone
- ☐ Television/radio
- ☐ Tub/shower
- ☐ Not answered

31. Do you have difficulty getting into your home or any other room in your house (*check all that apply*)?

- ☐ No
- ☐ Yes If "Yes", (*check all that apply*) ☐ Entrance ☐ Bedroom ☐ Bathroom ☐ Kitchen

32. How safe does the individual feel in his/her home?

- ☐ Very safe
- ☐ Somewhat safe
- ☐ Not safe
- ☐ Very unsafe
- ☐ Not answered Explain: _____

33. Does the individual feel that anyone is taking advantage of him/her physically, emotionally or in any other way?

- ☐ Yes Explain: _____
- ☐ No
- ☐ Unsure
- ☐ Not answered

34. *Please indicate which of the following informal support services the individual currently receives (mark all that apply):*

- ☐ Housework/laundry
- ☐ Meal preparation
- ☐ Medication administration
- ☐ Money management
- ☐ Personal care
- ☐ Shopping
- ☐ Transportation
- ☐ None
- ☐ Other (*specify*): _____

35. *Please indicate whether or not the individual has received any of the following community based services within the last two years (mark all that apply):*

- ☐ Adaptive home modification
- ☐ Adult day care
- ☐ Adult foster care
- ☐ Assisted living
- ☐ Attendant care
- ☐ Case management
- ☐ Chore services
- ☐ Congregate meals
- ☐ Other _____
- ☐ Durable med equip/ass't devices
- ☐ Home delivered meals
- ☐ Home health care
- ☐ Homemaker
- ☐ Hospice
- ☐ Independent living center
- ☐ Medical alert
- ☐ Medical attendant
- ☐ Mental health
- ☐ Minor home repairs
- ☐ Night support
- ☐ Respite care
- ☐ Shared housing
- ☐ Telephone reassurance
- ☐ Transportation
- ☐ Volunteer
- ☐ None

SECTION V: INTERVIEWER ASSESSMENT

36. *Based on completion of a mental status examination, please indicate whether or not you suspect that the individual has experienced or is experiencing any of the following conditions/situations (mark all that apply):*

- ☐ Abuses alcohol/meds/drugs
- ☐ Abuses/neglects self
- ☐ Agitation
- ☐ Assaultive
- ☐ Delusions/hallucinations
- ☐ Depression
- ☐ Exploited
- ☐ Impaired comprehension
- ☐ Impaired judgment
- ☐ Impaired memory
- ☐ Impaired orientation
- ☐ Physically abused/neglected
- ☐ Psychologically abused/neglected
- ☐ Suicidal/homicidal
- ☐ Unusual behavior
- ☐ Wandering
- ☐ None
- ☐ Other (*specify*): _____

Comments: _____

Client's initials _____

5-18

SECTION V: INTERVIEWER ASSESSMENT (continued)

37. Will the individual's orientation or judgment jeopardize her/his safety in a home setting?
☐ No ☐ Yes If "Yes", Explain: _____

38. Does the individual have physical impairments that will affect her/his ability to function safely in a community setting?
☐ Yes ☐ No

39. *Please indicate why the individual is seeking nursing facility care (mark all that apply):*
☐ Cannot manage household
☐ Chronic illness or disease
☐ Unsafe behavior
☐ Decline in activities of daily living (ADLs)
☐ Emergency placement
☐ Respite care
☐ Short-term stay <30 days
☐ Other (*specify*): _____

40. Given the individual's physical and/or mental condition, does he/she need NF level of care?
☐ Yes ☐ No

41. *Please indicate which of the following community based service(s) may prevent the individual's placement in an nursing facility or will be necessary for the individual to remain safely in the community (mark all that apply):*
☐ Adaptive home modification
☐ Adult day care
☐ Adult foster care
☐ Assisted living
☐ Attendant care
☐ Case management
☐ Chore services
☐ Congregate meals
☐ Other _____
☐ Durable med equip/ass't devices
☐ Home delivered meals
☐ Home health care
☐ Homemaker
☐ Hospice
☐ Independent living center
☐ Medical alert
☐ Medical attendant
☐ Mental health
☐ Minor home repairs
☐ Night support
☐ Respite care
☐ Shared housing
☐ Telephone reassurance
☐ Transportation
☐ Volunteer
☐ None

42. *Please indicate the individual's placement choice (direct client response, check one):*
☐ Alternative housing
☐ Family/Friend's home with CB services
☐ Home with CB services
☐ Home without CB services
☐ Nursing facility
☐ Unknown/None

43. *Please indicate to which of the following agencies the individual and/or her/his family were referred for services (mark all that apply):*
☐ AAA office (*specify*): _____
☐ Adult protective services
☐ Community Mental Health Center
Date referrals issued: _____
☐ County health department
☐ Home health agency
☐ Hospice
☐ Indep. living centers*
☐ Legal assistance
☐ SRS office
☐ None

*Requires self referral

44. **Financial Information** *(optional)*

Are you willing to contribute to the costs of long term care services?
☐ Yes ☐ No ☐ Unknown

If "no," is the individual interested in a referral to SRS or the Area Agency on Aging for a financial determination?
☐ Yes ☐ No ☐ Unknown

What is the individual's approximate total monthly income, including interest from bank accounts, dividends, etc.?
☐ $0-250 ☐ $251-500 ☐ $501-750 ☐ $751-1000 ☐ >$1000 ☐ Unknown

45. Who did you talk to to complete this assessment? _____

46. Assessor comments: _____

_____

_____

_____

I am interested in seeking nursing facility services and authorize and request the release of any information to make nursing facility and community based service eligibility determinations or placement recommendations, including a referral to the appropriate Area Agency on Aging. Moreover, I have knowlingly participated in the Level I nursing facility preadmission assessment and referral program, and the options for community based services have been shared with and explained to me by the assessor.

47. Individual's signature: _____

Date: _____

Substitute for HB 2581
Senate Public Health & Welfare Committee
March 16, 1994

My name is Jim Sund and I am from Merriam, Johnson County. I am an advocate in the Aging Network and I serve on the Johnson County Commission on Aging. I served 6 years as in the Silver Haired Legislature, 2 years as Speaker. I am here to support passage of the Substitute for House Bill 2581.

Madam Chairman and members of the Committee, thank you for giving me the opportunity to talk with you today and support this bill.

I believe the need for pre-admission assessment of people before commitment to nursing homes for custodial care has been well documented and agreed upon. Unfortunately, our first experiment with the program revealed some problems and short-comings. The assessments were made by a contractor and the shortcomings were attributed to a lack of transmittal of evaluations to the necessary agencies. A second contractor was employed through calendar year 1994, but this contractor is employing sub-contractors in each region and the shortcomings persist. Agencies on Aging, with one exception, are not getting the evaluations and hence, not able to follow up or act on them.

In my view, the KDOA and the 11 Area Agencies for Aging are well qualified to perform this function. In fact, I am a strong believer in the advantages of providing all of the in home, long term care services through the KDOA.

Two programs implemented during the last 2 or 3 years have served to enhance the capabilities and expertise of these agencies for providing these services.

The first program is the Information Referral and Assessment

Senate PH&W
Attachment #6
3-16-94

program. This activity has received state wide implementation and involved establishing telephone networks, toll free telephone systems and inventories of resources in the state and in local regions. A national toll free line or program known as the **Elder Care Locator** has been established. Trained people, including volunteers, provide information and refer potential clients to sources for aid and information. These networks and personnel are in place and operating.

A highly visible result is the "Explore Your Options" project. KDOA in conjunction with SRS developed a standardized format for a booklet, and each Area Agency on Aging prepared a section unique to its geographic area. The booklet lists all available resources in the area, whether for profit, charitable or government subsidized. A wide range of subjects is included, from alternate living choices, transportation, health care, in home care, and information sources. Both state wide and regional toll free numbers are provided. The booklets have been widely distributed to hospitals, doctors, nurses, nursing homes and the general public.

Creating the program and compiling the data have required close cooperation between the Department on Aging, the Department of Social & Rehabilitation Services and the Department of Health and Environment. It has also required a detailed inventory of resources available in the State and the local regions. I have here two examples of the booklet, one personalized for the Jayhawk Area Agency on Aging and one personalized for the Johnson County Area Agency on Aging. I have attached to my testimony supplied to you, a copy of the booklet personalized for Johnson County, as well as a copy of the brochure, **Eldercare Locator.** If you would like a copy of the "Explore Your Options" for your geographic area, just locate your county on the rear cover, note the bold face number for the area, and call the

toll free number for your Area Agency. They will be happy to supply you a copy at no charge.

The second program that has served to enhance in house capabilities of KDOA and the Area Agencies on Aging has been broadening of the Senior Care Act and care management to state wide coverage. This has required AAA's to become intimately acquainted with and to work with providers of services in the area. Whether personnel are in-house employees or contracted services, the activities have served to sharpen their expertise. Care management, or what we used to call case management has become an integral part of their daily job.

If the pre-admission assessment concept is to work, it requires close cooperation and exchange of information between all State agencies involved and the Area Agencies on Aging, as well as intimate knowledge of resources available. And of course, dedicated workers. I believe success can be achieved by assigning this responsibility to the Department on Aging.

I appreciate the attention you have given me and the opportunity to talk with you.

Madam Chairman, if you or your committee members have questions, I will be happy to answer them.

Jim Sund
7202 Mastin
Merriam,KS 66203

(913)362-1448

6-3

TESTIMONY PRESENTED TO SENATE PUBLIC HEALTH AND WELFARE:
March 16, 1994

RE: Substitute for HOUSE BILL No. 2581

My name is Ellen Elliston. I am the director of Patient Support Services at St. Francis Regional Medical Center. My department is a consolidated department that includes social work,discharge planning and other support services. I have a master's degree in Social Work and am currently working on another master's in Health Care Administration. I am here today to speak in favor of Substitute House Bill No. 2581.

The Wichita hospitals have been interested in the nursing home assessment program since it was first mentioned. This is my third time to testify before groups concerning our thoughts on the program. We had strong concerns that the bill as originally passed would add expenses to the health care system by requiring unnecessary work on the part of hospital discharge planners and by causing delays in the discharge planning system. And indeed it did! We all experienced less than effective communication with SRS and their intermediary, confusion over what was required from the hospitals, and increased anxiety on the part of patients who were required to be screened by community assessors who were not familiar with medical settings.

We are gratified to see that a bill has been suggested to take the place of the original bill, and we encourage the adoption of the substitute bill for the following reasons:

1) The program is presented in a more positive light by stressing that the it is for assessment and referral to community-based services *and* nursing homes. This wording does not give the message that the program is designed to exclude people from needed services. This change in terminology suggests interest in providing a service to the elderly. Even the name of the program, CARE, conveys a more positive message to the elderly and their families.

2) It places the program under the Secretary of Aging, to be administered by the area agencies. We hope this will mean that trained professionals will administer the program rather than a contracted group that may not be familiar with community resources.

3) It leaves the assessment of hospital patients in the hands of hospital social workers and discharge planners who have had specialized training in discharge planning, and who work under strict guidelines from accrediting agencies. We provide a high quality of service for our patients, and thorough assessments are an integral part of our service. We are gratified that this bill acknowledges the value of our service to patients and families. The changes will enable us to prevent unnecessary stress for patients and families and should eliminate the delays we experienced under the previous bill.

Senate PH&W
Attachment #7
3-16-94

929 N. St. Francis, Wichita, Kansas 67214-3882 / 316-268-5000 Toll Free 1-800-362-0070 / FAX 1-316-268-8697
Owned And Operated By The Sisters Of The Sorrowful Mother

4) The assessment instrument is designed to be a **one page instrument** which is much better than the lengthy instrument we have been using. We would hope that the new instrument will be concise, relevant, and easy to complete.

These are a few of the positive changes in the bill. But perhaps the most important change is the fact that this bill presents assessment and referral services as a team effort between hospitals, nursing homes, community agencies SRS, and the Agency on Aging. This is the way we have historically approached discharge planning for hospitalized patients, and we are very pleased to see this approach reflected in the bill as it stands before you today.

In all program development activities we learn from our mistakes, and we have learned from our mistakes this time. This substitute bill attempts to correct some of the misdirection we have experienced with this program, and appears to provide direction toward a more positive, effective program that will meet the goals that we all have - **to meet the increasing needs of the elderly in an effective manner.**

Thank you for your attention. We encourage adoption of substitute House Bill No. 2581 as a positive step in meeting the needs of the elderly in Kansas.

KINH Kansans for Improvement of Nursing Homes, Inc.

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

TESTIMONY PRESENTED TO
THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING SUBSTITUTE FOR HB 2581

March 16, 1994

Madam Chair and Members of the Committee:

There are many aspects of the CARE program that KINH can support. We are in complete agreement with the program's statement of purpose for data collection, assessment and referral to community-based services, and appropriate placement in long term care facilities. We believe this statement incorporates the original goals for a preadmission assessment and referral program.

KINH would accept the transfer of the CARE program to the Department on Aging, provided the necessary funding and staff support are transferred along with the responsibility. We agree that it would be sensible to phase in the transfer of administrative responsibility for the program. Such a transfer would appear to be consistent with preliminary recommendations of the National Long Term Care Resource Center for a single entry system for long term care services.

We have two concerns about the CARE Data Form:

1. We would prefer that the statute not specify the length of the form, and we note the National Long Term Care Resource Center report makes the same suggestion. We believe the existing statutory language requiring the form to be "as concise and short in length as is consistent with the purposes of the instrument" would provide adequate direction to the agency while allowing the form to be modified if needed.

2. The statement that the purpose of the form "is for data collection and referral services," contradicts the statement of purpose of the CARE Program, which includes data collection, referral, and appropriate placement in long term care facilities. How would the program assess the appropriateness of placements if the Data Form does not include a needs assessment? It might be possible to develop a one-page data entry form, but a useful needs assessment would probably exceed one page in length.

We find two definitions which need to be clarified or corrected:

1. The language on federal requirements is confusing. Does this language refer to the PASARR requirement? Does it also mean that Medicaid applicants must be assessed? The statute should specify in clear language which federal requirements the CARE Program would meet.

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2. We believe this bill intends to require assessments prior to admission to nursing facilities. However, requiring assessment and referral prior to admission to an "adult care home" would also include admissions to intermediate personal care homes, one to five bed adult care homes and boarding care homes.

We are concerned that, as written, the section which allows assessment services to be provided within ten days of admission to a nursing home would violate the federal PASARR requirement that all persons be screened prior to admission.

KINH continues to support assessment of all nursing home admissions, not just Medicaid applicants, for a number of reasons:

1. Not all families who seek nursing home placement for a loved one are aware of community-based alternatives which might meet the individual's need. The National Long Term Care Resource Center report indicates the program "should be seen as a process for informing consumers and family members to assist them accessing the long term care system, not simply one of many programs/services within the system."

2. If private-pay applicants are informed of less costly in-home services, they can be helped to stretch their resources and to postpone the time when they become eligible for Medicaid assistance. The Long Term Care Resource Center states: "For public policy reasons, people who are likely to 'spend down' once admitted to a nursing home should be assessed to evaluate their need for institutional care and the appropriate options."

3. If the state's long term care system is to benefit from the data collected by the CARE Program, the inclusion of private-pay individuals gives a more complete picture of the long term care needs and resources across the state.

KINH heartily supports the creation of a voluntary oversight council, and we are pleased that consumers would be represented. We suggest, in order to create a better balance between institutional and community service providers, that representatives from community-based services and home health agencies should also be included.

With these suggested modifications, KINH would support this bill.

Respectfully submitted,

Sandy Strand

Sandra Strand
Legislative Coordinator

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SOCIETY FOR SOCIAL WORK ADMINISTRATORS IN HEALTH CARE
KANSAS SUNFLOWER CHAPTER
Monica Flask, President
also representing the
MO-KAN CHAPTER

Regarding the Substitute for HB 2581 - CARE program

March 16, 1994

The Kansas Sunflower and Mo-Kan Chapters of the Society for Social Work Administrators in Health Care wish to express support for the Substitute for House Bill 2581. We believe the proposed CARE program will substantially improve current efforts to provide long-term care assessment services to Kansans.

As this committee is well aware, the current KPAR program has had numerous problems as it is currently implemented. We believe the CARE program is preferable for the following reasons:

1) The focus of the CARE program will be on assessment and referral services rather than on determination of eligibility criteria. This focus recognizes the fact that most Kansans will choose community services when they are available and avoids the patronizing position of having a contractor render an opinion on whether or not they need nursing home care.

2) The CARE program recognizes the expertise of social workers and discharge planners and avoids duplicating the efforts of these skilled professionals, when appropriate assessment services are already being provided to patients in medical care facilities.

3) The CARE program is much simpler in design than the current KPARI program. It avoids unnecessary data collection by mandating a 1-page form which has the specific purpose of meeting PASARR requirements and collecting resource data.

4) The CARE program should be much more inexpensive than the current KPAR program, which has been far too costly for the amount of benefit provided.

The Society of Social Work Administrators in Health Care supports the Substitute for HB 2581. We wish to thank the legislature for the hard work, including numerous hearings and committee meetings, which generated this bill. We believe our concerns have been heard and addressed by this legislation and encourage you to support the bill. Thank you.

Senate PH&W
Attachment #9

Testimony opposing substitute HB 2581
Rosie Williams, Pres. Caring Connections
913-357-1333

Thank you Madame Chairwoman and members of the committee. My name is Rosie Williams. I am the president of Caring Connections Inc., a private case management company in Topeka, Ks. Caring Connections has been a contracted provider of pre-admission screening since the program was implemented on January 1 of last year. I was asked to participate on the task force who were given the task of identifying the problems with preadmission screening and to make recommendations for changes. There were 26 professional individuals representing a cross-section of interests who were all affected in some way by the PAS process. I would like for you to consider the suggestions made by the task force. The subtitute HB2581 was drafted before consideration of these recommendations. Unfortunately, this bill presents conflicting ideas and thus I am opposed for the following reasons:

1. The CARE data form is not to exceed one page in length while at the same time is to evaluate an individual's health and functional status, determine the need for long-term care services, identify appropriate service options, and comply with PASSAR screening requirements. The professionals who have tested this Level One instrument in the field for fourteen months have made suggestions to the CQI team who have refined and improved this form. The result is an assessment tool 6 pages in length which for the first time has the consensus of AAA, SRS, and hospital staff. This is a cost-effective, concise instrument. To reduce this to one page is totally unworkable if meaningful data is to be gathered as is required by the bill. The only way a one page form would work is if there were a master questionaire with the assessor filling in answers on a one page sheet. If this section of the bill is passed, SRS will go back to having their form, AAA 's will have their form, etc. and we will have gone backwards instead of forwards in the assessment process. The concept of a one page form is appealing, but impractical in the real world of aging services.

2. I believe that private pay individuals have the same needs for information about long term care services as do those who are on Medicaid. Perhaps the private pay person should have the choice to opt out of the assessment, but certainly they should be given the option for the assessment if they so choose.

3. I believe that the community based assessors who have a good reputation and have worked to comply with SRS should continue to be used. These individuals have been trained and now have the experience needed to provide quality assessment services.

4. In my opinion, this bill is trying to "fix" some problem areas that have already been addressed. By allowing the proposed program changes to be implemented, the Legislature will certainly be pleased when the program is evaluated a year from now. A missing link this last year was implementation time. Please allow for that now.

Thank you.

Senate P+H C
Attachment #10
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