Approved: March 15, 2011
Date

MINUTES OF THE HOUSE AGING & LONG-TERM CARE COMMITTEE

The meeting was called to order by Chairman Bob Bethell at 9:00 am. on February 17, 2011, in Room 144-S of the Capitol.

All members were present except:
Representative Scott Schwab – absent
Representative Kay Wolf – excused
Representative Broderick Henderson – excused

Committee staff present:
Katherine McBride, Office of Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Craig Callahan, Kansas Legislative Research Department
Evelyn Walters, Committee Assistant\

Conferees appearing before the Committee:
Artis Perret, RN, Owner/Operator Heartland Haven Home Plus
Mitzi McFatrich, KS Advocates for Better Care
Cindy Luxem, Kansas Health Care Association

Others attending:
See attached list.

Chairman Bethell opened meeting with Monte Coffman, Executive Director of Windsor Place, Coffeyville, KS presenting on results of the Telehealth Remote Monitoring pilot project. (Attachment 1) Representative Weber asked questions.

Chairman Bethell opened the Hearing on:

HB 2147 – Relating to the definition of a home plus residence or facility

Katherine McBride, Office of the Revisor of Statutes, reviewed the bill contents. Questions were asked by Representative Moore and Representative Weber.
Proponents:
Artis Perret, RN, Owner/Operator Heartland Haven Home Plus provided testimony. (Attachment 2). Questions were asked by Representative Vickrey and Representative Otto.
Written testimony was provided by:
M. Christy Jacks, RN, (Attachment 3). Myrna Schmidt, consumer, (Attachment 4). and Joe Ewert, KAHSA, (Attachment 5).

Opponent:
Mitzi McFatrich, KS Advocates for Better Care, provided testimony. (Attachment 6). Questions were asked by Representative Weber, Representative Moore, Representative Worley, and Representative Hill. Representative Hill requested additional information.

Neutral:
Cindy Luxem, Kansas Health Care Association, testified in support of the bill. (Attachment 7). Questions were asked by Representative Worley, Representative Otto and Chairman Bethell.

No other conferees on **HB 2147.**
Chairman Bethell closed the hearing on **HB 2147** at 9:45 am.

Chairman Bethell asked for discussion on how the committee desired to proceed. **Representative Otto moved to pass HB 2147, seconded by Representative Gonzales.** Before voting occurred, discussion and comments were presented by Representative Moore, Representative Weber, Representative Flaharty, Representative Hill, Representative Otto and Chairman Bethell.

On a tie vote HB 2147 remains in Committee.

The next meeting is scheduled for February 22, 2011.

The meeting was adjourned at 9:55 am.

HOUSE AGING AND LONG TERM CARE COMMITTEE

DATE: 2/17

NAME	REPRESENTING
Sara Arif	KDOA
Marie LeBlanc	Windsor Place
Tom Burgess	" " Hmlc
Cindy Luxem	KHCA
Dan Murray	Federico Consulting
Joe Ewert	KAHSA
John Peterson	Capitol Strategies
Mitzi McKittrick	KABC
Artis Perret	Heartland Haven

PLEASE USE BLACK INK

House Aging and Long-Term Care Committee

Telehealth Remote Monitoring Presentation

Monte Coffman, Executive Director
Windsor Place, Coffeyville, Kansas
February 17, 2011

Windsor Place
Worthwhile Work

Telemedicine Defined

- Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term "telehealth", which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.
- Telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. Even in the reimbursement fee structure, there is usually no distinction made between services provided on site and those provided through telemedicine and often no separate coding required for billing of remote services.
- Telemedicine encompasses different types of programs and services provided for the patient. Each component involves different providers and consumers.

Telemedicine Services

- **Specialist referral services** typically involves of a specialist assisting a general practitioner in rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to a specialist for viewing later. Recent surveys have shown a rapid increase in the number of specialty and subspecialty areas that have successfully used telemedicine. Radiology continues to make the greatest use of telemedicine with thousands of images "read" by remote providers each year. Other major specialty areas include: dermatology, ophthalmology, mental health, cardiology an pathology. According to reports and studies, almost 50 different medical subspecialties have successfully used telemedicine.

- **Patient consultations** using telecommunications to provide medical data, which may include audio, still or live images, between a patient and a health professional for use in rendering a diagnosis and treatment plan. This might originate from a remote clinic to a physician's office using a direct transmission link or may include communicating over the Web.

- **Remote patient monitoring** uses devices to remotely collect and send data to a monitoring station for interpretation. Such "home telehealth" applications might include a specific vital sign, such as blood glucose or heart ECG or a variety of indicators for homebound patients. Such devices can be used to supplement the use of visiting nurses.

- **Medical education** provides continuing medical education credits for health professionals and special medical education seminars for targeted groups in remote locations.

- **Consumer medical and health information** includes the use of the Internet for consumers to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.

Kansas Medicaid LTC Services

Nursing Facilities

Medical Clinical Care	RN's ---------- LPN's
ADL and Personal Care	CNA's ---------- RA's ---------- Other Staff
Social Needs	Activity Directors Social Workers

Windsor Place
Worthwhile Work

Kansas Medicaid LTC Services

Care Needs	Nursing Facilities	Home and Community Based Services
Medical Clinical Care	RN's -------- LPN's	VOID
ADL and Personal Care	CNA's -------- RA's -------- Other Staff	Attendant Care Workers ---------- Homemaker Staff
Social Needs	Activity directors/Social workers	Companion Services (added October 2008) (ended January 2010)

In 2006, Windsor Place met with and proposed to KDOA Secretary Greenlee and her staff the application of home telehealth and remote monitoring for the purpose of managing chronic diseases more effectively in the home.

In Feb 2007, a KDOA grant funded our pilot project. On August 1, 2007, the pilot program was operational. Extremely promising results were realized during the pilot.

Windsor Place
Worthwhile Work

3 Benefits of Telehealth

-Access to care

-Quality improvement

-Efficiency and lower cost of care

Four Key Elements to Telehealth

-Accurate physiological information

-Shared data with patient

-Data-driven coaching/patient education

-Optimized provider involvement

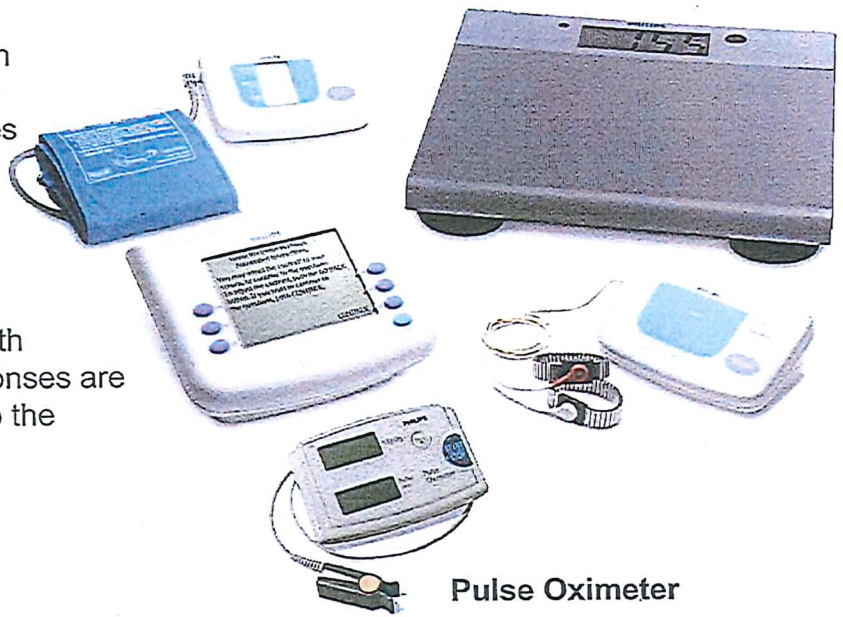
Windsor Place

Worthwhile Work

Award-winning Measurement Technologies
Accurate, Reliable, Unobtrusive and Easy to Use

Blood Pressure & Pulse

Takes readings when patient slides cuff up the arm, then presses "Start" button.



Standard Scale

Low step, a wide, steady platform, a large digital display and voice announcement.

TeleStation

Asks simple health questions. Responses are communicated to the clinical software.

ECG/Rhythm strip

Simple wristbands with snap-on connectors.

Pulse Oximeter

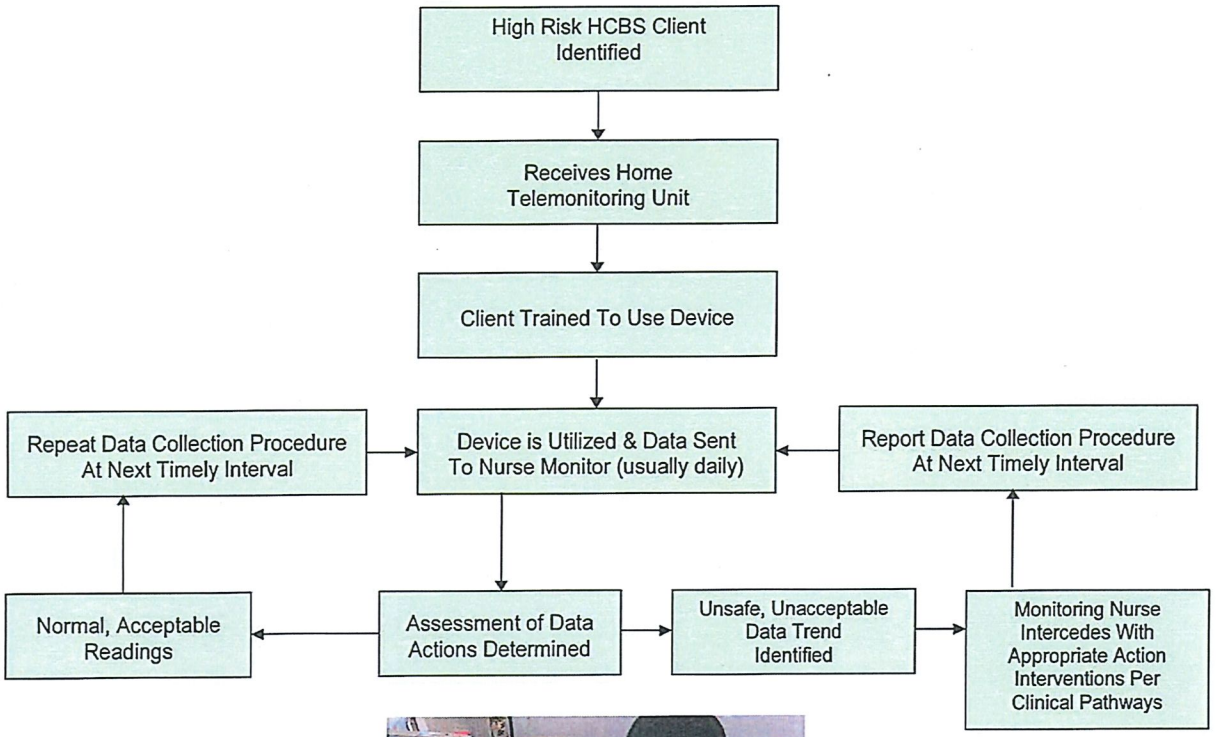
Spot checks oxygen saturation and pulse within seconds.

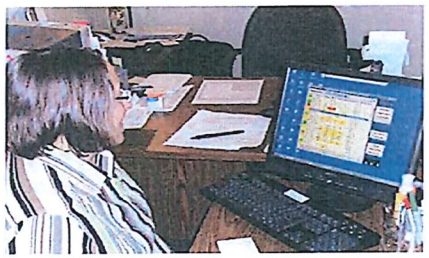
Glucose meter connection

Bayer Ascensia Contour 7151B

Windsor Place
Worthwhile Work

KDOA-HCBS PILOT PROJECT
Monitoring Process For High Risk HCBS Clients





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Worthwhile Work

Client's begin Telehealth session

Session Data Transmission

Sent to Nurse's Computer

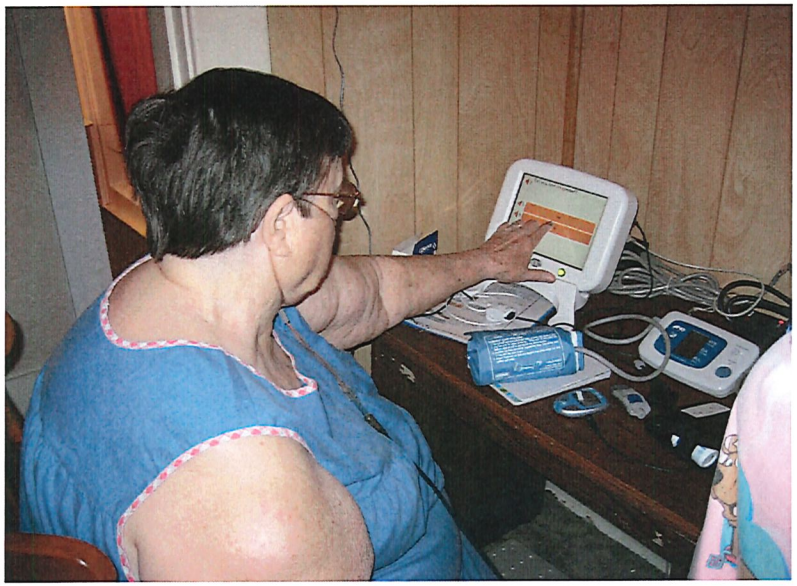
Data Reports Analyzed/Assessed

Communications Back to Client

Education Tips

Intervention Actions

Retake Measurements



Windsor Place
Worthwhile Work

MARY's DAY

Mary uses Telehealth equipment to measure her Weight, Blood Pressure, Pulse Oxygen and Blood Glucose readings. A typical day for Mary is as follows:

07:30am Mary wakes, walks into her dining room and sitting relaxed, places the **Blood Pressure** cuff on her arm and presses the START button on the B/P meter. Her B/P is automatically transferred to the TeleStation (main monitor).

07:32 Mary places the **Pulse Oxygen** clip on her finger, presses start and the meter measures the oxygen in her blood. This is transferred to the TS.

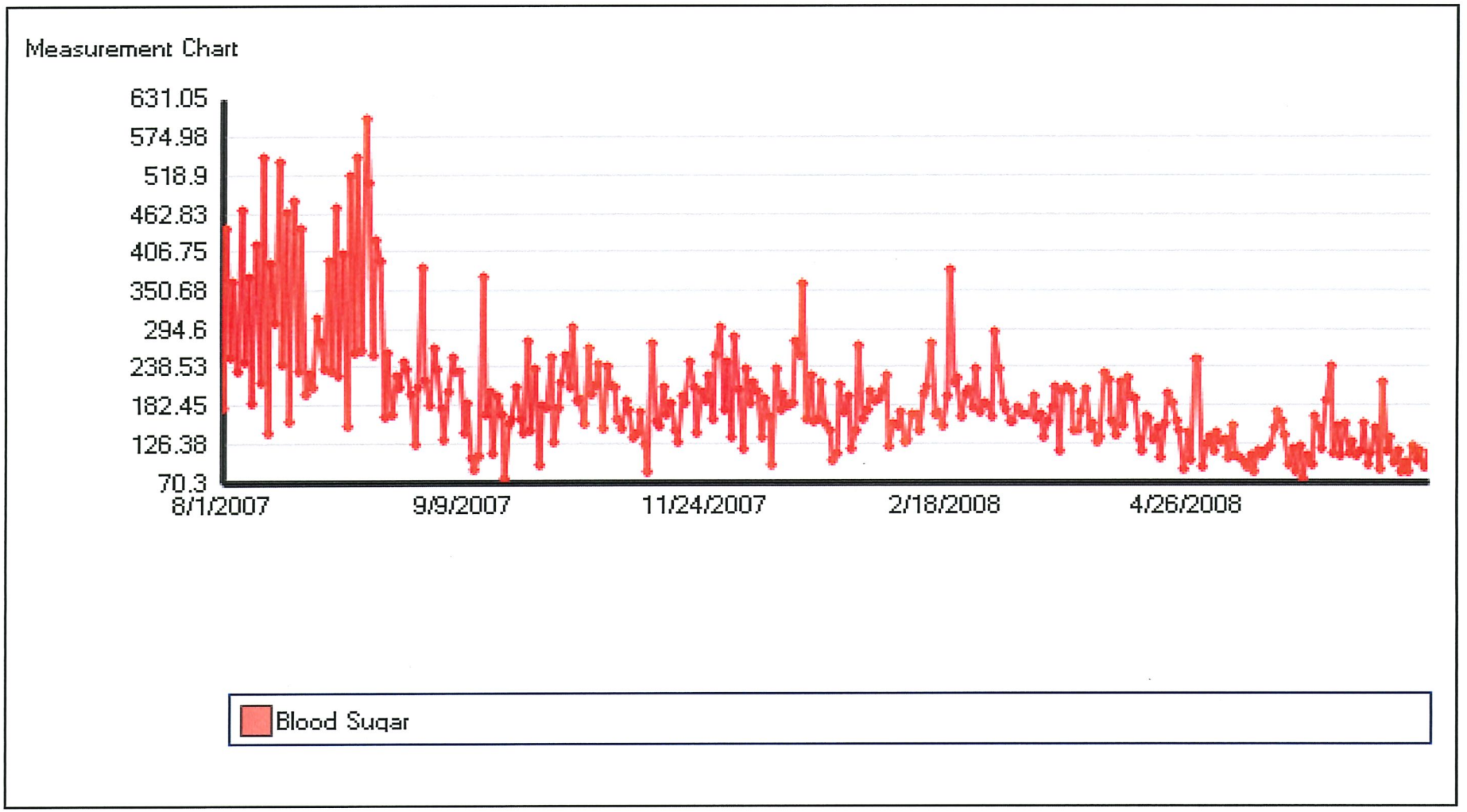
07:34 Mary checks her **Blood Sugar.** Once the measurement is taken, she will plug a cable from the TeleStation into the glucose meter. This transmits that reading to the TS.

07:37 Next, Mary gets up to do her **Weight.** In about 10 seconds, this measurement will automatically go to the TS.

07:40 Taking all these measurements in the comfort of her home, Mary has used about **10 minutes** of her day.

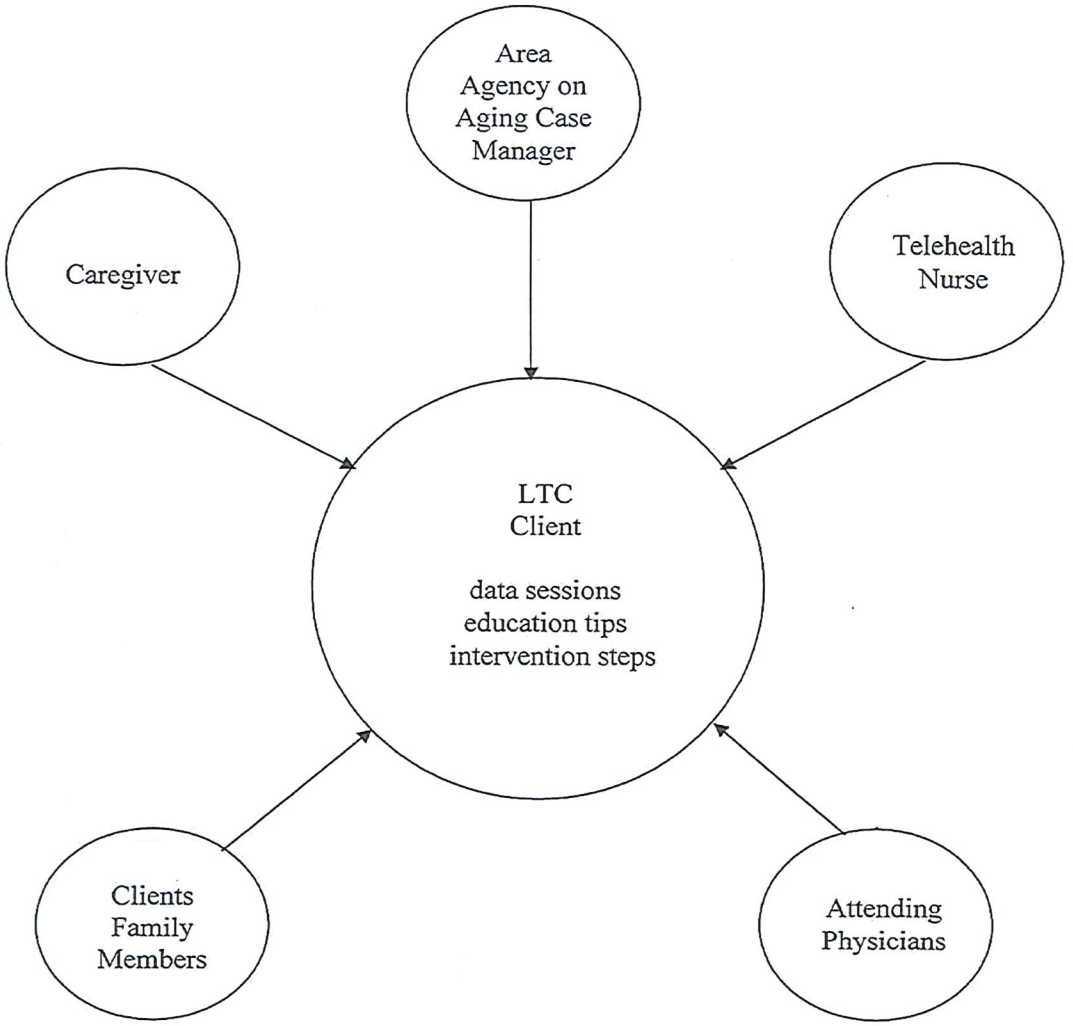
The **TeleStation will transmit** the readings it has received from each device via a **TOLL FREE** number and send them to a **secure, password protected website** so that the **TeleHealth nurse can see them**. This transfer happens about 15 – 20 min after the first measurement was taken, giving Mary ample time to do all measurements.

On occasion, Mary will have assessment questions, information or education, or a simple Birthday greeting. She will answer these in a matter of minutes and the TeleStation, as with the measurements, will transmit the answers to the secure website.



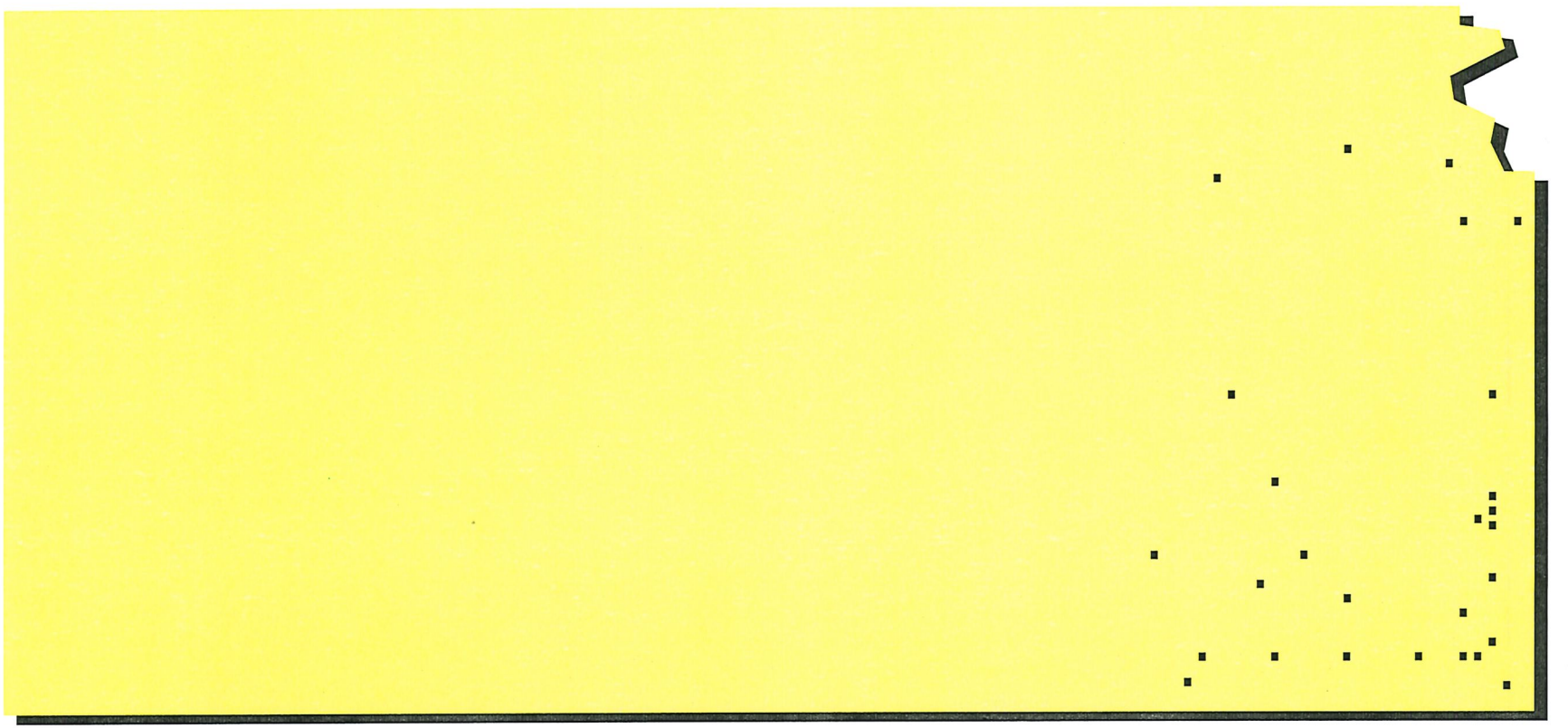
Windsor Place
Worthwhile Work

Care Coordination and Integration Expansion



Windsor Place
Worthwhile Work

Kansas Telehealth Participant Locations



Arma-3
Baxter Springs-2
Chanute-6
Cherryvale-2
Coffeyville-10
Columbus-1
Dearing-2
Desoto-1
Frontenac-3
Ft. Scott-3
Galena-5
Girard-1
Erie-2
Fall River-1
Lawrence-2
McLouth-1
Mulberry-2
Neodesha-3
Independence-5
Iola-1
Pittsburg-3
West Mineral-2
Topeka-1
Yates Center-1
Oswego-1
Parsons-1
Scammon-1
Olathe-2
Howard-1

Excerpts from KUMC's Year 3 Telehealth Pilot Report

Utilization and Costs – By the end of the third year, all six original variables were statistically different between baseline and intervention periods across the three years (Table 1). These data mean that there is likely an effect of the telehealth intervention on the HCBS/FE study participants' use of health care services and the associated CMS costs.

Variable	Rate of Change	Significant Change?	p-value*
Hospital Visits	↓ by 38% per day	Yes	.0000
Hospital Days	↓ .028day/day or 10.23/year	Yes	.0014
Hospital Costs	↓ $72/day or $26,298/year	Yes	.0024
E.D. Visits	↓ by 67% per day	Yes	.0290
E.D. Costs	↓ $21.10 per day**	Yes	.0300
Total Costs	↓ $73/day or $26,663/year	Yes	.0004

Table 1: Comparison of baseline and intervention mean rates of pilot variables.
*Probability at the .05 level
*For Year 3 participants only. Year 1 and 2 participants were not different from baseline.

Participant Perceptions

HCBS/FE participants' perceptions of the intervention were positive during all three years of study.

Discussion

- The results of this home telehealth pilot project demonstrated that home telehealth intervention reduced the rate of emergency department utilization, inpatient hospitalizations and the associated Medicare costs for HCBS/FE clients. The cost savings of a hospitalization alone ($26,298 per patient annually) are substantial.
- In addition, the annual rate of nursing home placement during the three-year period was lower than the observed rate for all Kansas HCBS/FE clients. Patient perceptions of the intervention remained positive and stable over time.
- As with any pilot study, this pilot served its intended purpose of determining whether further study is warranted and what methodological issues should be revised. Specifically, this project yielded a number of positive findings that indicate the effectiveness of home telehealth for HCBS/FE clients and a number of lessons learned.

Medicaid Cost Savings Opportunities Through Reduced NF Admissions

	NF		HCBS
	Approx 10,400 people are here approx cost $3200 per month	seniors/funding source want to move this trend from NF to HCBS	Approx 6100 frail elders are here approx cost $1150 per month
medical/clinical needs	RN/LPN's provide care here		There is a void of care here. Telehealth would fill this need and allow seniors to stay in their homes longer.
Personal/ADL needs	CAN/RA's provide care here.		Attendant care and homemakers provide care here
Social Needs	Activity Directors/Social workers		Companion services added Oct 2008 but stopped Jan 2010

Windsor Place
Worthwhile Work

HCBS-FE Impacts

- During the three year pilot study, HCBS-FE telehealth pilot participants were admitted to nursing facilities 20.4% less than other persons in HCBS-FE waiver
- Of the telehealth participants who were admitted to the nursing facility, their average length of stay was only ten months, compared to two year average length of stay for other Medicaid nursing residents. A 58% reduction in length of stay.

Potential HCBS-FE Medicaid LTC Savings

If 500 units on likely NF admissions, the 100 residents would be deferred.

Deferral Savings 100 X $ 2,000/month X 12 Months	=	$2,400,000
LOS Savings 400 X $ 2,000/month X 12 Months X 58%	=	$5,568,000
	=	$7,968,000
Less: Telehealth cost for 500 units	=	$1,100,000
Potential Net Medicaid Savings on 500 units	=	**$6,868,000**

Medicaid Cost Savings Opportunities Through Reduced HCBS-PD Hospitalizations

Long Term Care

	NF	HCBS
medical/clinical needs	RN/LPN's provide care here.	**There is a void of care here.** Telehealth would fill this need and allow disabled persons to stay in their homes longer and out of the hospitals.
Personal/ADL needs	CNA/RA's provide care here.	Attendant care and homemakers provide care here.
Social Needs	Activity directors/Social workers	Companion services added Oct 2008

Cost savings opportunities 1372 PD consumers incurred $24M in Medicaid hospital costs in FY 2008.
Projected FY2009 Medicaid hospital cost for PD consumers is $28M.
If 500 consumers could be averted, savings could be $10.2M annually or more.

HCBS-PD Impacts

- In FY 2009, HCBS-PD consumers incurred $28,000,000 in Medicaid hospital costs.

- During the three year home telehealth pilot, the results of this project demonstrated that home telehealth intervention significantly reduced the rate of emergency department utilization, inpatient hospitalizations and the associated Medicare costs for HCBS-FE clients. The cost saving of hospitalizations ($26,298 per patient annually) are substantial.

Potential HCBS-PD Medicaid Hospital Cost Savings

With 500 PD consumers with repeated histories of Medicaid hospitalizations, an average of 38% reduction could be made.

$20,000,000 X 38%	**=**	**$7,600,000**
Less cost of Telehealth		<$1,100,000>
Potential HCBS-PD Medicaid hospital cost savings	=	$6,500,000

1-23

Contact Information

Monte Coffman

Executive Director

Voice: (620)252-4926
Fax: (620)251-5029
Email: m.coffman@windsorplace.net

2921 W 1st Street
Coffeyville, KS 67337

www.windsorplace.net

My name is Artis Perret, RN, ARNP, operator/owner of Heartland Haven Home Plus in Inman Kansas.

I am writing in support of HB 2147 to increase Home Plus facility capacity to 12.

We added 8 private rooms to our home approximately 4 years ago to go into the Home Plus Business of caring for elderly. We have employed 2 C N A/CMA's on days and evenings and one night CMA from 10p-6a. I also have an additional CMA who sleeps at night and is available as needed. I have 2 part-time LPN's who together work a total 30-40 hours a week on top of sharing call with me 24hr/7days a week.

When we initially opened Heartland Haven we admitted several HCBS residents. After several years it was evident that we needed to reduce the amount of HCBS residents we admitted. This decision was made because we could not pay the expenses we had incurred each month. HCBS only pays for the care we provide, not for the room and board. Several residents have run out of money after living here and have had to go on HCBS. A couple of them have homes and could not get them sold so when they passed, that money went back to HCBS to pay HCBS back for what they paid us for their care. We do not get any reimbursement for the amount we have lost while they are on HCBS. The reimbursement we get back from HCBS is about half of what we receive from private pay residents and those with long term care insurance.

If we were able to increase the number of residents we have, we could utilize our staff better and it would be much more efficient. We presently can take care of 8 residents easily with 2 staff members and a nurse. It would be much more efficient and financially feasible for us to stay in business if we were able to have an additional 4 residents.

I have been in the business of elderly care for over 30 years in different capacities. I believe Home Plus facilities are an alternative that should be available for the elderly whether HCBS, private pay or if they have long term care insurance. It is a very good long term care alternative. We have had very positive responses from our residents and the families involved in Heartland Haven. But it is very difficult to make ends meet with only 8 residents even when we decreased the amount of HCBS residents. Giving good quality care is very important to us.

The first place people cut when expenses get tight is staffing. Most residents who come to Home Plus facilities still need assistance with ADL's, personal cares, activities, social needs, home cooked nutritious meals, and a clean house. To be able to accomplish this, a facility will need adequate appropriate staff members. We have to be somewhat competitive in salaries, but being a small business, we do not offer any kind of benefits. The people who work for us are there because they love the people, home atmosphere and the excellent care and attention the people who live at Heartland Haven receive.

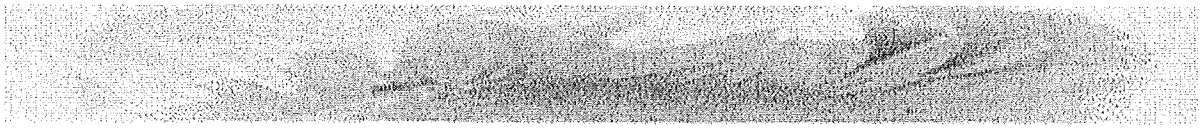
Home Plus facilities are the ultimate 'resident centered care'. We continually tell each other we are aiming to make each individual life the best that it can be, no matter what. No matter what their disease, emotional, spiritual, physical state or where they are in the process of dying. I believe other facilities have been encouraged to try harder to become more of a Home Plus model of care, because we all know of the positive benefits these facilities have for the people who live there, work there and visit there.

Please help us stay in business by passing the HB2147. Please call me if you have any questions 316-772-6855.

HOUSE AGING & LTC
DATE: 2/17/11
ATTACHMENT #2

Evelyn Walters

From: Christy Jacks, RN [christy@homeagainseniorliving.com]
Sent: Monday, February 14, 2011 3:21 PM
To: Evelyn Walters
Subject: Home Plus



My name is Melanie C. Jacks, RN Operator of Home Again Senior Living in Haviland, Kansas. I am writing in support of increasing Home Plus facility capacity to 12. I have been the Operator here for almost a year. Our census when I started was 3 and in 5 months we became full at 8. With the needs of the Residents I employ 2 CNA/CMA on day and evening shift with 1 on night from 12am to 7am. In addition to a nurse on call 24 hours a day. In December I completed all the requirements by the state to change my license to Residential Health Care so I could house 2 more Residents (my buildings capacity). It was a $9600 expense and our building is 5 years old. I don't believe the changes improved Resident Care. But I felt it was necessary due to the expenses we have. The day after my license was approved I had 2 more Residents move and am full presently. My building isn't big enough to house 12 but I do believe that would help pay the bills greatly. These types of facilities are such a wonderful place for the elderly as opposed to nursing homes. If I can answer any questions feel free to call me, 620-862-5867. Thank you for your consideration on this topic.

Sincerely,

M. Christy Jacks, RN

HOUSE AGING & LTC
DATE: 2/17/11
ATTACHMENT # 3

Evelyn Walters

From: Myrna Schmidt [oneoftheschmidts@gmail.com]
Sent: Wednesday, February 16, 2011 6:38 AM
To: Evelyn Walters
Subject: Please support HB2147 !

To whom it may concern:

I would like to share about our experience with my Mother in the Home Care Plus setting at Heartland Haven at Inman, Kansas.

When Mom was informed that she would have to move from Assisted Living she was heart broken and really discouraged. I came home and went to look at the home - Heartland Haven that was close to our home and was so impressed. She came out and toured it and visited with people and rather quickly she decided it would be her next home.

We had an awesome experience as she was so well taken care of, had the personal care - not a number or room number - she was a person. She also got home cooked meals, not instutional meals, and it was a lovely home setting. I can not say enough good about the setting and care and the pleasant experience even up to the day of her death. They were so caring and we knew that everything that mattered to her mattered to them - each of the employees and the owner, Artis Perret of whom she loved.

I would like to encourage you to support HB2147 as these homes are a great place for people to go to have a home away from home and feel like they can still count as someone with dignity.

Thanks for your time,

Myrna Schmidt
453 13th Ave.
Inman, Kansas 67546
620-585-2222
oneoftheschmidts@gmail.com

HOUSE AGING & LTC
DATE: 2/17/11
ATTACHMENT # 4

KAHSA
creating the future of aging services

To: Chairman Bethell, and Members,
House Aging and Long Term Care Committee
From: Joe Ewert, KAHSA Government Affairs Director
Date: Thursday, February 17, 2011

Testimony in Support of House Bill 2147

Thank you, Chairman Bethell and Members of the Committee. I am Joe Ewert, Government Affairs Director of the Kansas Association of Homes and Services for the Aging. Over 20,000 older Kansans are served everyday by KAHSA's 160 not-for-profit nursing homes, retirement communities, assisted living and senior housing facilities, and community-based service programs.

We support the provisions of House Bill 2147 that would increase the maximum number of individuals allowed to live in a single Homes Plus residence to 12. The current number of residents allowed under the Homes Plus licensure creates challenges to the financial feasibility of this model, especially during periods of turnover between residents. By providing greater flexibility, HB 2147 will strengthen the Homes Plus model, granting Kansas seniors greater options in choosing how to receive the long term supports and services they need.

Thank you. I would be happy to answer questions.

785.233.7443
kahsainfo@kahsa.org
fax 785.233.9471

HOUSE AGING & LTC
DATE: 2/17/11
ATTACHMENT #5

Kansas Advocates
for
Better Care

"Advocating for Quality Long-Term Care" since 1975

Kansas Advocates for Better Care Testimony
February 14, 2011
HB 2147 Increase of Home Plus Size Capacity
Position: Strongly Oppose

Representative Bob Bethell, Chair
Aging & Long Term Care
Chairman Bethell and Members of the Committee:
Thank you for hearing testimony on this bill today. Kansas Advocates for Better Care has been advocating for quality care in all adult care homes for 35 years.

The issue before you in House Bill 2047 would increase the number of maximum beds in a Homes Plus licensed adult care home from eight (8) to twelve (12).

Kansas Advocates for Better Care is strongly in opposition to this increase for the following reasons:

1) Recently the number of residents in Home Plus was increased from 5 to 8. The rationale was related to a business model and staffing costs. With eight residents there could be more than two people in the house during high need times. At that time there was a proposal to raise Homes Plus capacity to 10 residents. Pat Maben, an RN that worked at KDHE, surveyed providers with a questionnaire asking their input about number of residents and the rationale for an increase. The consensus was that if there were more than 8 residents, staffing would have to be increased to ensure safe care, but there would not be enough income to support the increase.
2) Insufficient Staffing Requirements: Since a Home Plus can be operated by a medication aide and a nurse consultant, we would be very reluctant to increase the number of residents above eight. Oregon has a very successful program and only allows 5 residents. State of Washington allows only six residents. Minnesota was used as a model for Home Plus in Kansas and still limits the number of residents to five.
3) Operator Educational Requirements must increase along with acuity of population served and numbers served in one setting. The operator of a Home Plus is required only to have a high school diploma or GED equivalent, there is a short Operator Course that must be taken and a test that must be passed. The operator of a Home Plus is not required to have any background in health care even though the level of care required by residents may be significant as in the case of someone needing assistance with eating (choking risk), or with behaviors and conditions related to an Alzheimer's diagnosis (aggressive behavior). Operators are responsible for having enough staff "sufficient to meet resident needs" and yet the operator may have no health care knowledge, background or training from which to make such a determination.
4) The fewer regulations required for Home Plus are in part due to the originally envisioned small size of 5 residents with fewer health care needs relative to nursing facilities, assisted living facilities or other adult care licensure categories.
5) Nursing staffing is defined by resident care plans, not by any specific staffing requirement beyond "sufficient to meet resident needs". Raising the number of residents in a Home Plus should be done only if there is a concurrent required increase in daily nurse staffing, and in specific licensed nurse categories. A few years ago Kansas Advocates director spoke with an operator of several Homes' Plus in Kansas. The owner operator was an LPN. The facilities got several citations

913 Tennessee Suite 2 Lawrence, Kan
phone: 785.842.3088 fax: 785.749.0029 toll-free: 800.525.1782 e

HOUSE AGING & LTC
DATE: 2/17/11
ATTACHMENT # 6

including some that dealt with insufficient staffing. In talking with the operator, her position was that the surveyors were "picking on" her; she didn't think that she was spread too thin to do right for her residents. And that was from someone with a health care background in nursing.

7) Each adult care home category is seeing an increase in the level of need for assistance in the population which they serve. Older Kansans and their families are choosing out-of-home placements, much later in the care process than in the previous three decades. The level of care Home Plus and other licensed adult care homes are providing will likely only increase in the future. If the number of residents served increases, the required levels of staffing must concurrently increase to ensure health and safety for persons residing in Home Plus.

13 Homes Plus that according to KDOA have special care units (Alzheimer's and Dementia).

Special Care Unit HP			
Facility Name	**Code**	**Physical Address**	**City**
Bridge Haven Memory Care Residence, LLC	HP	1126 Hilltop Dr.	Lawrence
Comfort Care Homes of KC #9833	HP	9833 Overbrook Ct.	Leawood
Comfort Care Homes of KC #7010	HP	7010 W. 69th Terr.	Overland Park
Comfort Care Homes, Inc. #641	HP	641 N. Broadmoor	Wichita
Comfort Care Homes, Inc. #509	HP	509 Tallyrand	Wichita
Sunflower Meadows #2	HP	5502 Polo	Wichita
Meadowlark Adult Care Home 1	HP	438 S. Socora	Wichita
Comfort Care Homes Inc. #441	HP	441 Morningside	Wichita
Sunflower Meadows #1	HP	649 N. Stratford	Wichita
Comfort Care Homes #6504	HP	6504 Oneida	Wichita
Comfort Care Homes, Inc. #1434	HP	1434 N. Armour	Wichita
Comfort Care Home, Inc. #147	HP	147 South Ridgewood	Wichita
Comfort Care Homes #6505	HP	6505 E. 10th	Wichita

For these reasons Kansas Advocates requests that you not approve and increase in size for Home Plus from 8 to 12 residents/licensed beds.

Thank you,

Home Plus Facilities in Kansas with deficiencies cited for "Staff Treatment of Residents" (ANE)

Facility Name	City	Last Survey	Total Deficiencies	ANE Deficiencies
Bridge Haven Memory Care Residence, LLC	Lawrence	11/5/2009	1	1
VNA Care Cottage	Lawrence	11/12/2009	7	1
Galway Homes**	Leawood	11/1/2007	16	1
Deer Park Senior Group Home South	Meriden	4/27/2010	1	1
Tammy the Pro LLC	Topeka	12/15/2010	6	1
Arbor Home-Farmstead	Wichita	8/25/2010	6	2
Sunflower Meadows #2	Wichita	6/15/2010	4	1
Comfort Care Homes #6505	Wichita	6/24/2010	4	1

** Per Patty Brown at KDOA: Cited for Staff Treatment of Residents 4/23/2008 as a result of a complaint investigation; 11/1/2007 is the last resurvey data available; the facility was closed for remodeling through September 2010.

Total of 93 Home Plus in Kansas

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House Aging and Long Term Care Committee
February 17, 2011

Chairman Bethell and Committee Members

My name is Cindy Luxem, Executive Director of the Kansas Health Care Association and Kansas Center for Assisted Living, a trade association with a membership of over 185 nursing homes, assisted living, residential health care, home plus, and nursing facilities for mental health. Thank you for the opportunity to testify.

HB 2147 changes the number of residents residing in a Home Plus residence. We have Home Plus providers in our membership. Additionally, through the Operator's course which we provide three times a year qualifies the registrant to operate a state-regulated home of less than 60 residents, which includes Home Plus.

In my testimony I would like to provide you with points on both sides of the issue. First, for those currently providing services in a home plus model, they would like to have the number increased because it becomes financially impossible with only eight residents. One of my providers shared a story with me about how of the eight residents, five passed in a short amount of time. It is difficult replace the revenue. She is a registered nurse and also employs licensed practical nurses so she is doing exactly what this model is about. And of course, this is a popular model for many people because it serves fewer people. And because it is state regulated, the burden of weeding out incompetent providers would be left up to the surveyors. We do have the concern some Home Plus operators might choose to have this kind of home to avoid federal regulations and because potential residents are not screened, these folks could be running mini nursing homes.

Our concerns are some of the following. Home Plus is a state-regulated living environment. There are no staffing requirements. All the regulations say are: direct care staff or licensed staff shall be in attendance and responsive at all times. A registered professional nurse shall be available to provide supervision to licensed practical nurses…The issue about consistent quality care also concerns us because we see many entrepreneurs who believe senior care is the place to be and because they have taken care of a family member or friend believe they could just expand and start making money.

Also because Home Plus traditionally does not accept Medicaid, it might serve only well to do seniors and Medicaid clients would be relegated to the nursing home. The funding of HCBS is probably not feasible because there is nowhere to absorb the costs. Most Assisted Living providers write off about $1400 per month because of low reimbursement of waiver services.

We do believe there is a place for the Home Plus particularly in the rural settings. And a Home Plus is certainly home-like.

In conclusion, I would respectfully ask that this have more time to be studied and put in the proper safe guards before we just make the change.

Thank you. I would be happy to answer any questions Cindy Luxem

HOUSE AGING & LTC
DATE: 2/17/11
ATTACHMENT #7