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M I N U T E S

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

June 23 and 24, 1976

Members Present

Senator Wesley H. Sowers, Chairman
Representative Richard B. Walker, Vice-Chairman
Senator Bert Chaney
Senator Elwaine F. Pomeroy
Representative Theo Cribbs
Representative Arthur Douville
Representative Sharon Hess
Representative Michael G. Johnson
Representative Marvin L. Littlejohn

Staff Present

Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes Office
Sherman Parks, Jr., Revisor of Statutes Office

Others Present

Doug Johnson, Kansas Pharmaceutical Association, Topeka, Kansas
Jerry Slaughter, Kansas Medical Society, Topeka, Kansas
Petey Cerf, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Terry Whelan, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Ruth Dickinson, Division of Planning and Research, Topeka, Kansas
James H. Hays, Division of the Budget, Topeka, Kansas
Carl Schmitthenner, Kansas State Dental Association, Topeka, Kansas
Dave Dallam, Division of the Budget, Topeka, Kansas
David Watson, Office of Long-term Care, Social and Rehabilitation Service, Region VII, HEW, Kansas City, Missouri
John Morefield, State Operations Branch, Medical Services Division, Social and Rehabilitation Service, Region VII, HEW, Kansas City, Missouri
Richard Swanson, Department of Health and Environment, Topeka, Kansas
J. D. Mankin, Department of Health and Environment, Topeka, Kansas
Carl Hawkins, Department of Social and Rehabilitation Services, Topeka, Kansas
George D. Blume, Department of Social and Rehabilitation Services, Topeka, Kansas
William E. Richards, Sr., Department of Social and Rehabilitation Services, Topeka, Kansas
Robert Harder, Department of Social and Rehabilitation Services, Topeka, Kansas
Gary Robbins, Kansas State Nurses Association, Topeka, Kansas
Mrs. L. R. Pyle, Kansans for the Improvement of Nursing Homes, Topeka, Kansas
Barbara L. Murphy, Student, Topeka, Kansas
Virginia Y. Morton, Kansas Public Health Association, Topeka, Kansas
Pauline Bork, Department of Health and Environment, Topeka, Kansas
Dick Brown, Kansas Health Care Association, Topeka, Kansas
Ray Briggs, Nursing Home Administrator, Topeka, Kansas
Harriet Nehring, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Jessie Branson, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Nancy Hodges, Kansans for the Improvement of Nursing Homes, Salina, Kansas
George White, First Presbyterian Church, Atchison, Kansas
Dwight Metzler, Department of Health and Environment, Topeka, Kansas

The meeting was called to order at 10:10 a.m., by the Chairman, Senator W. H. Sowers, who announced the following dates for meetings: July 14 and 15, August 18 and 19, September 22 and 23 and October 13 and 14.

Proposal No. 32 - Adult Care Home Study

Staff presented the following background: The Department of Health and Environment has the basic responsibility for the licensing of all classes of adult care homes (skilled, intermediate nursing care, intermediate personal care and boarding care). Homes are inspected at least annually by a three-member team -- a nurse, a sanitarian and a representative of the firemarshal's office. The latter member, following state and federal requirements, certifies to the Department of Health and Environment that a home meets fire safety standards. In some counties, the Department of Health and Environment contracts with the local health department to do the inspections.

Because of Medicare and Medicaid payments, the Department of Social and Rehabilitation Services is required by HEW to certify skilled and intermediate nursing care homes and to do an annual quality-of-care assessment of them. SRS contracts with the Department of Health and Environment to do the certification inspections and make recommendations for certification. SRS currently does the care assessment inspection with a team of one nurse and one social worker. 1976 appropriations will allow the addition of another nurse to this team. Staff gave statistics relative to expenditures and number of personnel in both departments to carry out adult care home programs, noting the 1976 Legislature appropriated funds to cover an increase in personnel and the increased cost of providing care through the medicaid program.

Staff reviewed the statutes pertaining to adult care homes which are in Committee members' notebooks. The following points were noted: K.S.A. 39-927 does not include the 1976 amendments to the certificate of need statutes but the amendments did not significantly change the statute. Inspection reports must be filed with the licensing agency and are open to the public in such a way as not to identify individuals. Because the question of sufficient medical supervision and adequate care is frequently raised, K.S.A. 39-936 is a significant part of the statutes.

Reference was made to the report of the 1975 Special Committee on SRS Institutions and the two bills they introduced. Copies of this report and the two bills are to be put in the Committee members' notebooks. Staff noted that last year's Committee made surprise visits to adult care homes and filled out evaluation forms. The Committee requested they be given copies of this form. In answer to questions, staff stated that the Committee does not need permission from the Department of Health and Environment to visit adult care homes but might need clarification from the Legislative Coordinating Council that this is within the scope of the proposal and authorization from them to cover reimbursement. Permission from the home's administrator is necessary but does not have to be secured in advance. By consensus, the Committee will give consideration to making visits to look at the quality of care in adult care homes.

In answer to a question, staff stated they did not know if OSHA is involved in the area of adult care homes.

The Chairman noted that the Senate Public Health and Welfare Committee was informed during the last session that the Department of Health and Environment was making a study of the quality of personnel in adult care homes and what the professional qualifications and requirements for such personnel should be. Indications are that the final draft of this study will be given to the Committee tomorrow. Representative Littlejohn referred to a letter dated June 14, 1976, from the Kansas Department of Education and a copy of the proposed nurse aide training curriculum to be offered by the area vocational-technical schools. (Attachment A).* Staff noted the curriculum was developed by an advisory committee and referred to the Department of Education who will have the responsibility for implementing it. Some questions to be kept in mind are: How direct is the relationship between professional training and level of care given? If training is desirable, how should it be acquired and paid for? Will this raise the cost to the individual resident?

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* The proposed nurse aid curriculum is on file in the Research Department. The proposed rules and regulations are attached hereto.

It was noted that approximately 8,500 persons will need this training the first year. There is about a 65% turnover in this type personnel and there is no assurance that the training program will decrease this percentage. There is concern that when aides are trained they will leave for better paying positions such as in hospitals although there may eventually be a "filling of this pipeline".

Concern was expressed over the fact that beginning July 1, 1976, all persons holding medical assistance cards will have to pay the first 50¢ on all prescriptions and the impact this will have on nursing home residents. It was noted that the state protects $25.00 per month of any income received by a nursing home resident. Pharmacists are concerned about the amount of bookkeeping required and the problem of getting physicians to write prescriptions to cover longer time periods. It was noted that over two million prescriptions were written for medical assistance card holders last year.

It was reported that Dr. Harder, Department of Social and Rehabilitation Services, had indicated he was considering setting up a computer program -- 60% of the cost to be federal dollars -- to monitor this co-payment program.

Doug Johnson, Kansas Pharmaceutical Association, stated they had previously recommended a co-payment prescription program as a step toward decreasing the use of unnecessary drugs but recommended excluding nursing home residents. However, they were told that this exclusion would be contrary to federal regulations and would jeopardize federal funds unless a waiver could be obtained. In addition to the problems mentioned earlier, there is the problem of nursing home residents who do not have funds and the cost of billing them for 50¢. The Association has recommended quantities for Medicaid prescriptions to the Department of Social and Rehabilitation Services and have adopted regulations relative to maintenance prescriptions. They are setting up a monitoring system.

Jerry Slaughter, Kansas Medical Society, stated they feel this requirement will help stop people from going from doctor to doctor to get prescriptions. They are working with their members to inform them of this new regulation and will also be monitoring the program.

It was noted the Senate Public Health and Welfare Committee had expressed concern over federal regulations which pertain primarily to facilities and equipment and which, because they are constantly changing, add to the cost and thus interfere with care. A request was made to look at these federal regulations and their effect on care.

Proposal No. 33 - Health Care Services in Medically Underserved Areas

Staff summarized the memo under Proposal No. 33 in the notebooks. (Attachment B) and presented information regarding the problem of maldistribution of health care providers and the reasons for it. (See Attachment C.)

Staff noted that although it would seem imperative for the Committee to have information relative to how many doctors (M.D. and D.O.) there are in Kansas, where they are located, and what specialty they are practicing, current information of this type does not seem to be readily available. No single agency is responsible for collecting this data. Staff referred to a map (which has been placed in Committee notebooks) showing the distribution of MD's and DO's, but emphasized this information was not necessarily current. Information from different sources varied as much as 800 to 900 doctors.

In answer to a question, staff stated that the map does not include physicians practicing at the medical school in Kansas City or physicians practicing at military installations but does include those practicing in state institutions. It was noted that the Board of Healing Arts could collect data relating to practice specialty, etc., in conjunction with licensing and it was suggested the Committee may want to consider making it mandatory to report such information.

Staff referred to their visit to the KU Medical School where they visited with those in direct contact with students and graduates. They discussed curriculum and training changes and getting students away from the medical school environment as an approach to the problem of maldistribution.

The Committee recessed at 12:10 p.m. and reconvened at 1:40 p.m.

Staff noted there were some implicit assumptions in the discussion of data presented during the morning session and pointed out the following: National data may or may not hold true when applied to Kansas. Even though there are a large number of doctors in an urban area, sections of this urban area may be underserved. Since the specialist settles in the larger areas and the family care practitioner tends to settle in smaller areas, there may be another dimension to the problem of urban areas being underserved.

Proposal No. 34 - Safe Drinking Water Standards

Staff, noting this proposal related to P.L. 93-583, reviewed the material under Proposal No. 34 in the notebooks. Staff referred to the letter and the memo from the Regional Office of HEW which sets forth what Kansas needs to do to comply with federal law. Under No. 7 of the memo, staff referred the Committee to pages 2 and 3 of the first attachment under Proposal No. 34 in the notebooks. No. 8 of the memo was taken care of by legislation enacted during the last session. In his Message to the Legislature, the Governor indicated he wanted the state to assume the primary responsibility for the enforcement of the Safe Drinking Water Act. Federal grants to the state are dependent on the state assuming this responsibility, and complying with the federal regulations. If the state does not administer the program, EPA will have the authority to do so.

In answer to questions, staff stated the present federal grant expires October 1, 1977. Legal counsel for HEW has indicated they would take exception to additional grant funds if Kansas had not complied with requirements necessary for state administration by that date. If Kansas did not comply, it would lose the authority to enforce standards and grant exemptions. In this region, Nebraska has enacted a law and Iowa has enacted a law not yet signed by the Governor. Regional staff has been requested to encourage states to take primary enforcement responsibility.

The Committee requested staff to furnish them with a summary of the federal law. When Mr. Metzler appears on this proposal, he is to be asked to bring what he considers minimum changes needed.

Proposal No. 35 - Alcoholism and Intoxication Treatment Statutes

Staff noted that this Act is based on the Care and Treatment Act which was amended during the last session. Some of the procedural changes would be applicable to this Act.

A Committee member requested that testimony be heard regarding the functioning of the present law because of the concerns of law enforcement people when it was enacted. Staff noted that much of the criticism died down once it was understood that if a person commits an illegal act while under the influence of alcohol, he can be handled through the criminal justice system.

In answer to a question, staff noted that a few years ago a Committee considered a similar law for drug addicts, but did not recommend action because a drug user is committing a criminal act. They found the courts were using probation as a means of getting a person to treatment.

Staff reviewed the alcoholism and intoxication treatment statutes, noting amendments made when implementation and enforcement of the statutes was given to SRS and noting changes made by S.B. 26 in comparable sections of the Care and Treatment Act. Staff noted that as the Committee reviews changes made by S.B. 26 in relation to these statutes, they will need to keep in mind the differences between the mentally ill and the alcoholic and intoxicated person.

Proposal No. 36 - Welfare Overview

Staff reviewed the background of the Welfare Overview Committee. In the past, SRS has given a brief monthly fiscal report and a review of the status of cases. Last year the Committee monitored development of the Title XX program and recommended that a legislative committee continue monitoring the program. Staff reviewed services included under Title XX, noting the federal law gives states leeway as to what services will be offered and to whom. An annual social service plan must be developed and submitted for public hearing. Last year the emphasis was on keeping the elderly in their own homes and on services for children. It included those things SRS felt the legislature had asked for through the appropriation process.

Staff also reviewed Title IVD, noting that last year an interim committee recommended four bills based on changes in the federal law relative to parent locator services which were passed by the 1976 Legislature. The Committee last year had some question as to the cooperation of local county attorneys and other local officials. The Committee may wish to monitor this to see if any legislation is needed to get this cooperation.

Staff reviewed the programs for aging and how they are administered, suggesting the Committee may want to look at whether or not area agencies on aging are monitoring the effectiveness of the programs being offered.

By consensus future Committee meetings will start at 10:00 a.m. on the first day and adjourn at 4:00 p.m; will start at 9:00 a.m. on the second day and adjourn at 4:00 p.m. If more time is needed, adjournment on the first day will be extended or an earlier meeting time will be set for the first day.

The Chairman asked the Committee to give consideration to giving priority to Proposal Nos. 32 and 33 and to deal with the other proposals to the extent time permits.

Staff was asked to balloon the alcoholism and intoxication treatment statutes to incorporate material from S.B. 26 to determine if it is appropriate to amend the alcoholism and intoxication treatment statutes or to make other changes.

The meeting was recessed at 4:05 p.m.

June 24, 1976

The meeting was called to order at 9:10 a.m. by the Chairman, Senator W. H. Sowers.

Proposal No. 32 - Adult Care Home Study

Dwight Metzler, Secretary, Department of Health and Environment, summarized the material in Attachment D, emphasizing their agency is the only one authorized to license and regulate adult care homes. He also emphasized that although the number of homes has decreased, the number of beds has increased. The Department has licensed 359 nursing homes: 51 skilled nursing homes, 212 intermediate care homes and 96 personal care homes. They certify, for SRS, 53 skilled nursing homes and 267 intermediate care facilities. The discrepancy in figures is due to the fact that some skilled nursing homes are in hospitals which are not licensed as nursing homes and some skilled nursing homes are also certified for intermediate care.

Dr. James Mankin, Director of the Bureau of Medical-Dental Health, Department of Health and Environment, referred to the items starting on page 2 of Attachment D and the outline of further actions taken on these items appearing as Attachment E.

Referring to Item 1 on page 1 of Attachment E, Dr. Mankin noted that the Department approved a medication aide training course consisting of 48 classroom hours and 20 practicuum hours developed by the Kansas Health Care Association. Currently 674 are enrolled in this course. The Department maintains quality by certifying those

teaching the course. It was noted some persons had completed the course some time ago but but said they had been unable to take the tests required by federal regulations. Dr. Mankin stated they are just getting ready to start the testing phase.

In answer to questions, Dr. Mankin stated that federal regulations require the state to have an approved medication aide training course and require a home to have some aides who have successfully completed the course. The Department received an Attorney General's Opinion stating there is no conflict between the job description for medication aides and present statutes relating to the dispensing of medications.

In answer to questions, it was noted that medication aides are trained in how to give medications, to look for adverse reactions, to explain medication to the patient, and are given a background in drugs to help avoid mix-up of medications.

The Department now has an approved course for nursing home aides which was developed by the Advisory Committee. The course, to be taught by vocational-technical schools, consists of 90 clock hours and will be available on a voluntary basis next month. The student or home pays $10.00 and the Department of Education picks up the rest of the $100.00 cost per person. (See Attachment A.)

In answer to a question, Dr. Mankin stated Dr. Bridges of the Department of Education explained it would cost about three times as much for the course to be offered through junior colleges because of the method of funding of vo-tech schools. Courses will be offered either at the school or in the community. Aides with experience will have an opportunity to test out rather than taking the course.

The Department is proceeding on the assumption that all aides working in long-term care units, including those in hospitals, will be required to test out or to take the course. It was noted this creates a problem for the small hospital which has to move aides from one unit to another depending on need. It could mean all aides in the hospital would have to test out or to take the course.

A copy of the curriculum for each training program was passed around for Committee members to review.

Referring to Item 3 on page 1 of Attachment E, Dr. Mankin stated this has been accomplished, although some homes are having difficulty finding licensed nurses to cover on weekends.

Re Item 4 on page 1 of Attachment E it was noted that because H.B. 2702, introduced by the Special Committee on Institutions, which would have provided for a system of fines, did not pass, this is still a problem. Present law limits action to those cases where "substantial" non-compliance can be proved in court.

In reference to Item 5 on page 1 of Attachment E, Dr. Mankin noted that the first draft has been sent to various state agencies and organizations. A final draft will be written giving consideration to any comments received and a public hearing will be held. State rules and regulations will follow the federal ones closely because most Kansas homes participate in federal programs.

In discussing Item 6 on page 1 of Attachment E, it was noted that coordinating inspections has not been feasible because of the varying amounts of time it takes various team members or agencies to complete their part of the inspection. However, the Department does try to do their inspection for state licensing and SRS certification at the same time.

In answer to questions, Dr. Mankin stated that they can contract with the local department of health to do the licensure inspection but they have to do the federal certification inspections with their own staff. They have contracts with about 36 local health departments. About twelve complaints are received per month. The nature of the complaint determines who checks it out and how quickly this is accomplished. Local departments operate on the assumption they have about the same authority as the state department since they are acting as agents of the state department. All accidents are reported but regular deaths are not.

In answer to a question, Dr. Mankin stated there is a specific number on the team for certification inspections but not for licensure inspections. There are 13 health care surveyors in area offices, six sanitary engineers in regional offices and four inspectors in the fire marshal's office plus some in local offices who have passed federal requirements to do inspections.

The Department has licensed 421 nursing home administrators. Basic qualifications are: at least 18 years of age, high school graduate, and completion of 100 hours of course work approved by the Department. Courses are offered at Kansas State University, by appropriate associations and others.

David Watson, Director of the Office of Long-term Care, Social and Rehabilitation Services, Region VII, HEW, presented a statement. (Attachment F). In answer to a question, he stated they are required to do a 10% validation survey each year to see that programs are being carried out according to federal regulations. If the state survey agency is not administering the program properly they work with them to correct the problem before recommending discontinuation of funding.

Asked about the pilot programs relating to proposed changes in regulations, Mr. Watson stated these projects, being conducted in about 200 facilities throughout the country, focus on an assessment of whether or not patients are receiving the services they need rather than on physical plant or other physical things. The projects are aimed toward developing new regulations to be implemented about 1978 and to changes in the survey technique and document.

Mr. Watson clarified that skilled nursing facilities can be certified for both Medicare and Medicaid but intermediate care facilities can be certified for only Medicaid.

In answer to a question, Mr. Watson stated that medication aides can give injections. A registered nurse is on duty only eight hours in an ICF. Since required service, such as medication during the night, must be offered, it is necessary to have trained medication aides.

Mr. Watson, in answer to a question, stated the Life Safety Code was changed in 1973 for the first time since 1967. The 1973 code will apply only to new homes being built. Homes already built, if they meet the 1967 code, will be grandfathered in.

Dr. Robert Harder, Secretary of the Department of Social and Rehabilitation Services, stated that SRS becomes involved in adult care homes through Title XIX and are involved only in skilled nursing homes and intermediate care homes. He presented information relating to inspections, rates and costs. (Attachment G).

In answer to a question relative to the table on page 5 of Attachment G, Dr. Harder stated the decrease in the number of patients in skilled nursing facilities is due, in part, to their being discharged to facilities providing less skilled care based on utilization review.

In explaining the differences between the types of reviews listed on page 1 of Attachment G, Dr. Harder stated SRS is responsible for only the last two. The purpose of the independent professional review is to determine the level of care being provided a person. The utilization review is to determine the appropriatness of the level of care being prescribed.

Responding to a question, Dr. Harder stated the average paid per person as shown on page 5 of Attachment G "bounces" around because a patient's liability varies from month to month and the level of care a patient receives may vary. These affect the amount for which the state is responsible.

In response to some comments, Dr. Harder emphasized that SRS is not a placement agency nor do they function as a guardian. If a relative or guardian contacts them, they will cooperate to the extent possible in helping them find a home.

In answer to questions, Dr. Harder stated that in cases where the patient and SRS are both responsible for costs, SRS pays the difference and the home collects the amount for which the patient is reponsible from the patient. SRS signs an agreement with each Medicaid provider doing business with them which stipulates the provider accepts the level of payment and will let SRS look at their records, etc. If a home should attempt to collect the difference between this level of payment and what they see as their cost from a relative or estate, SRS would consider it a fraudulent claim in cases they could document.

Reference was made to the aide training programs and the affect they will have on costs. Dr. Harder stated they consider training costs as a legitimate cost of providing services and allow a home to include it as a cost of operation. SRS will reimburse accordingly as long as it still falls within the 75 percentile. As more training is required and as more homes participate in training, costs will be affected and will affect the 75 percentile point. SRS would probably not see paying a person while he is being trained as a legitimate cost because of the precedent it would establish. Increased wages would seem to follow increased training. SRS cannot estimate at this time what the increased costs would be but could probably cost it out in six months based on experience.

In answer to a question about the co-pay program for prescriptions, Dr. Harder stated that every patient should have at least $25.00 per month for personal needs. They have met with the pharmacists and have asked them to live with the program for awhile and if there are problems to come to SRS to discuss them. They estimate the co-pay program for prescriptions will save $960,000 in this fiscal year. In response to questions, Dr. Harder noted Kansas offers a full medical program including most of the optional programs. Money will have to be taken from the first pay tape for next year to pay for medical services provided during the last pay tape of this year. Co-pay can be applied to optional services. Limiting the scope of services may also have to be considered as the costs of medical assistance increase.

Dr. Harder noted that an ombudsman for nursing home patients has been hired. Although this person is attached to SRS, he is a free agent. A report of his activities will be furnished for the Committee. By consensus the ombudsman is to be asked to appear before the Committee as the first person on the agenda at the next Committee meeting.

In answer to a question, Dr. Harder stated factors contributing to the over-budget expenditure for medical services in FY 1976 were failure to figure in a high enough inflation factor, a higher increase in case load than was projected especially in the medical assistance-only group (40% increase compared to 10% or 15% increase in other categories), increase in general assistance medical-only group (all state dollars). There are classes of persons not GA related who are medical-only and there is federal financial participation for them.

Wes Worthington, Kansas Health Care Association, presented a written statement. (Attachment H). They feel changingthe occupancy percentage used when computing the reimbursement rate for new homes at from 75% to 85% will work a hardship on them. In answer to questions, Mr. William Richards, Department of Social and Rehabilitation Services, explained that when the per diem figures are computed for new homes, 85% of occupancy will be used to figure patient days. The Department feels this figure is a truer reflection of the present actual occupancy rate which is about 98% across the state.

Mr. Worthington stated they also have the problem of state agencies making demands regarding physicial facilities (spinkler systems) and staff (training) and not allowing a pass-through or a projected budget for these things. Therefore, the homes must cover these expenses by cutting somewhere else.

Homes will now have the additional problem of collecting the first 50¢ for prescriptions. In answer to a question, he stated they try to get relatives or a guardian to handle the patient's funds but this is not always possible. Some homes have a fund and if the patient needs money, he draws it from this fund and is billed for it.

According to Mr. Worthington, in some cases certified residential care facilities are offering the same level of care as nursing homes but with inadequate staff. This reflects on nursing homes because the public does not know the difference. These homes are competition for them. The question was raised as to how these homes could be competition for them unless people are being taken care of in inappropriate facilities. In answer to a question, Mr. Richards stated they do have some licensing authority in this area for mental health and mental retardation facilities of the group living or workshop type.

Ms. Harriet Nehring, Kansans for the Improvement of Nursing Homes, introduced Petey Cerf to speak for them. Ms. Cerf stated they are also concerned that mentally retarded are being placed in substandard homes which are licensed by the Department of Health and Environment and certified as to level of care by the Department of Social and Rehabilitation Services. She then presented a written statement. (Attachment I).

Ms. Nehring introduced Jessie Branson, who presented another written statement (Attachment J). Ms. Branson noted that visits were made by teams of two or three members of the organization. One member was always an R.N. She was asked to give examples of what they were referring to when they talked about violations. She mentioned two homes, one of which was an ICF, in which they saw unemptied bedpans, general state of desrepair, dirty conditions, call cords which were difficult to find, an unlocked janitor's room in which cleaning supplies were kept, dirty linen which obviously was not being changed frequently enough. In one home about one-half of the patients were elderly and required heavy care and the other half appeared to be mentally retarded who just wandered around. There was an obvious lack of adequate staff.

In answer to a question, Mr. Richards stated licensing and certification are done by the Department of Health and Environment and the Department of Social and Rehabilitation Services is the payment agency. When groups like KINH make a complaint, SRS looks into it and asks the survey agency to verify the situation. The two homes mentioned have been the subject of inquiries. In cases where a home is not relicensed, SRS stops payments and this is why the nursing home industry is talking about homes being closed. He noted he was encouraged by the citizen participation made evident by KINH.

Speaking to the question of inappropriate placements, Mr. Richards stated they do find this a problem, especially in placements made several years ago. The patient's rights bill for the mentally ill and the mentally retarded states a person cannot be institutionalized indefinitely without some opportunity to come back into the community. However, there is a lack of community facilities. SRS thought they had some ICFs for the mentally retarded ready to be certified but HEW would not certify them for the increased rates under the ICFMR program. SRS is caught between patient's rights and concerned citizens and limited resources to meet the problem.

Staff noted SRS did not get involved in placements of the mentally retarded unless the person had been in a state institution or SRS was making the payments for care. If a person is discharged from an institution, the state agency does not have any legal responsibility for placing him and the person or his guardian has the right to determine where he goes.

Ms. Branson stated that administrators told them most of the people to which they are referring come from state institutions and SRS puts pressure on them to take these people. Ms. Cerf stated they have a letter from Dr. Harder stating that when a person leaves the institution, SRS no longer has control. However, KINH feels this should not be the responsibility of the nursing home or the boarding home administrators.

Staff noted that a large number of mentally retarded never get into a state institution. If KINH is asking the state to assume responsibility for these persons, legislation may be needed. It was pointed out that more and better statistics are needed about these people in nursing homes, where they came from and how they got there.

Mr. Richards noted SRS has accepted some responsibility for people coming out of the institutions under the reintegration program. They maintain a tracking system for those coming out and a social worker visits them but they have no legal way to make these people make certain decisions. Ms. Branson stated they have talked to some of these social workers who say their caseload is so heavy they do not have time to visit these people.

Stewart Entz, Kansas Association of Homes for the Aging, stated they are also concerned about cost reimbursement, aid training and some other problems mentioned previously. They feel serious consideration should be given to comments and recommendations being made by interested groups. He noted the dialogue such as took place today is encouraging.

The Chairman thanked the representatives of the various groups for appearing and expressed appreciation for their interest and concern. Matters brought to the attention of the Committee will be brought to the attention of the appropriate agencies and all recommendations will be given consideration by the Committee. Copies of the testimony presented today are to be sent to the Department of Health and Environment and SRS with a request they respond to the recommendations made by these groups. They are to

be asked to tell the Committee why the laws presently on books do not seem to be adequate, or if adequate, why they are not being enforced. The Committee may want to consider if additional legislation in the area of enforcement is needed.

By consensus, staff is to get data on the degree of utilization of beds in SNFs and ICFs - how many beds are empty and how this relates to cost - if such data is available.

By consensus the Committee will give priority to studying Proposal Nos. 32 and 33.

Suggestions for groups or persons to be invited to appear before the Committee regarding Proposal No. 33 were: the School of Medicine, including the outreach programs and the department of continuing education. The latter are to be asked to share what they are hearing from doctors and to discuss curriculum changes being made to better meet the needs of the general practitioner. Students close to completing their medical training, including one from western Kansas if possible, are to be invited to discuss why they are staying or are not staying in Kansas. The Kansas Medical Society, Representative Hayden, a doctor who uses physician extenders in rural practice, Regional Medical Program, Kansas Association of Osteopathic Medicine, dentists, and the Board of Healing Arts.

Staff is to continue their efforts to get data about where health care providers are located and what specialty they practice.

Staff distributed copies of the form used by the Special Committee last year for evaluating nursing homes they visited.

The meeting was adjourned at 3:30 p.m.

Prepared by Emalene Correll

Approved by Committee on:

8-18-76
(Date)

Attachment A

(3) Physicians' verbal orders for drugs shall be given only to a licensed nurse, pharmacist, or physician and immediately recorded and signed by the person receiving the order. (Oral orders for Schedule II drugs are permitted only in the case of a bona fide emergency situation.) Such orders shall be countersigned by the attending physician within 48 hours.

(4) The attending physician shall be notified of an automatic stop order prior to the last dose so that he may decide if the prescription is to be renewed.

(J) Storage of Drugs and Biologicals

(1) Drugs and biologicals in all areas of the facility shall be securely stored and maintained. Procedures for storing and disposing of drugs and biologicals shall be established by the pharmaceutical services committee under the direction of the pharmacist. These procedures must be in accord with federal and state laws.

(2) All drugs and biologicals, including those that require refrigeration, shall be stored in locked compartments. Only authorized personnel shall have access to the keys.

(3) Separately locked, permanently affixed compartments shall be provided for storage of controlled substances listed in Schedule II in the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse.

(4) An emergency medication kit approved by the pharmaceutical services committee shall be kept readily available and under the control of a practitioner licensed by law to dispense or prescribe drugs.

(K) Nursing Home Aide Qualifications

Draft Only

(1) Education

(a) All nursing home aides employed in skilled nursing homes shall complete a program of education, approved by the Department of Health and Environment, on or before July 1, 1978, or shall within 30 days following employment be enrolled in the next available course and shall satisfactorily complete the program in order to continue employment.

(b) Each adult care home shall comply with the following time-table in registering employees for completion of courses:

(i) Approximately 20 percent registration by July 1, 1977
(ii) Approximately 50 percent registration by January 1, 1978
(iii) 100 percent registration by July 1, 1978

(2) Certification

Each person seeking employment from and after July 1, 1978, shall present a certificate of completion of the Kansas Vocational Education program or shall within 30 days following employment be enrolled in the next available course and shall satisfactorily complete the program in order to continue employment.

(3) Qualification

(a) All nursing home aides who do not hold a Kansas Vocational Education certificate and who have been employed as a nursing home aide at least six months of a two-year period prior to March 23, 1976, shall be entitled to earn a certificate of competency by completing an examination.

(b) An application for such examination shall be submitted on a form to be supped by the Department of Education.

(c) The examination shall cover the content of the approved curriculum and shall be administered by a Kansas Division of Vocational Education.

(d) A passing grade as established by the Department of Education shall be acceptable.

(e) Examinations shall be announced at the convenience of the respective institution.

Attachment B

egislative Research Department June 21, 1976

MEMORANDUM

TO: Special Committee on Public Health and Welfare

RE: Major Federal Programs Affecting the Supply of Health Manpower

Federal Assistance to Health Professions Schools

Since the early 1960's federal legislation has reflected the concern of the Congress over the availability of health care professionals. Early in the decade, several studies prepared for the Department of Health, Education and Welfare and one report prepared for the Senate Appropriations Committee concluded that the supply of physicians and other health professionals was not keeping up with population growth. In general, the reports indicated that there was a need to construct new facilities and to expand and renovate existing facilities to increase the nation's capacity to educate health professionals.

In 1963, the Congress enacted the Health Professions Educational Assistance Act (PL 88-129) which authorized construction grants for certain health professions schools and schools of public health. In addition, the act also authorized student loans for students of medicine, osteopathy and dentistry.

By 1965, it was recognized that the 1963 act would not insure an increase in the supply of health manpower. As a result, the Health Professions Educational Assistance Amendments of 1965 (PL 89-290) were enacted. Under the 1965 act, funding for support of a portion of the operational costs of health professions schools was initiated. Such federal support took the form of basic and special improvement grants which were supposed to relieve the financial deficiencies of many schools, improve student-faculty ratios, attract more qualified faculty and strengthen basic curricula.

Two years after enactment of the 1965 legislation, reports prepared for the Congress indicated that drastic shortages of health manpower continued. The result was passage of the Health Manpower Act of 1968 (PL 90-490) which provided for higher levels of institutional support. Under the 1968 act, 45% of the federal funding was earmarked for basic institutional grants which were conditioned on enrollment expansion and 55% was earmarked for special project grants for stated purposes. The principal purpose of the special project grants was "saving" health professions schools which were in serious financial difficulty. The Health Training Improvement Act of 1970 (PL 91-519)

was designed primarily to provide additional emergency assistance to medical and dental schools which were in extreme financial distress.

The Comprehensive Health Manpower Training Act (PL 92-157) was enacted in 1971. The 1971 act authorized formula grants called "capitation" grants to health profession schools. The capitation grants are based on statutorily established amounts per student per year. For example, schools of medicine, osteopathy and dentistry can receive $2,500 per enrolled student annually and schools of optometry, podiatry and pharmacy $800 per enrolled student. In addition, a bonus is authorized for enrollment of first year students beyond mandated levels. As a condition of receiving capitation grants, schools are required to expand enrollment, maintain non-federal effort, and submit plans assuring that they will conduct at least three of nine stipulated programs considered to be national priorities, for example, increased emphasis on primary care specialties, etc.

In addition to institutional assistance noted above, the federal acts have provided for federal matching funds for institutions which have established student loan programs. Schools of medicine, osteopathy, dentistry and optometry have been included in the student loan programs since FY 1965. Schools of pharmacy and podiatry were added in FY 1967 and schools of veterinary medicine were added in FY 1968. Scholarship assistance was initiated in FY 1967. Scholarship funds are awarded on a formula basis to health professions schools and, since 1970, to schools of veterinary medicine.

Distribution of Health Personnel

The Emergency Health Personnel Act of 1970 (PL 91-623) was the first substantial effort by the Congress to address the problem of geographic maldistribution of health manpower personnel. The 1970 legislation established a program under which members of the Public Health Service and other health personnel could volunteer to practice in areas where health personnel and service are inadequate.

In 1972, the Emergency Health Personnel Act Amendments of 1972 (PL 92-585) was enacted. The 1972 act officially established the National Health Service Corps (NHSC) and charged the Corps with implementing the 1970 act and amendments. The 1972 legislation also set up a scholarship program under which scholarships are awarded to health professions students who agree to serve at least one year in critical health manpower shortage areas for each year of scholarship assistance.

Physician Extenders

Between FY 1972 and FY 1975 the Department of Health, Education and Welfare expended $22.5 million for the development and operation of programs to train physician assistants and expanded-function-dental-auxiliary personnel. Funding is provided in the form of capitation grants, special project grants, and contracts with schools of medicine, osteopathy and dentistry for direct support of programs to train physician assistants.

Allied Health Personnel

Under the Allied Health Professions Training Act of 1966 and the Health Training Improvement Act of 1970, federal support has been provided to centers for the allied health professions and other entities for construction of teaching facilities, improvement of educational programs, advanced traineeships, and special project grants for the training of allied health personnel (professional, technical and vocational health personnel).

Nursing Education

The most recent federal legislation (PL 94-63) relating to nursing education was enacted in 1975 and provides for $20 million for each of fiscal years 1976 through 1978 for grants, loan guarantees and interest subsidies for the construction of nurse training facilities. The act also provides for capitation grants to nursing schools in the amount of $400 annually per student for each student enrolled in the last two years of a baccalaureate school of nursing, $250 for each student enrolled in an associate degree school, and $250 for each student enrolled in diploma (hospital) schools of nursing. The Secretary of HEW is also authorized to award financial distress grants to public or nonprofit schools of nursing which are in serious financial trouble and is authorized to provide special grants to establish programs for advanced training of nurses in special fields. Other grants are authorized for schools of nursing which expand and maintain advanced education programs for professional nurses who will teach and for nurse practitioners.

PL 94-63 also continues federal contributions for student loan funds established for schools of nursing through FY 1978 and authorizes traineeships for nurses who will enter teaching, administration or advisory fields.

Proposed Legislation

The Health Professions Educational Assistance Act and the various amendatory acts noted above expired June 30, 1974. During the 93rd Congress, the House passed HR 17084 and the Senate passed S 3585. However, the conference committee on the two bills was unable to reach a compromise on the differing measures by the time the Congress adjourned and legislation was enacted to extend the funding for the expired health manpower programs for FY 1975 at the FY 1974 authorization level.

In July 1975, the House passed HR 5546 (the Health Manpower Act of 1975) and on April 7 the Senate version (S 3239, the Health Professions' Education Assistance Act) was reported by the Senate Labor Committee to the full Senate.

While the federal health manpower legislation of the 1960's and early 1970's concentrated on increasing the aggregate supply of health manpower through increasing enrollments in health professions schools and maintaining the fiscal viability of such schools, the legislation currently before the Congress reflects the realization that health manpower problems currently relate not so much to total numbers but to the distribution of health professionals, the shortage of primary care physicians, and the increased reliance on foreign medical graduates to fill these gaps. Accordingly, both HR 5546 and S 3239 address themselves to these problems.

Both the House and Senate bills would amend those sections of the Public Health Service Act under which assistance is provided to schools and students of medicine, osteopathy, optometry, veterinary medicine, podiatry and allied health. The House bill would continue capitation support to health professions schools but would require that students pay back the amount of the capitation grant. The Senate bill would continue capitation support contingent on the requirement that 35% of the enrolled students accept National Health Service Corps scholarships and, that by 1980, 50% of the school's residencies must be in primary care specialties.

Both S 3239 and HR 5546 would continue and expand student assistance programs and expanded funding for the NHSC. Both would expand the funding for special project grants including family medicine training, physician assistants and dental auxiliary training, and expanded Area Health Center funding.

Both the House and Senate bills would affect residency positions. Under HR 5546, by 1980 the number of residency positions offered by accredited schools of medicine would be limited to 125% of the estimated number of graduates in the preceding calendar year with the recommendation that at least 50% of such residencies be in primary care and no less than 7% be in obstetrics

ıd gynecology. S 3239 would limit the number of residency positions in the U.S. to 125% of expected graduates by 1980 and to 110% thereafter.

In addition, S 3239 would require that federal guidelines for state licensure of physicians and dentists be developed.

The attached comparison of the major provisions of the two bills was prepared by the staff of the National Conference of State Legislatures as was the summary of proposed capitation grants and requirements for such grants.

Attachment No. 2 is data relative to the amount of funding received by various of the health professions schools through the Bureau of Health Manpower for the period 1965-1975. If there is a Kansas school, the appropriate fiscal data has been included for that school. We have also included the Kansas City College of Osteopathy and Surgery and the University of Missouri Dental School at Kansas City since both serve a number of Kansas students.

Attachment No 1

MAJOR PROVISIONS OF THE LEGISLATION

I. Capitation Support to Health Professions Schools

H.R. 5546 — The House passed bill mandates that health professions schools, to be eligible for capitation support beginning in the school year '76-'77, must contract with each enrolled student to insure that one year following graduation, or completion of internship or residency, the student will begin repaying the full amount of capitation received by the school. The requirement will be waived for students who agree to practice in medically underserved locations. (Presently enrolled students are exempt from these provisions.)

A second condition which must be met for schools of medicine and osteopathy to receive support is the expansion of enrollment in either the first or third years or the operation of a remote site training program in which at least 50% of the students will have spent at least six weeks of training before graduation.

S. 3239 — The Senate bill requires no student payback of capitation funding. In general, schools of medicine and osteopathy would have to assure that by fiscal year 1980, 35% of their enrolled students, prior to admission, have submitted applications for National Health Service Corp (NHSC) scholarships and have agreed to accept such scholarships. Dental schools would have to ensure that 20% of their students apply for such scholarships.

Other conditions of the Senate bill require that 50% of the filled residencies be in family practice, primary internal medicine, and primary pediatrics by 1980. For dental schools, 70% of their residency programs established after 1975 must be in general dentistry or pedodontics.

II. Student Assistance

H.R. 5546 — H.R. 5546 provides $30 million for fiscal years 1976-77 for loans to students. The existing HEW program designed to identify disadvantaged students and assist them in entering health professions schools has been expanded authorizing $20 million per year for each of these three years. Authorizations for the National Health Service Corp are substantially increased to $40 million in FY '76; $80 million in FY '77; and $120 million in FY '78.

S. 3239 — The Senate bill extends existing authority, with funding modifications, for fiscal years '76 and '77. Funding for 1978-80 for the HEW student loan program would be $22 million, $24 million, and $26 million respectively. A new program of federally insured loans for students of medicine, osteopathy, and dentistry (MOD) would be established authorizing funds totalling $400 million, $410 million, and $420 million for fiscal years '78-'80. Scholarships for first year students of exceptional need are funded at $10 million, $11 million, and $12 million for fiscal years '78-'80. During this same period, NHSC scholarships would be funded at $85, $150, and $233 million respectively.

III. Limitation of Residencies

Both the Senate and House Health Manpower bills address the problem of the increasing influx of Foreign Medical Graduates (FMG's) into the country.

.R. 5546 In the House bill, the number of first year positions available in calendar year 1978 may not exceed 155% of the estimated number of graduates from accredited schools of medicine in the proceding calendar year. In calendar year 1979, this number may not exceed 140%, and by 1980 and thereafter, it may not exceed 125%.

This bill makes every effort to keep the accreditation of medical residency training programs, beginning in 1978, a private sector responsibility. The Secretary is authorized to designate an entity to accredit all such programs and a second authority to coordinate them under statutory guidelines. The bill states that every effort shall be made to designate the Coordinating Council on Medical Education (CCME) and the Liaison Committee on Graduate Medical Education (LCGME) as the official agencies to fulfill these duties. Following the establishment of such entities, the accrediting agency is to review and accredit or disapprove residency programs every three years. It is recommended in accrediting training programs that a minimum of 50% of medical residencies should be in family medicine, general internal medicine, and general pediatrics and no less than 7% in obstetrics and gynecology.

. 3239 As the House bill, the Senate bill mandates that by 1980 the number of residency positions could not exceed 125% of the number of graduates from accredited schools of medicine; however, for all later years, the allowable number could not exceed 110%.

As a condition for receiving capitation funds, schools of medicine and osteopathy would have to assure that by 1980 at least 50% of filled residencies would be in family practice, primary internal medicine, and primary pediatrics. Dental schools must assure that 70% of residency programs established after 1975 are in general dentistry or pedodontics.

The Senate bill authorizes the Secretary of Health, Education and Welfare to establish the total number of postgraduate physician training positions beginning on July 1, 1978. These positions would be recertified annually. The bill establishes a public body, the National Council on Postgraduate Physician Training, comprised of twenty four members representing the federal government, physicians, health professionals, and public sector representatives. The duties of this body include: studying physician specialty distribution, assessing the need for financial support of specialty training, guaging the role of post-graduate physician trainees to meet service needs of hosptials; and determining the impact of foreign medical graduates in the U. S.

IV. Special Project Grants

Both the House and Senate Health Manpower bills contain special project grant funds for:

- Family medicine traineeships programs;
- Physician assistant and expanded function dental auxiliary traineeship programs;
- Area Health Education Centers;
- Graduate programs in hospital administration, health planning, health administration, environmental and occupational health;and
- Remedial training of U. S. citizens previously enrolled in foreign medical schools

V. Licensure

S. 3239 The Senate bill requires that within two years of enactment, the HEW Secretary shall develop (with appropriate professional consultation) model standards for state licensure of physicians and dentists and appropriate examinations for initial licensure. Procedures for renewal of licenses at least every six years and appropriate continuing education programs for physicians and dentists must also be established by the Secretary.

H.R. 5546 The House bill contains no such provision.

ATTACHMENT A

CAPITATION AMOUNTS AND REQUIREMENTS FOR RECEIPT OF GRANTS UNDER HR 5546

SCH	AUTHORIZATIONS (Per student basis) FY '76	FY '77	FY '78	CONDITIONS
A. Medicine & Osteopathy	$2,100	$2,100	$2,000	Must either expand enrollment in their first or third years, or operate a remote site training program in which at least 50% of their students, upon graduation, will have spent at least 6 weeks of training in a site remote from the main teaching facilities.
B. Dentistry	2,100	2,200	2,200	SAME AS ABOVE
C. Public Health	1,500	1,500	1,500	Must increase enrollment in the first year.
D. Veterinary Medicine	1,500	1,500	1,500	Must either increase first year enrollment or enroll at least 20% of their students from states that have no such schools.
E. Podiatry	1,100	1,100	1,100	Must either increase first year enrollment or enroll 40% of their students from states which have no such schools.
F. Optometry	700	700	700	Must either increase first year enrollment or enroll 25% of their students from states which have no such schools, if it is a public school; 50%. if it is a private school.
G. Pharmacy	650	690	730	Must either increase enrollment or conduct two of three special training programs--clinical pharmacology, teaching in clinical settings or doctor/patient counseling in drugs.

ATTACHMENT B

CAPITATION AMOUNTS AND REQUIREMENTS FOR RECEIPT OF GRANTS UNDER S.3239

SCHOOLS	AUTHORIZATIONS (Per student basis) FY '78	FY '79	FY '80	CONDITIONS
A. Medicine & Osteopathy	$1,800	$1,900	$2,000	Assure that by 1980 35% of total school enrollment has submitted NHCS applications and agreed to accept such scholarships. Also, by 1980 50% of filled residencies would have to be in family practice, primary internal medicine and primary pediatrics.
B. Dentistry	1,800	1,900	2,000	Assure that (1) 20% of students apply for NHSC scholarships; (2) a TEAM (Training in Expanded Auxiliary Management) program be established and operating or enrollment increase requirements be met; and (3) 70% of residencies established after 1975 be in general dentistry or pedodontics.
C. Public Health	1,225	1,300	1,375	Enrollment increase requirements.
D. Veterinary Medicine	1,350	1,425	1,500	Enrollment increase requirements.
E. Podiatry	755	830	885	Enrollment increase requirements.
F. Optometry	600	640	680	Enrollment increase requirements.
G. Pharmacy	650	690	730	Maintain minimum student-faculty ratio; include inpatient and outpatient clinical pharmacy clerkship experience and training in drug information retrieval and analysis.

BHM SUPPORT TO KANSAS UNIVERSITY MEDICAL CENTER

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965				$96,562		$878,022				$974,584
1966	$86,677			$157,261						$243,938
1967	$244,629			$200,250	$25,000					$469,879
1968	$262,500			$225,293	$44,490					$532,283
1969	$269,000	$168,560		$230,362	$65,000					$728,922
1970	$269,000	$190,500		$115,533	$90,000					$665,033
1971	$269,000	$317,845		$170,603	$89,127					$846,575
1972	$1,143,635	$471,820		$220,445	$86,567					$1,922,467
1973	$1,187,272	$331,701		$246,424	$74,518					$1,839,915
1974	$1,533,244	$712,748		$227,249	$71,268	$4,574,253				$7,118,762
1975	$1,250,982	$285,558		$198,640	$17,480					$1,752,660
TOTAL	$6,515,939	$2,474,732		$2,088,622	$563,450	$5,452,275				$17,095,018

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, ETC.	PRECEPTORSHIP TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHER*
1969										
1970										
1971	$200,000									
1972	$170,000	$284,500				$17,320				
1973	$128,253	$191,739				$11,709				
1974	$271,747	$420,211								
1975	$199,072					$20,790				
						$86,486				
TOTAL	$969,072	$896,450				$136,305				

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968			
1969	$168,560		
1970	$190,500		
1971	$117,845		
TOTAL	$472,905		

*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY AWARDED THROUGH JUNE 30, 1973. IN A FEW PROGRAMS, SOME FY 1973 FUNDS WERE IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER DATA IN FISCAL YEAR OF AWARD.

* INCLUDED IN SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
a INCLUDES SPECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYSICIANS ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PROD UCTIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

Attachment No 2
1.

BHM SUPPORT TO SCHOOLS OF MEDICINE

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965				$6,628,787		$53,827,023				$60,455,810
1966	$6,566,249			$9,784,259		$41,895,952				$58,246,460
1967	$18,780,518			$14,217,790	$1,809,200	$90,957,810				$125,764,918
1968	$20,239,500	$5,476,610		$14,736,356	$3,234,880	$79,431,003				$123,118,349
1969	$21,123,000	$19,783,689		$14,240,726	$5,292,984	$85,798,700				$146,239,099
1970	$21,254,226	$34,942,170		$8,442,212	$7,258,222	$96,718,005				$168,614,835
1971	$21,823,763	$55,175,300		$13,184,745	$7,143,457	$81,098,490	$2,197,616	$2,500,000	$630,273	$178,425,655
1972	$90,190,672	$40,860,495	$6,610,281	$15,866,188	$7,209,163	$9,197,707		$6,300,000	$629,948	$175,262,395
1973	$95,884,646	$29,025,391	$5,767,351	$19,496,071	$6,785,696	$28,166,699	$4,110,000	$3,750,000	$584,003	$192,055,802
1974	$105,603,745	$60,075,352	$7,446,775	$18,686,382	$6,398,573	$67,886,940				$314,697,722
1975	$85,817,703	$27,829,158	$2,054,762	$18,503,116	$2,888,170	$17,769,783	$1,820,087			$156,682,779
TOTAL	$487,284,022	$273,168,165	$21,879,169	$153,786,632	$48,020,745	$652,748,212	$8,127,703	$12,550,000	$1,844,224	$1,659,408,872

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, ETC.	PRECEPTORSHIP TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHER*
1969										$969,481
1970	$472,641	$335,225								
1971	$12,307,831	$610,500								
1972	$23,573,942	$1,368,160				$2,917,466	$2,244,909	$441,349	$2,700,859	$253,641
1973	$25,637,331	$3,829,502	$385,007	$2,197,266		$2,127,279	$1,851,829	$430,426		$253,565
1974	$21,395,262	$2,086,117	$248,986	$1,285,492						
1975	$41,228,433	$4,244,302	$715,612	$3,109,912		$4,983,850	$3,277,819	$1,223,695	$964,606	$52,336
	$12,096,719	$1,713,707	$736,790	$2,431,086		$4,958,696	$3,132,616	$905,703	$718,513	$53,158
TOTAL	$36,712,159	$14,187,513	$2,086,395	$9,023,756		$14,987,291	$10,106,773	$3,001,173	$4,379,578	$359,135

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968	$5,476,610		
1969	$19,975,823		
1970	$20,070,124	$1,953,715	
1971	$14,730,982	$11,170,585	$331,631
TOTAL	$63,253,539	$13,124,300	$331,631

*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY AWARDED THROUGH JUNE 30, 1973. IN A FEW PROGRAMS, SOME FY 1973 FUNDS WERE IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER DATA IN FISCAL YEAR OF AWARD.

* I IN SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
a IN SPECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYSICIANS ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PROD UCTIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

Summary Selected Information on Health Professions Schools Part II HEW BHM

BHM SUPPORT TO KANSAS CITY COL OF OSTEOPATHY AND SURGERY

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965				$93,455						$93,455
1966	$82,642			$153,734						$236,376
1967	$226,931			$303,045	$22,400					$552,396
1968	$219,000	$146,667		$241,622	$40,479	$6,537,929				$7,205,697
1969	$247,000	$221,000		$203,706	$66,200					$737,906
1970	$247,000	$321,755		$103,054	$89,200					$761,009
1971	$247,000	$627,084		$155,187	$81,073					$1,110,344
1972	$1,002,763	$66,536		$195,951	$76,948					$1,342,198
1973	$1,065,029	$57,099		$220,699	$66,738					$1,409,565
1974	$1,168,140	$154,124		$197,206	$61,846					$1,581,316
1975	$902,887	$144,090		$190,890	$35,446					$1,273,313
TOTAL	$5,428,412	$1,738,355		$2,058,549	$540,330	$6,537,929				$16,303,575

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, ETC.	PRECEPTOR-SHIP TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHERS
1969										
1970										
1971	$148,530									
1972						$66,536				
1973						$57,099				
1974						$154,124				
1975						$144,090				
TOTAL	$148,530					$421,849				

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968	$146,667		
1969	$221,000		
1970	$115,755	$206,000	
1971		$478,554	
TOTAL	$483,422	$684,554	

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*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY *
*AWARDED THROUGH JUNE 30, 1973. *
*IN A FEW PROGRAMS, SOME FY 1973 FUNDS WERE *
*IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED *
*AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER *
*DATA IN FISCAL YEAR OF AWARD. *
****

* INCLUDED IN SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
@ INCLUDES SPECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYSICIAN'S ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PRODUCTIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

BHM SUPPORT TO SCHOOLS OF OSTEOPATHY

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965				$371,820						$371,820
1966	$355,838			$648,459						$1,004,293
1967	$983,293			$1,262,638	$97,800	$1,924,910				$4,268,637
1968	$1,063,000	$410,299		$1,084,945	$177,049	$6,537,929				$9,233,222
1969	$1,126,000	$1,118,612		$892,880	$287,600					$3,425,092
1970	$1,126,798	$2,050,420		$952,650	$391,800	$488,482				$4,510,150
1971	$1,183,875	$2,194,925		$729,683	$381,205					$4,489,689
1972	$4,921,241	$380,035	$360,000	$952,523	$379,434				$126,393	$7,019,626
1973	$5,763,479	$397,910	$340,131	$1,161,259	$367,722				$126,425	$8,156,925
1974	$6,505,425	$855,063		$1,048,418	$328,797	$8,455,618	$720,000		$128,770	$18,042,091
1975	$5,404,871	$436,128	$68,211	$1,104,152	$201,994		$540,000			$7,755,356
TOTAL	$28,333,816	$7,843,392	$768,342	$9,669,422	$2,613,401	$17,406,939	$1,260,000		$381,588	$68,276,900

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, ETC.	PRECEPTOR-SHIP TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHERS
1969	$240,000									$116,689
1970	$579,383									
1971	$731,362									
1972	$313,499					$66,536				
1973	$340,811					$57,099				
1974	$645,592			$55,387		$154,124				
1975	$134,104			$63,854		$144,090	$94,000			
TOTAL	$2,984,931			$119,201		$421,849	$94,000			

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968	$410,299		
1969	$879,612		
1970	$889,143	$621,894	
1971	$780,009	$723,554	
TOTAL	$2,878,063	$1,345,448	

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*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY *
*AWARDED THROUGH JUNE 30, 1973. *
*IN A FEW PROGRAMS, SOME FY 1973 FUNDS WERE *
*IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED *
*AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER *
*DATA IN FISCAL YEAR OF AWARD. *
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* INC N SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
@ INC ECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHY S ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PROD UC- TIVI NTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

BHM SUPPORT TO UNIV OF MISSOURI AT K C SCHOOL OF DENTISTRY

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965				$102,777						$102,777
1966	$89,134			$162,242		$4,011,916				$4,263,292
1967	$247,973			$307,235	$23,600					$578,808
1968	$262,000			$229,740	$43,579					$535,319
1969	$277,500	$376,230		$226,077	$72,000					$951,807
1970	$277,500	$369,510		$117,149	$101,400					$865,559
1971	$277,500	$365,312		$186,018	$97,180					$926,010
1972	$1,090,201	$90,998		$240,716	$94,526					$1,516,441
1973	$1,124,377	$61,127		$260,413	$78,748					$1,524,665
1974	$1,110,963	$132,575		$228,021	$71,509					$5,554,968
1975	$843,696			$216,601	$21,850					$1,082,147
TOTAL	$5,600,844	$1,395,752		$2,276,989	$604,392	$4,011,916				$13,989,893

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, PRECEPTOR-SHIP ETC.	TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHER@
1969										
1970										
1971										
1972	$90,998									
1973	$61,127									
1974	$132,575									
1975										
TOTAL	$284,700									

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968			
1969	$376,230		
1970	$369,510		
1971	$365,312		
TOTAL	$1,111,052		

*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY AWARDED THROUGH JUNE 30, 1973. IN A FEW PROGRAMS, SOME FY 1973 FUNDS WERE IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER DATA IN FISCAL YEAR OF AWARD.

* INCLUDED IN SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
@ INCLUDES SPECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYSICIAN'S ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PROD UCTIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

BHM SUPPORT TO SCHOOLS OF DENTISTRY

5

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965				$2,870,964		$19,180,469				$22,051,433
1966	$2,975,283			$4,623,921		$14,997,421				$22,596,625
1967	$8,440,653			$7,132,000	$829,200	$35,539,033				$51,940,886
1968	$8,862,500	$2,689,059		$6,822,121	$1,445,234	$23,416,225				$43,235,139
1969	$9,213,000	$8,722,630		$6,777,734	$2,354,245	$31,380,149				$58,447,758
1970	$9,204,031	$12,961,689		$3,584,393	$3,164,945	$29,642,380				$58,557,438
1971	$9,119,767	$15,844,674		$5,471,318	$3,004,606	$25,726,301				$59,166,666
1972	$34,988,087	$6,773,091	$2,240,565	$6,636,274	$2,893,175	$1,267,756	$1,112,343		$204,751	$56,116,033
1973	$36,851,875	$3,547,566	$1,933,410	$7,580,961	$2,655,543	$10,143,979			$204,751	$62,918,085
1974	$40,390,830	$6,316,709	$2,691,906	$7,165,377	$2,462,718	$12,911,948	$2,291,455			$98,162,195
1975	$31,777,426	$3,400,706	$2,021,672	$6,883,304	$1,305,269	$5,548,657	$1,220,963			$52,157,897
TOTAL	$191,823,452	$60,256,114	$8,887,554	$65,548,367	$20,114,935	$209,754,317	$4,624,761		$409,502	$561,419,002

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, PRECEPTOR-SHIP ETC.	TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHER@
1969										
1970	$1,171,257	$294,188								
1971	$434,117	$765,143								$498,357
1972	$1,167,260	$3,184,550	$373,350	$1,002,787	$282,473					
1973	$327,030	$2,381,657	$39,645	$657,461	$141,773					$762,661
1974	$795,724	$3,708,358	$70,661	$1,488,279	$240,659				$13,032	
1975	$139,003	$1,641,458	$67,591	$623,779	$420,633				$13,885	$498,357
TOTAL	$4,034,391	$11,975,350	$551,247	$3,772,306	$1,085,538				$26,917	$1,257,019

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968	$2,689,059		
1969	$7,822,630		
1970	$8,991,113	$2,605,131	
1971	$9,737,916	$5,997,998	$9,500
TOTAL	$29,140,718	$8,503,129	$9,500

*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY AWARDED THROUGH JUNE 30, 1973. IN A FEW PROGRAMS, SOME FY 1973 FUNDS WERE IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER DATA IN FISCAL YEAR OF AWARD.

* INCLU SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
@ INCLUDES SPECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYSICIAN'S ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PROD UCTIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

BHM SUPPORT TO UNIVERSITY OF KANSAS SCHOOL OF PHARMACY

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965										
1966					$9,600					$9,600
1967				$27,000	$20,786					$87,786
1968				$34,200	$34,000					$68,200
1969										
1970	$116,492			$36,000	$35,600					$188,092
1971	$125,129			$40,500	$36,152					$201,781
1972	$149,807			$40,500	$34,494					$224,801
1973	$154,670			$53,100	$31,390					$239,160
1974	$167,571			$61,740	$29,836					$259,147
1975	$125,804			$27,919	$6,797					$160,520
TOTAL	$844,473			$320,959	$238,655					$1,404,087

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, ETC.	PRECEPTOR-SHIP TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHER@
1969										$21,060
1970										
1971										
1972										
1973										
1974										
1975										
TOTAL										

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968			
1969			
1970			
1971			
TOTAL			

*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY AWARDED THROUGH JUNE 30, 1973. IN A FEW PROGRAMS, SOME FY 1973 FUNDS WERE IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER@ DATA IN FISCAL YEAR OF AWARD.

* INCLUDED IN SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
@ INCLUDES SPECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYSICIAN'S ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PRODUCTIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

BHM SUPPORT TO SCHOOLS OF PHARMACY

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965						$40,000				$40,000
1966						$2,975,332				$2,975,332
1967				$1,638,887	$1,017,200	$4,863,128				$7,519,215
1968				$1,810,357	$1,879,372	$1,385,658				$5,075,387
1969				$2,019,517	$2,730,588	$536,403				$5,286,508
1970	$10,196,498	$267,500		$1,781,149	$3,086,981	$6,141,736				$21,473,860
1971	$9,629,657	$109,177		$2,812,775	$3,808,985	$3,083,311				$19,043,905
1972	$15,102,662	$1,921,802	$1,150,341	$3,251,653	$3,830,715				$38,583	$24,895,756
1973	$16,555,580	$911,590	$155,144	$3,939,145	$4,204,680	$252,137			$38,876	$26,057,152
1974	$20,282,775	$1,518,976	$184,788	$5,369,562	$4,072,735	$3,358,887				$37,723,055
1975	$16,753,272	$2,615,429	$172,189	$5,742,180	$1,777,132	$1,725,351				$28,785,553
TOTAL	$88,520,440	$7,344,474	$1,622,462	$28,365,225	$25,608,388	$24,361,943			$77,459	$175,900,391

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, ETC.	PRECEPTOR-SHIP TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHER@
1969										
1970	$222,256									$842,401
1971										
1972	$118,142	$484,092	$100,000	$800,446						
1973	$129,135	$371,630		$410,825				$459,122		
1974	$195,289	$335,849	$219,314	$510,436				$89,536	$168,592	
1975	$102,700	$327,142	$267,006	$300,826	$444,824			$75,259	$255,271	$842,401
TOTAL	$767,482	$1,478,713	$586,320	$2,022,533	$444,824			$164,795	$882,985	$842,401

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968			
1969			
1970		$45,244	
1971		$109,177	
TOTAL		$154,421	

*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY AWARDED THROUGH JUNE 30, 1973. IN A FEW PROGRAMS, SOME FY 1973 FUNDS WERE IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER@ DATA IN FISCAL YEAR OF AWARD.

* INCL SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
@ INCL CIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYS ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PROD UC-TIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

BHM SUPPORT TO SCHOOLS OF VETERINARY MEDICINE

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965										
1966										
1967										
1968				$1,154,786		$1,152,771				$2,307,557
1969				$1,308,777		$5,508,346				$6,817,123
1970	$2,506,981	$781,725		$921,380	$908,100	$582,432				$5,700,578
1971	$2,549,462	$685,025		$1,299,589	$844,219	$9,172,822				$14,550,117
1972	$6,970,381	$960,379	$385,518	$1,657,237	$868,117					$10,841,632
1973	$3,785,695	$400,151	$297,642	$1,902,485	$784,720	$10,111,115				$17,281,808
1974	$12,666,389	$828,225	$871,275	$1,868,426	$735,775					$16,966,090
1975	$7,011,770	$316,427	$137,417	$1,879,563	$293,763	$8,517,027				$18,155,967
TOTAL	$35,489,638	$3,971,932	$1,691,852	$11,988,243	$4,434,694	$35,044,513				$92,620,872

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, ETC.	PRECEPTORSHIP TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHER@
1969										$125,400
1970										
1971										
1972			$50,000	$410,090				$382,401		$11,888
1973				$400,151						
1974				$469,839	$88,392			$269,994		
1975			$19,922	$96,029	$99,953			$100,253		
TOTAL			$69,922	$1,376,109	$188,345			$752,648		$117,888

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968			
1969			
1970		$781,725	
1971		$685,025	
TOTAL		$1,466,750	

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*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY *
*AWARDED THROUGH JUNE 30, 1973. *
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*IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED *
*AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER *
*DATA IN FISCAL YEAR OF AWARD. *
****

* INCLUDED IN SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
@ INCLUDES SPECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYSICIAN'S ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PROD UCTIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINIEG, AND INTERDISCIPLINARY TRAINING.

BHM SUPPORT TO SCHOOLS OF PODIATRY

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965										
1966	$186,515									$186,515
1967	$568,270			$203,906	$51,000					$819,176
1968	$635,000	$919,127		$238,800	$108,856					$1,896,783
1969	$883,500	$1,053,584		$306,034	$160,000					$2,213,118
1970	$636,553	$1,007,438		$166,824	$226,600					$2,095,415
1971	$693,500	$865,964		$334,007	$208,497	$4,249,138				$6,351,106
1972	$956,133	$1,560,243	$134,731	$833,283	$202,818					$3,287,208
1973	$1,061,584	$641,516	$391,998	$621,468	$187,931					$2,904,497
1974	$1,359,443	$1,410,152	$600,125	$582,364	$192,786	$979,250				$5,124,120
1975	$1,219,220	$721,212	$545,749	$638,658	$161,208	$2,070,158				$5,352,201
TOTAL	$8,063,718	$8,178,236	$1,672,603	$3,517,340	$1,499,696	$7,298,546				$30,230,139

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, ETC.	PRECEPTORSHIP TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHER@
1969										
1970	$193,982									
1971										
1972	$1,310,959	$159,154	$50,000	$40,130						
1973	$385,994	$222,540		$73,082						
1974	$278,967	$95,992	$383,316	$651,877						
1975			$534,001	$61,811						$125,400
TOTAL	$2,129,902	$477,686	$967,317	$826,900						$125,400

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968	$318,127		
1969	$1,053,584		
1970	$913,856		
1971	$848,355	$17,609	
TOTAL	$3,133,922	$17,609	

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*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY *
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*IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED *
*AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER *
*DATA IN FISCAL YEAR OF AWARD. *
****

* INCLUDED [illegible]CIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
@ INCLUDES SPECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYSICIAN'S ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PROD UCTIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

HHH SUPPORT TO KNS ST UNIV OF AG & APP SC COL OF VET MED

FISCAL YEAR	(1) FORMULA GRANTS	(2) SPECIAL PROJECT GRANTS	(3) FINANCIAL DISTRESS GRANTS	(4) STUDENT LOANS	(5) SCHOLARSHIPS	(6) CONSTRUCTION AWARDS	(7) START-UP GRANTS	(8) CONVERSION GRANTS	(9) TEACHER TRAINING GRANTS	(10) TOTAL
1965										
1966										
1967										
1968										
1969				$150,400		$672,675				$823,075
1970	$162,584			$73,939	$64,000					$300,483
1971	$154,287			$111,336	$58,165	$2,345,707				$2,669,495
1972	$491,556			$139,361	$54,726					$685,643
1973	$238,981			$151,193	$45,720					$435,894
1974	$761,184			$129,032	$40,465					$930,641
1975	$409,986			$128,550	$12,625					$551,161
TOTAL	$2,218,498			$883,811	$275,701	$3,018,382				$6,396,392

SPECIAL PROJECT GRANTS BY PURPOSE

FISCAL YEAR	ENROLLMENT INCREASE	SHORTENED CURRICULUM	TEAM APPROACH	MINORITY, LOW INCOME	NEW ROLES, ETC.	PRECEPTOR-SHIP TRAIN.	FAMILY MEDICINE	CLINICAL CURRICULUM PHARM. IMPROVEMENT	NUTRITION	OTHER@
1968										
1969										
1970										
1971										
1972										
1973										
1974										
1975										
TOTAL										

FISCAL YEAR	FINANCIAL NEED* RELATIVE NEED	DIRE NEED	COST ALLOCATION STUDY
1968			
1969			
1970			
1971			
TOTAL			

*NOTE: THE FY 1973 DATA REFLECT FUNDS ACTUALLY AWARDED THROUGH JUNE 30, 1973. IN A FEW PROGRAMS, SOME FY 1973 FUNDS WERE IMPOUNDED. THESE FUNDS, SUBSEQUENTLY RELEASED AFTER JUNE 30, 1973, ARE INCLUDED WITH OTHER DATA IN FISCAL YEAR OF AWARD.

* INCLUDES SPECIAL PROJECT GRANT PROGRAM FY 1968-71; REPLACED BY FINANCIAL DISTRESS GRANT PROGRAM FY 1972 (SEE COLUMN 3 ABOVE).
@ INCLUDES SPECIAL PROJECT GRANTS FOR EXPERIMENTAL TEACHING PROGRAMS, NEW INNOVATIVE PROGRAMS, EXPERIMENTAL CURRICULUM, PHYSICIAN'S ASSISTANT TRAINING, GEOGRAPHIC DISTRIBUTION, EMERGENCY MEDICAL SERVICES, IMPROVED DISTRIBUTION, IMPROVED PRODUCTIVITY, INTERDISCIPLINARY TRAINING/IMPROVED DISTRIBUTION, NEW ROLES/INTERDISCIPLINARY TRAINING, AND INTERDISCIPLINARY TRAINING.

STAFF SUMMARY - PROPOSAL NO. 33

The absolute increase in the total of health manpower brought about by federal legislation can be seen by comparing first year student totals.

	Medicine	Osteopathic Medicine
1963-64	8,722	441
1973-74	14,034	808

Dentistry	Optometry	Pharmacy	Podiatry
3,770	516	4,390	195
5,445	1,003	8,400	477

Geographic Maldistribution

Increases in the supply of health professionals have not led to more equitable distribution of health manpower; in fact, the maldistribution has worsened in the past decade.

In 1975, the national ratio of physicians was 156 physicians for every 100,000 people or one physician for every 641 people. But this health manpower is maldistributed by region and by demographic units within regions. The New England and Pacific regions now have much larger per capita supplies of health manpower than do the Midwestern and Southern regions. These two regions now have on a per capita basis over 50 percent more physicians than do the Midwest and South. Even within the New England and Pacific regions, rural and inner city urban areas have significantly smaller per capita numbers of health manpower than do the suburban and smaller urban areas.

The attached tables indicate that in 1970 the physician population range varied from 67 percent to 126 of the national average. The last table shows that those areas that had a high per capita ratio in 1959 have increased substantially in the past few years. In addition to the maldistribution by region, there is a lack of balance within regions: the suburban and smaller urban areas generally have a higher physician ratio on a per capita basis than do rural and inner city areas. In 1975, the ratio was 170 per 100,000 population in urban areas and 80:100,000 in nonurban areas. In 43 states this maldistribution worsened between 1960 and 1970. This problem has been recognized for at least 50 years and has worsened even in those areas where specific programs have been directed toward the problem.

According to a Congressional report there are three most important reasons for the present geographic maldistribution:

1. high level of financial return for medical services;
2. the life style of middle-class Americans;
3. nature and location of medical training

1. Studies show that regardless of the number of physicians serving a given population group, a physician can readily establish and maintain a thriving practice. Affluent groups in our society apparently have an unlimited demand for, and ability to pay for, health services. A committee of the National Board of Medical Examiners reported in 1973:

> "The commercial market place operates on the premise that overproduction of a product leads to lower prices, curtailment of supply, and the automatic introduction of the product into undersupplied areas. There is no evidence that such a process operates within the health care system. The suburbs of this country appear to have an unlimited capacity to absorb physicians."

The net effect is that it is impossible to train so many physicians that they are forced by economics into undersupplied areas.

2. Given a choice not influenced by economic considerations, many middle-class Americans want to live on the east and west coasts. Within any region, most middle-class Americans choose to live in suburbs and smaller urban areas with good housing and schools, easy access to shopping areas and cultural attractions. A study prepared by the AMA reported that the quality of life in a community is the most important influence on physician location decisions. Access to medical facilities, including academic medical centers for continuing or advanced education is also a primary consideration in choosing a practice location.

3. The 3rd factor important to the maldistribution of physicians is the nature and location of medical education. Most undergraduate and postgraduate medical training is provided in large academic medical centers which specialize in providing complex, tertiary level care. This becomes the medical model for medical students. This influences the overproduction of specialists at the expense of primary care physicians. In addition, most medical schools are located in large cities. As a result, medical students and their spouses become accustomed, over a seven year period or more, to an urban life style.

Speciality Maldistribution

The maldistribution of specialities in medicine has been increasing over the past decade as an increasingly smaller proportion of students have entered primary care specialities such as family practice, general internal medicine, general pediatrics and obstetrics and gynecology. In 1975, 47 percent of physicians were in the primary care specialties. In the area of family or general practice, the shortage is even more severe, i.e., the American Academy of Family Practice suggests there should be one family practitioner for every 2,500 persons. Only three states -- Arizona, Iowa and Maine had this ratio in 1970. Kansas had 637 family and general practitioners in 1972 plus 158 osteopathic physicians for a total of 795 as opposed to 905 needed to meet the 1/2,500 ratio based on 1970 population. This left Kansas 110 short -- but with one of the 12 lowest needs ratios among the states.

Specialities are determined by postgraduate training, -- internships, residency and fellowships, and the availability of such postgraduate training is considered by some to be the determining factor in the speciality mix of graduates, i.e., there are some financial incentives to have speciality training for medical schools and hospitals -- also ambulatory based training is not as attractive to the sponsoring institution as are in-hospital specialities.

Speciality boards certify postgraduate speciality training but consider that attempting to influence or control the numbers in their speciality field is outside their jurisdiction.

A Congressional committee found that there were too many postgraduate positions in the sub-specialities and too few in primary care positions. The committee also found that the total number of physician traineeships in the US exceeds the total number of graduates of US medical schools, i.e. in 1974 there were 1.69 positions for every graduate of a US medical school in the previous year. In that year only 37 percent of the trainees were in primary care specialities. This compares with 47 percent of physicians now in practice. If this trend continues, the imbalance in primary care physicians will continue to increase.

According to testimony presented by the AMA, if 50 percent of new physicians were to enter family practice, internal medicine and pediatricts during the next decade the percentage of physicians in these specialities would increase only from 35 percent to 38.5 percent.

DISTRIBUTION OF PHYSICIANS (MD AND DO) IN THE UNITED STATES

PHYSICIAN: POPULATION RATIO BY REGION AND REGIONAL RATIOS AS A PERCENTAGE OF THE NATIONAL AVERAGE RATIO

	Number of active physicians per 100,000 population (M.D.'s and D.O.'s Dec. 30, 1970)	Physicians per 100,000 as percentage of national average
United States	156	100
New England	190	122
Middle Atlantic	196	126
South Atlantic	149	96
East south-central	105	67
West south-central	132	85
East north-central	135	87
West north-central	135	87
Mountain	150	96
Pacific	183	117

Source: Health Resources Statistics, 1971, NCHS, DHEW publication No. 72-1509, 1971 ed.

PHYSICIAN POPULATION RATIO BY STATE AND STATE RATIOS AS A PERCENTAGE OF THE NATIONAL AVERAGE RATIO

	Number of active physicians per 100,000 population (M.D.'s and D.O.'s Dec. 31, 1970)	Physicians per 100,000 as percentage of national average
United States	156	100
Northeast	195	125
New England	190	122
Connecticut	189	121
Maine	125	80
Massachusetts	213	137
New Hampshire	139	89
Rhode Island	169	108
Vermont	184	118
Middle Atlantic	196	126
New Jersey	152	97
New York	236	151
Pennsylvania	163	104
South	133	85
South Atlantic	149	96
Delaware	141	90
District of Columbia	525	337
Florida	146	94
Georgia	117	75
Maryland	232	149
North Carolina	114	73
South Carolina	97	62
Virginia	134	86
West Virginia	111	71
East South Central	105	67
Alabama	93	60
Kentucky	107	69
Mississippi	89	57
Tennessee	123	79
West South Central	132	58
Arkansas	95	61
Louisiana	126	81
Oklahoma	122	78
Texas	134	86
North Central	135	87
East North Central	135	87
Illinois	142	91
Indiana	103	66
Michigan	144	92
Ohio	141	90
Wisconsin	123	79
West North Central	135	87
Iowa	115	74
Kansas	129	83
Minnesota	153	98
Missouri	150	96
Nebraska	118	76
North Dakota	102	65
South Dakota	95	61
West	176	113
Mountain	150	96
Arizona	160	103
Colorado	197	126
Idaho	97	62
Montana	111	71
Nevada	116	74
New Mexico	139	98
Utah	141	90
Wyoming	103	66
Pacific	183	117
Alaska	106	68
California	194	124
Hawaii	151	98
Oregon	148	95
Washington	158	101

Source: "Health Resources Statistics, 1971," NCHS, DHEW publication No. 72-1509, 1971 ed.

CHANGE IN PHYSICIAN POPULATION RATIO BY REGION: 1959-70

	Number of active physicians per 100,000 (M.D.'s and D.O.'s)		Increase in ratio as percentage of 1959 national average
	1959	1970	
United States	132	156	18
New England	164	190	20
Middle Atlantic	165	190	23
South Atlantic	112	149	28
East south-central	88	105	13
West south-central	106	132	20
East north-central	122	135	10
West north-central	124	135	8
Mountain	119	150	23
Pacific	161	183	17

Source: "Health Resources Statistics, 1971," NCHS, DHEW, publication No. 72-1509, 1971 ed. and "Health Manpower Sourcebook," sec. 10, PNS publication 263-10, 1960.

SOURCE: Report of the Committee on Foreign and Interstate Commerce to Accompany H.R. 5546

Attachment D

ACTION PLAN FOR THE CARE OF THE ELDERLY IN NURSING HOMES IN KANSAS

Submitted to the
Special Committee on SRS Institutions
November 7, 1975

Submitted by
The State Department of Health and Environment
Dwight Metzler, Secretary

and

The State Department of Social and Rehabilitation Services
Robert Harder, Secretary

A. AN OVERVIEW

This interim report on the care of the aged in Kansas Nursing Homes is offered at this time as a dispassionate analysis of the existing situation as it relates to nursing home operations within the state. It was, in part, precipitated by a report from the Attorney General's office which in its turn was reflecting a national concern with nursing home operations. The value of that report was to cause us at this time to define in more detail for the SRS Committee the exact operations of the Departments of Social and Rehabilitation Services and Health and Environment relative to nursing home operations.

In July of 1975 the Attorney General's office requested the Departments to provide names of nursing homes deemed by the Departments to be sub-optimal. From this list eight were chosen and investigated and that agency's report is based on that limited sampling. It does not represent the typical Kansas nursing home operation, nor do we believe that it was intended in any sense as a blanket indictment of an entire industry.

Of the eight homes investigated, several were already identified as only marginal operations; in fact, two of them were scheduled for reinspection, and as it turned out, for decertification, before the initiation of any outside investigation.

B. NORMAL PROCEDURES AND RESPONSIBILITIES OF THE DEPARTMENTS

The Department of Health and Environment is solely responsible for the licensing of nursing homes (K.S.A. 39-932). It has the additional responsibility to certify to Social and Rehabilitation Services that facilities which wish to do so are qualified to participate in Federal programs. The certification process is basically that of assuring the adequacy of facilities, although this adequacy, must, of course, be related to quality of care. The Department of Social and Rehabilitation Services has the responsibility for assuring the quality of care of Title XIX patients through its periodic medical review inspections and such quality is, of course, related to facilities (K.S.A. Chapter 39, Article 7). In that sense alone is there any overlap of function, and this is desirable for it looks at the problem twice, each from a slightly different perspective.

The Department of Health and Environment inspections for the purpose of licensure are annual. Inspections for certification are also annual and, where possible, coincident with licensure inspections. In most cases the licensure and certification inspections are out of synchronization, so that the facility is actually inspected twice by Health and Environment during a twelve-month period. In addition to this, there are follow-up inspections to insure progress made on plans of correction, and there are a number of simple unscheduled visits by both state and local health authorities. The Department of Social and Rehabilitation Services, through its periodic medical review teams, inspects each facility yearly to insure that Title XIX patients are receiving the care required in accordance with their medical needs.

C. CORRECTIVE ACTIONS

The Departments have recognized the complexity of the issues which have arisen with the burgeoning of the nursing home industry from the viewpoints of consumers, providers and taxpayers. We continually re-evaluate the adequacy of our operation and the rules and regulations and make changes as appropriate. Since this review of operations and regulations is a process and never an accomplished and finished fact, considering the dynamics of the nursing home industry, there is no point in time at which further constructive change may not be appropriate.

1. The Department of Health and Environment will assume responsibility for coordination of all nursing home training efforts.

2. A nursing home ombudsman position has been approved for Social and Rehabilitation Services. One of his primary responsibilities will be investigation of personal needs accounts.

3. The Department of Health and Environment will insure that every certified nursing home in operation on May 30, 1976, will have a licensed nurse and administrator.

4. The Department of Health and Environment has proposed to the Special Committee on SRS Institutions a system of fines and receivership to encourage compliance as an alternative to closure of homes.

5. The Department of Health and Environment will complete its revision of State Licensing Regulations which was begun in fall of 1974 and submit them for review and adopt them by June 30, 1976.

6. The Department of Health and Environment will work towards the coordination of all inspections so that state licensing, fire and periodic medical reviews are accomplished simultaneously.

7. The Departments of Health and Environment and Social and Rehabilitation Services will, by January 30, 1976, combine the training session for their respective inspection team and conduct joint training in overlapping areas.

8. The Department of Health and Environment will expand its inspection staff by six with the approval of two inspectors in the 1977 budget, doubling the Department's inspection capability over October 1975.

9. A joint inspection team from the Departments of Health and Environment and Social and Rehabilitation Services has reinspected all eight facilities investigated by the Attorney General. Action will be taken to insure deficiencies are corrected or facilities are terminated as a nursing home.

10. The Department of Health and Environment in coordination with the Department of Social and Rehabilitation Services and with cooperation of the nursing home industry will develop and recommend a state standard for nursing home medical records by July 1, 1976.

11. The Department of Health and Environment will stimulate and encourage the development of an Aide Training Program with the objective of training 500 aides by January 1, 1977.

12. The Department of Health and Environment and the Department of Social and Rehabilitation Services, working together with the Department of Education, the Nursing Home Industry and an educational institution, will cause the development of a state approved Aide Training Program by July 1, 1976, to be used in inservice training in nursing homes.

13. The Department of Social and Rehabilitation Services will expand its Periodic Medical Inspection staff by more than one hundred percent with the approval of the sixteen additional staff requested in the fiscal year 1977 budget.

14. The Department of Social and Rehabilitation Services will increase its capability to conduct medical audits by two hundred percent effective July 1, 1976, with the approval of two accountants in the proposed fiscal year 1977 budget.

15. Effective May 1, 1976, the Department of Social and Rehabilitation Services will obtain balance sheets and revenue statements on nursing home operations enabling the department to justify Title XIX reimbursements.

16. The Department of Social and Rehabilitation Services will review personal needs funds of Medicaid recipients during periodic medical inspections conducted on and after November 10, 1975.

17. The Department of Social and Rehabilitation Services will suggest possible amendments to the legislature by January 1, 1976, for its proposed rules and regulations which will require each nursing home participating in the Title XIX program to post a certification certificate for public review.

18. The Department of Social and Rehabilitation Services in coordination with the Department of Health and Environment and the Nursing Home Industry will establish criteria, policies and guidelines for the use of consultants in nursing home operations.

19. The Department of Social and Rehabilitation Services, by January 1, 1976, will review payment policies for physician services provided Title XIX recipients in nursing homes to eliminate any financial burden upon physicians for these services.

D. PROBLEMS IDENTIFIED AND CORRECTIVE ACTIONS TAKEN

The problems identified in the Attorney General's report had been recognized by the Departments of Health and Environment and Social and Rehabilitation Services.

1. The Department of Health and Environment had budgeted for additional survey and inspection staff.

2. The Department of Social and Rehabilitation Services had budgeted for additional periodic medical review staff and accountants for nursing home audits.

3. The Department of Social and Rehabilitation Services' regulations effective March 1972 prohibit supplementation.

4. The Department of Social and Rehabilitation Services' nursing home claims forms state that fraud and misrepresentation is subject to criminal penalty.

5. The Department of Health and Environment inspection staff all meet minimum federal standards for education and training prior to conducting surveys.

6. The Department of Social and Rehabilitation Services has conducted 40 nursing home audits since September 1974.

7. The Department of Social and Rehabilitation Services submitted on July 1, 1975, proposed rules and regulations requiring revenue statements and balance sheets from nursing homes.

8. Training of nursing home consultants was begun October 1975 by the Kansas Pharmaceutical Association which conducted a training session for nursing home administrators, staff, and pharmacist consultants.

9. The Department of Health and Environment has since June 1974 aggressively enforced adult care licensing and certification regulations.

A. Adult Care Home Licensures

Jan. 1, 1974	Homes 433	Beds 22,146
July 31, 1975	Homes 367	Beds 23,039
Sept. 30, 1975	Homes 363	Beds 22,948

B. Certifications to SRS of Nursing Homes

March 18, 1975 (certified)	ICF's 312 SNF 55	Sept. 30, 1975 (not certified)	19% of the 86 homes reinspected 25% of the 20 homes reinspected

10. The Department of Health and Environment will request additional administrative staff to manage the inspection and training programs for nursing homes.

The Departments of Social and Rehabilitation Services and Health and Environment have integrated their efforts wherever possible. This has resulted in the Departments functioning together in a smoothly coordinated fashion. A program of inspections for licensing and certification efforts of the Departments of Social and Rehabilitation Services and Health and Environment is successful. It is an ongoing effort which is continually responsive to the need for adjustment and change.

The Departments of Health and Environment and Social and Rehabilitation Services fully recognize their responsibility for the aged of Kansas. The problems of management of a health care delivery system, such as the nursing home industry, can only be resolved through cooperative efforts of all the concerned parties, the controlling agencies, the providers, the people being cared for, their families and their representatives.

Attachment E

JOINT COMMITTEE ON PUBLIC HEALTH AND WELFARE

June 24, 1976

Submitted by
The State Department of Health and Environment
Dwight F. Metzler, Secretary

Corrective Actions

1. Training courses for medication aides and nursing home aides have been developed.
2. S.R.S.
3. Every certified nursing home in operation has a licensed nurse and administrator.
4. House Bill #2702 was introduced in the last session of the Legislature, but did not pass.
5. The first draft of the proposed rules and regulations for licensing adult care homes has been completed.
6. Progress has been made in synchronizing the Department of Health and Environment licensure and certification inspections.
7. Joint training sessions have been held.
8. The Department of Health and Environment, at the present time, has 13 qualified health facility surveyors conducting inspections in adult care homes. Two additional positions are approved in the FY '77 Budget.
9. The status of the eight facilities in the Attorney General's report is as follows:

   Federal Program
   3 - Certified
   4 - Decertified, appealing their decertification
   1 - Decertified, did not appeal

   State Licensure
   7 - Licensed
   1 - Provisional license

10. Meetings have been held, but this is still in the draft stage.
11. More than 500 nursing home aides should be trained by January 1, 1977.
12. A state approved course will be available on a voluntary basis in July, 1976.
13. - 17. S.R.S.
18. Training sessions for pharmacy consultants have been conducted.
19. S.R.S.

Adult Care Home Licensures		
Janauary 1, 1974	Homes 433	Beds 22,146
July 31, 1975	Homes 367	Beds 23,039
September 30, 1975	Homes 363	Beds 22,948
January 31, 1976	Homes 362	Beds 23,319
May 31, 1976	Homes 359	Beds 23,526

Adult Care Home Certification - May 1976

A. Skilled Nursing Facilities - 53	Beds	4,234
B. Intermediate Care Facilities - 267	Beds	17,355

Attachment F

The Office of Long Term Care is located in the Regional Director's Office of HEW.

Under Medicare, the Office of Long Term Care, acting for the Secretary, determines whether or not a SNF is eligible to participate in the program based upon a recommendation of the State Survey Agency. SNFs are considered in compliance with the condition of participation (18) upon acceptance by the Office of Long Term Care of the findings adequately documented and certified by the State Survey Agency operating under an agreement with the Federal Government. We have authority to approve Medicare provider agreements with SNFs and to terminate (or decline to renew) agreements when the SNFs do not meet the Federal Regulations. Participation is at the SNFs option.

For long term care facilities participating solely in the Medicaid program the surveying responsibility and final certification authority for compliance with Federal Health and Safety Standards , with two exceptions, rests with the State Survey Agency. The two exceptions are (1) decisional authority on requests for waivers of SNF Life Safety Code provisions and (2) review of compliance for institutions for the mentally retarded to determine whether they qualify as an ICF under the law. In these two areas final decisions will be made by HEW on a pre-certification basis.

In all other areas the State itself has operations responsibility and authority to administer its Medicaid Program in accordance with State program policy and within SRS Federal Regulations and Implementing Methods and Procedures.

In addition to the SNF Life Safety Code waiver and IMR plans of compliance functions, we also have the responsibility, on a post-certification basis, for the montioring and surveillance of the State's survey and certification action related to long term care facilities. Our monitoring and surveillance is to confirm whether the State Survey Agnecy has surveyed and certified a facility in accordance with Federal Regulations and such methods and procedures as may be established by SRS and the single State agency.

Our responsibility with respect to Medicaid SNF and ICF agreements is to monitor the validity of the single State agency's execution of its provider agreements against the conditions and provisions of the regulations and such methods and procedures as may be prescribed by SRS.

Our primary function with respect to Title XIX SNFs and ICFs is to assure that the State Title XIX SNF and ICF program is being administered in accordance with the Federal Regulations. This is done through on-site validation surveys, and review of certification records or other reports which may be required.

David Watson, Director
Office of Long-term Care
Social and Rehabilitation Service
Region VII
Health Environment & Welfare

STATE OF KANSAS

ROBERT F. BENNETT, *Governor*

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

State Office Building
TOPEKA, KANSAS 66612

ROBERT C. HARDER, *Secretary*

Division of Vocational Rehabilitation

Division of Social Services

Division of Mental Health and Retardation

Division of Children and Youth

Division of Administrative Services

Alcohol and Drug Abuse Section

State Office Economic Opportunity

FACT SHEET

NURSING HOME PROGRAM

PRESENTED TO SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

June 24, 1976

MI-1074

June 24, 1976

Kansas Medicaid Nursing Home Program

Definitions of Types of Care:

Skilled Care
24-hour, 7 days a week, professional nursing supervision, R.N. or L.P.N.

Intermediate Care
Professional nursing services 7 days a week on the day shift.

Kinds of Inspections:

State Licensing Inspection
By State Department of Health and Environment or local health department.

Certification Inspection
Federal requirement for participation in the Title XIX program. Essentially the same as licensing inspection. Measurement is against federal standards. Performed by State Department of Health and Environment under contract from the State Department of Social and Rehabilitation Services.

Medical Reviews of Skilled Nursing Homes
Independent Professional Reviews of Intermediate Care Facilities
Federally required inspections which are essentially the same. A yearly patient-oriented review of only Title XIX recipients. A team from SRS, consisting of a nurse, a social worker, and if necessary, an M.D., reviews to see if patient needs and care they are receiving and if they are receiving all the care they require.

Utilization Review
Federally required periodic review to ensure proper medical placements of patients.

Skilled Care Facility Utilization Review - at least every 30 days.
Intermediate Care Facility Utilization Review - at least every 6 months.

Institutional Intermediate Care Facility

Kansas Neurological Institute
Winfield State Hospital
Norton State Hospital
Parsons State Hospital

1,650 Recipients Mentally Retarded
As of June 1976

Approximately $5,000,000

Facilities Participating in Medicaid Program

Skilled - 52

Intermediate - 327

June 24, 1976

Kansas Medicaid Nursing Home Program

Cost Formula

Nursing home facilities' rates were established by allocating their reported costs into four major cost centers: administration, property, room and board, and health care. To the administration (exclusive of owners' compensation an amount was added to adjust costs on a historical inflated basis to the end of the reporting period and a factor was added for estimated inflation. The Consumer Price Index was used as the basis for determining the appropriate increase in the historical inflation rate. An annualized factor equal to a 6% yearly inflation rate was added for estimated inflation. Administrators' and co-administrators' salaries were added together, not inflated, and limited to the 90th percentile of administrators' and co-administrators' salaries, which is $1.16 per patient day. The total per day limit was established at the 75th percentile. Costs in the individual cost centers were allowed up to the 75th percentile.

A factor was included in the rates of facilities which were below the total per day limit to reflect minimum wage increases which were not reported in the costs. The minimum wage is calculated on a scale based on the facility's fiscal year end.

An efficiency factor was added to the rate of all facilities whose allowable costs were below the average allowable cost for their type of care. The reported allowable average cost for skilled nursing facilities is $16.63 and $11.46 for intermediate care. The efficiency factor is 25% of the difference between the cost and the average.

Facilities which did not timely submit cost information were assigned the lowest rate for the type of care at which the facility is certified. The lowest rate for skilled nursing facilities is $14.84 and $8.91 for intermediate care facilities.

June 24, 1976

FY76 Nursing Home Rate Analysis

1. Of the 52 skilled nursing facilities, 12 are at the maximum rate of $21.61 and of the 327 intermediate care facilities, 65 are at the maximum rate of $14.55.

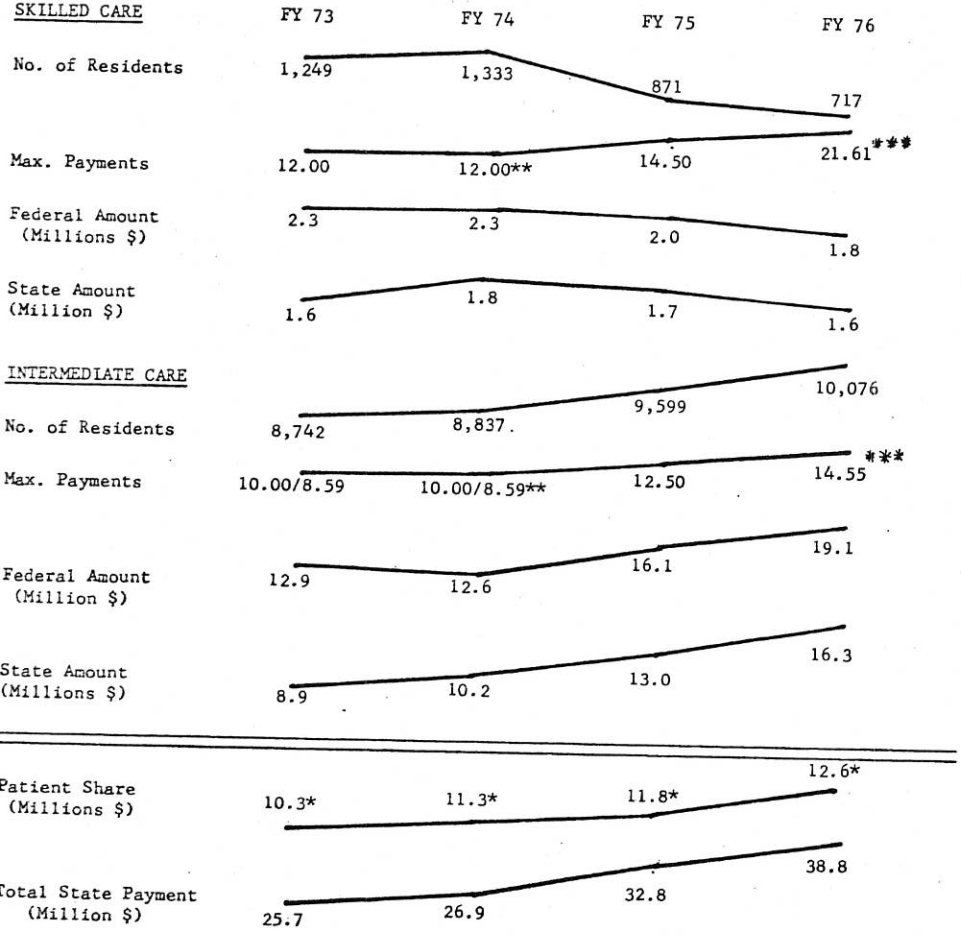
2. There are now "0" skilled nursing facilities receiving the lowest rate of $14.84 and "3" intermediate care facilities receiving the lowest rate of $8.91.

3. The average skilled nursing facility rate is $18.45 and the average intermediate care facility rate is $13.13.

June 24, 1976

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
DEPARTMENT OF SOCIAL SERVICES

FACT SHEET
NURSING HOME PROGRAM



* Estimated
** Increased by .75 per patient day 5-1-74 - 12.75 SNF 10.76/9.34 ICF
** Increased to 20.77 SNF 13.71 ICF from 16.63 SNF 12.98 ICF 12-1-75
Increased .84 per patient day 1-1-76 to 21.61 SNF 14.55 ICF

Skilled Nursing Facilities and Intermediate Care Facilities

	Skilled Nursing Facilities			Intermediate Care Facilities			Skilled Nursing Facilities and Intermediate Care Facilities		
	Persons	Expenditures	Avg. Per Person	Persons	Expenditures	Avg. Per Person	Persons	Expenditures	Avg. Per Person
July 1974	1,304	373,131	286.14	8,884	2,074,584	233.52	10,188	2,447,715	240.25
August	1,179	348,517	295.60	8,975	2,174,819	242.32	10,154	2,523,336	248.51
September	1,125	324,932	288.83	8,942	2,160,097	241.57	10,067	2,485,029	246.85
October	1,044	320,157	306.66	9,203	2,410,966	261.98	10,247	2,731,123	266.53
November	1,039	333,392	320.88	9,214	2,525,225	274.06	10,253	2,858,617	278.81
December	1,034	310,618	300.40	9,293	2,455,735	264.26	10,327	2,766,353	267.88
January 1975	993	327,488	329.80	9,084	2,484,229	273.47	10,077	2,811,717	279.02
February	947	298,240	315.99	9,281	2,613,059	281.55	10,228	2,912,299	284.74
March	906	258,864	285.72	9,143	2,263,210	247.53	10,049	2,522,074	250.98
April	900	300,969	334.41	9,219	2,636,801	286.01	10,119	2,937,770	290.32
May	917	281,978	307.50	9,545	2,610,440	273.49	10,462	2,892,418	276.47
June	871	273,597	314.12	9,599	2,725,270	283.91	10,470	2,998,867	286.42
FY 1975 Total	12,259	3,752,883	306.13	110,382	29,134,435	263.94	122,641	32,887,318	268.16
July 1975	869	266,981.75	307.23	9,563	2,613,679.67	273.31	10,432	2,880,661.42	276.14
August	826	284,535.34	344.47	9,712	2,793,368.39	287.62	10,538	3,077,903.73	292.08
September	815	283,831.36	348.26	9,756	2,827,571.65	289.83	10,571	3,111,403.01	294.33
October	802	274,545.37	342.33	9,850	2,734,919.60	277.66	10,652	3,009,464.97	282.53
November	754	264,558.30	350.87	9,858	2,819,010.17	285.96	10,612	3,083,568.47	290.57
December	731	238,026.37	325.62	9,733	2,701,503.60	277.56	10,464	2,939,529.97	280.92
January 1976	727	284,998.94	392.02	9,932	2,927,467.76	294.75	10,659	3,212,466.70	301.39
February	737	299,191.42	405.96	9,959	3,197,183.19	321.03	10,696	3,496,374.61	326.89
March	729	271,685.32	372.68	10,091	3,030,363.98	300.30	10,820	3,302,049.30	305.18
April	759	318,547.55	419.69	10,122	3,269,362.07	323.00	10,881	3,587,909.62	329.74
May	739	296,183.68	400.79	10,107	3,115,992.56	308.30	10,846	3,412,176.24	314.60
June*	722	303,138.73	419.85	10,167	3,284,090.61	323.01	10,889	3,587,229.34	329.43
FY 1976 Total*	9,210	3,386,224.13	367.66	118,850	35,314,513.25	297.13	128,060	38,700,737.38	302.20

*Estimated pending final data.

STATE BY STATE RATE COMPARISON

		SKILLED NURSING FACILITIES						INTERMEDIATE CARE FACILITIES							
		OCTOBER 1974		AUGUST 1975		APRIL 1976		OCTOBER 1974		AUGUST 1975		APRIL 1976			
	TYPE OF PAYMENT	CEILING LIMIT	AVERAGE LIMIT	CEILING LIMIT	AVERAGE LIMIT	CEILING LIMIT	AVERAGE LIMIT	CEILING LIMIT	AVERAGE LIMIT	CEILING LIMIT	AVERAGE LIMIT	CEILING LIMIT	AVERAGE LIMIT	ADD-ONS	PROJECTED COSTS OF COMPLIANCE
KANSAS	Cost-Related	14.50	12.51	16.63	14.37	21.61	17.61	12.50	9.49	12.98	10.88	14.55	12.29	Oxygen	No
COLORADO	Cost-Related	14.99	14.99	16.60	*	17.70	*	14.99	13.81	16.60	*	17.70	*	None	No
IOWA	Cost-Related	-----	-----	N/A	32.27	N/A	** 35.80	14.79	13.24	19.00	14.00	19.00	17.30	None	No
MISSOURI	Cost-Related Flat Fee	N/A	12.89	N/A	15.50	18.70	16.01	14.30	11.84	N/A	15.00	17.20	14.84	None	No
NEBRASKA	Flat Fee	15.62	15.62	16.93	16.93	17.00	17.00	13.15	11.11	13.97	11.01	14.00	12.00	Oxygen (excessive use)	No
OKLAHOMA	Cost-Related Flat Fee	15.12	12.49	16.11	13.48	17.00	*	12.49	11.51	13.48	13.15	15.00	*	Oxygen IV's Catheters	No

* Not available at time of survey.

** Relates to Medicare reimbursement formula.

Attachment H

Wes Worthington - Mound City, KS.

TITLE XIX - COST REIMBURSEMENT (85% OCCUPANCY FACTOR)

At the June 1 hearing on the Title XX program, Bill Newman (SRS) brought to light four proposed changes affecting nursing homes in the Title XIX program. One of these proposed changes is as follows:

> The Department of SRS in computing cost reimbursement for a nursing home will use the 85% occupancy level for a new facility in its second year of operation if a facility did not come up to the 85% occupancy.

NEW FACILITIES ARE ALREADY BEING PENALIZED

The SRS reimbursement formula already has a ceiling on the property cost center which is $3.11 per patient day whereas new facilities are running property costs in excess of $5.00 per patient day. The ceiling on the property cost center penalizes new facilities and results in their being reimbursed less than actual costs. The 85% occupancy factor would be an additional penalty.

We recommend a check be made with the Department of Health and Environment concerning the following:

> Number of Nursing Homes closed
>
> Number of Nursing Home Beds closed
>
> Number of Nursing Homes now out of compliance with Title XIX
>
> Number of Nursing Home Beds now out of compliance with Title XIX

We recommend that the 85% occupancy factor not be implemented at this time to give the H.S.A.'s an opportunity to control the building of new Nursing Homes.

The recommendation to use the 85% occupancy is unreasonable and arbitrary. It would result in the Nursing Homes receiving considerable less than what it cost to deliver these services. We recommend that the 85% occupancy factor be deleted from the proposed changes affecting Title XIX reimbursement for nursing homes.

Thursday 24 June 1976

FIRE - Ronake, Virginia Nursing Home. Four Killed.

THIS WAS NOT A NURSING HOME

Local newspapers reported it was a nursing home. It was not a nursing but was a multi-level (six story) apartment building. According to Louise Spiral, Commonwealth of Virginia Welfare Licensing Specialist for Ronake area, the home was for persons who are aged, infirmed and disabled but do not require nursing care.

Kansas Health Care Association supports legislation to extend fire safety regulations which nursing homes must operate under to also cover elderly residential boarding homes.

TITLE XX PROGRAM

We support the rehabilitative objectives of the Title XX Program. However, we are concerned about the Department of Social and Rehabilitative Services (State Welfare Department) using sub-standard housing facilities as Boarding Homes under the Title XX Program. (Some of these facilities were nursing homes that no longer meet licensure standards.) As one HEW official put it, "These places are unfit to be lived in and some are firetraps".

We have recommended that the licensure and inspection of Title XX Boarding Homes (Certified Adult Residential Homes) be under the Department of Health and Environment, Adult Care Home Section. We feel that this is necessary to assure the Title XX recipients sanitary living standards and adequate fire safety standards.

TITLE XX BOARDING HOMES - FIRE HAZARD

A Chicago facility that burned to the ground and claimed several patients lives was a Title XX facility. When that sort of tragedy occurs (in Kansas), it will be called a nursing home fire. People who are not informed will blame the nursing home profession instead of the bureaucracy.

The Department of SRS intends to move residents out of the certified licensed nursing homes that meet State and Federal Standards and relocate them in Title XX Boarding Homes.

TITLE XX BOARDING HOMES

Carol Vining, a newspaper reporter, made the following comment concerning Title XX Boarding Homes: THE FEDERAL REHABILITATION SECTION IS BEING SYSTEMATICALLY SUBVERTED BY THE STATE WELFARE BUREAUCRACY IN AN EFFORT TO PINCH SRS PENNIES.

TITLE XX BOARDING HOMES/CERTIFIED RESIDENTIAL CARE HOMES

The SRS proposal for Title XX Boarding Homes as it is presently written does not provide for inspection of these facilities to assure the residents of safe sanitary living conditions. There are no provisions for reviewing residents to see if they need any other level of care. The present proposal as written prohibits medical services from being provided in Title XX Boarding Homes. Medical supervision and services are prohibited. These Boarding Homes have lower standards than did the old nursing homes we have been trying to get rid of for the past ten years.

TITLE XX FACILITY REVIEW
Boarding Home/Certified Residential Care Homes

The Title XX Boarding Homes periodic review consists of reviewing the annual application sent to the Department of SRS. On sight reviews are conducted only when deemed necessary by the Department of SRS.

INTERVIEW WITH LOCAL COUNTY WELFARE WORKER
Question: Do you go out and review the Title XX Boarding Homes periodically to see if they are meeting the requirements?
Answer: The same way we used to do nursing homes.

The Title XX Boarding Homes promoted by SRS receive less monitoring and regulation than did the old substandard nursing homes that we have been trying to eliminate for the past ten years.

TITLE XX FUNDING

The Federal Government provides 75% of the funding in the Title XX program which makes it a very attractive program for the states to get involved in. However, it was not the intent of Congress for the states to use this money to promote and subsidize substandard living conditions. (See Moss report)

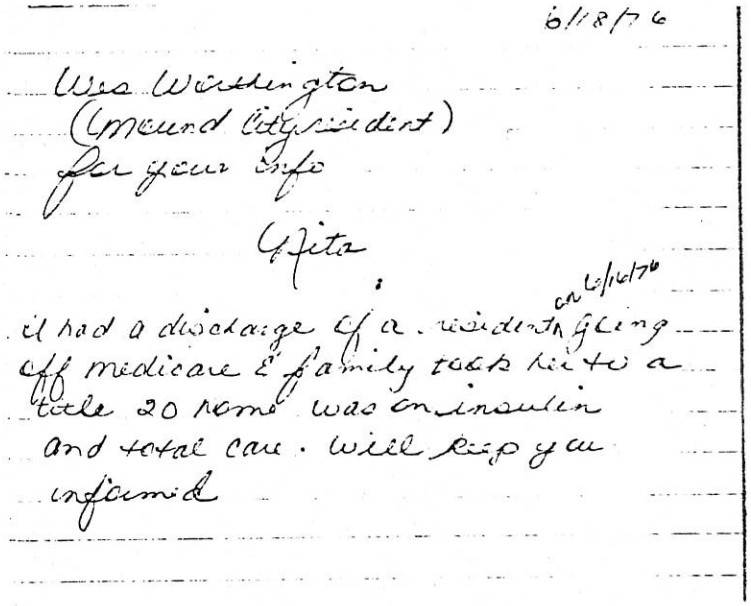
TITLE XX

Phyllis Henney, Kansas Department of Social & Rehabilitative Services, states that they intend to work on depopulating nursing homes of about 50% of their residents and place them in Title XX Boarding Homes.

Example 1: A licensed nursing home in Wichita, Kansas, declined to readmit a patient to their facility after the patient had been in the hospital because they felt that the patient needed a higher level of care than they provided. The patient was later taken to a Title XX Boarding Home.

Example 2: Mr. Bob Blume, a nursing home administrator, told me that he recently had a phone call from his pharmacist who had taken medication to a Title XX Boarding Home where they were keeping their medications in a wall cupboard and were also administering oxygen to one of their residents on a regular basis.

Example 3:


6/18/76

Was Washington
(Mound City resident)
for your info

Gita

it had a discharge of a resident on 6/16/76 going
off medicare & family took her to a
title 20 home was on insulin
and total care. will keep you
informed

TITLE XX

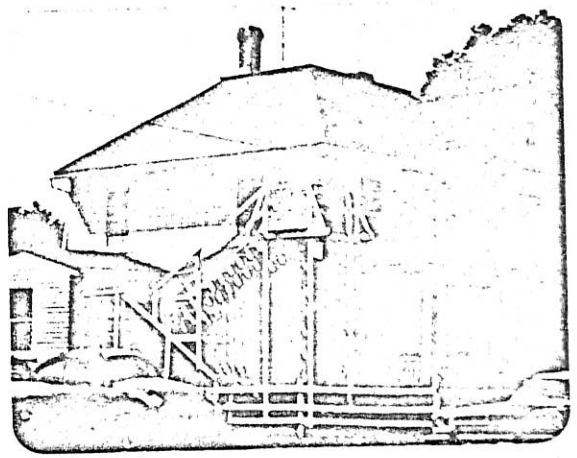
PLACEMENT OF PATIENTS IN SUBSTANDARD BOARDING HOMES

Phyllis Henney, Kansas Department of Social & Rehabilitative Services, states that they intend to work on depopulating nursing homes of about 50% of their residents and place them in Title XX Boarding Homes.

Two patients were dismissed from a Medicare facility (Holiday Manor, Osawatomie, Kansas) and were taken directly to a boarding home. One of these patients had recently had hip surgery and was in need of skilled care but wound up in a Boarding Home.

One gentleman had a stroke in the Boarding Home, went to the hospital, and was taken back to the Boarding Home. His relatives felt that he needed better care and tried to get him into the Holiday Manor Nursing Home at Osawatomie but were unable to get him released from the Boarding Home.

Mr. Bob Bloom, Nursing Home Administrator in Winfield gave me the following information. Sadie Daras Boarding Home in Winfield is giving medications listed in the Federal Control Substance Regulations (Tranquilizers and Narcotics) and has patients using indwelling catheters.



Photograph of Boarding Home in Paola, Kansas
Taken June 13, 1976

R - Mental Retardation A - Alcohol Abuse
H - Mental Health D - Drug Abuse
P - Cerebral Palsy

REPORT OF REINTEGRATION CLIENTS IN
CERTIFIED ADULT RESIDENTIAL HOMES
AS OF APRIL 31, 1976

OMES - CHANUTE AREA	#LEVEL	TYPE-CAP.		VACANCIES	REINTEGRATION CLIENTS Former 7-1-74 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Moved to Ind.Living Apr.
reen Acres Residential Home . R. #4 redonia, Kansas 66735 316) 378-2040	I	MH/MR	49	18	9	0	9	1	0
OMES - EMPORIA AREA									
e Care, Inc. 18 Exchange mporia, Kansas 66801 316) 342-5963	II	MR	15	1	1	0	1	0	0
OMES - GARDEN CITY AREA									
w Chance, Inc. 14 Military odge City, Kansas 67801 316) 225-0476									
314 Military	III	A	14	2	3	2	5	0	0
603 Avenue C	III	A	14	1	0	0	0	0	0
ioneer Home ox 48 akin, Kansas 67860 316) 355-6212	II	MH/MR	26	2	3	0	3	1	0
OMES - HAYS AREA									
mer B. Reed Adjustment & Training Center 7 West 13th Street ys, Kansas 67601 13) 625-2522					15		15		
Prairie Developmental Center									
Atwood									
105 So. Page	III	MR	10	0	6	0	6	1	0
400 No. 2nd	III	MR	15	4	0	0	0	0	0
Hays									
527 W. 15th	III	MR	12	0	3	0	3	0	0
403 W. 8th	III	MR	6	1	4	0	4	1	0

MR - Mental Retardation A - Alcohol Abuse
MH - Mental Health D - Drug Abuse
CP - Cerebral Palsy

REPORT OF REINTEGRATION CLIENTS IN
CERTIFIED ADULT RESIDENTIAL HOMES
AS OF APRIL 31, 1976

HOMES - HAYS AREA (Continued)	#LEVEL	TYPE-CAP.		VACANCIES	REINTEGRATION CLIENTS Former 7-1-74 to 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Moved to Ind.Living Apr.
Homer B. Reed Adjustment & Training Center (Continued)									
Hays									
107 E. 7th	III	MR	12	0	2	0	2	0	0
807 Walnut	III	MR	7	1	2	0	2	0	0
518 W. 21st	III	MR	14	0	6	0	6	0	0
1401 Oak	III	MR	10	0	6	0	6	0	0
80 Ash	III	MR	12	1	7	1	8	0	0
1705 Elm	III	MR	13	0	3	0	3	0	0
Borum Residential Home 892 Eighth Phillipsburg, Kansas 67611 (913) 543-5116	II	MH/MR	15	4	0	0	0	0	0
HOMES - HIAWATHA AREA									
Hubener Ranch Home R. R. #1 Hoyt, Kansas 66440 (913) 986-6347	II	MH	15	0	2	0	2	0	0
HOMES - HUTCHINSON AREA									
Reno Occupational Center, Inc. 127 East Avenue B Hutchinson, Kansas (316) 663-1596									
Plum House 500 East Avenue A	II	MR	11	1	8	0	8	0	0
Westblade Care Home 131 N. Second Lindsborg, Kansas (913) 227-2712	II	MR	8	2	3	0	3	1	0

REPORT OF REINTEGRATION CLIENTS IN CERTIFIED ADULT RESIDENTIAL HOMES AS OF APRIL 31, 1976

OMES - HUTCHINSON AREA (Continued)	#LEVEL	TYPE-CAP.	VACAN-CIES	REINTEGRATION CLIENTS Former 7-1-74 to 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Moved to Ind.Living Apr.
eadowlark Homestead, Inc. ox 703 ewton, Kansas 67114 316) 283-2570								
Meadowlark Rural Campus Home Box 703	III	MH 26	2	4	2	6	0	0
Cottage Grove Box 703	II	MH 5	0	0	0	0	0	0
id-Kansas Developmental Disab. ox 467 ewton, Kansas 67114 316) 283-2400								
Leisy House 303 E. 24th	III	MR 8	0	9	0	9	0	0
irror, Inc. 22 W. 1st Street ewton, Kansas 67114 316) 283-6743								
F.A.R.M. House 122 W. 1st Street	II	D 8	3	0	1	1	0	0
OMES - JUNCTION CITY AREA								
ig Lakes Developmental Center 30-A Poyntz Avenue anhattan, Kansas 66502 913) 776-9201								
304 So. Washington Junction City	III	MR 7	0	2	0	2	0	0
415 Leavenworth Manhattan	III	MR 6	0	1	1	2	0	0
infrey Residential Center 015 Colorado anhattan, Kansas 66502 913) 537-0930	I	MH/MR 7	4	4	0	4	1	0
ary's Residential Home 03 N. 6th t. Marys, Kansas 66563 913) 437-2219	I	MH/MR 4	2	0	0	0	0	0

REPORT OF REINTEGRATION CLIENTS IN CERTIFIED ADULT RESIDENTIAL HOMES AS OF APRIL 31, 1976

HOMES - JUNCTION CITY AREA (Continued)	#LEVEL	TYPE-CAP.	VACAN-CIES	REINTEGRATION CLIENTS Former 7-1-74 to 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Moved to Ind.Living Apr.
Day's Residential Home 712 Oak Wamego, Kansas 66547 (913) 456-9300	I	MH/MR 5	0	1	1	2	0	0
HOMES - OLATHE AREA								
Leavenworth County Assn. for the Handicapped 426 Miami Leavenworth, Kansas (913) 651-6810								
Residential Home for Men 615 North Esplanade	II	MR 8	0	17	0	17	0	0
Residential Home for Women 723 Miami	II	MR 4	0	1	0	1	0	0
Cedar House, Inc. 107 W. Cedar Olathe, Kansas 66061 (913) 782-3662								
Cedar House 107 W. Cedar	III	MH 14	4	52	3	55	4	3
Cedar House Annex 101 W. Cedar	III	MH 6	2	8	2	10	3	1
Johnson County Mental Retardation Center 5900 Flint Street Shawnee, Kansas 66203 (913) 268-8400								
Cloverleaf Apartments 6127 Marty Lane Overland Park	II	MR 6	0	0	0	0	0	0
Co-resident Apartments 10000 Camino Royal Merriam	III	MR 20	13	0	0	0	0	0
Dorfman House 6306 W. 57th Mission	II	MR 10	0	0	0	0	0	0
Flint Hall	III	MR 21	0	12	0	12	0	0

MR - Mental Retardation A - Alcohol Abuse
MH - Mental Health D - Drug Abuse
CP - C[illegible]al Palsy

REPORT OF REINTEGRATION CLIENTS IN
CERTIFIED ADULT RESIDENTIAL HOMES
AS OF APRIL 31, 1976

HOMES - OSAWATOMIE AREA	#LEVEL	TYPE-CAP.	VACANCIES	REINTEGRATION CLIENTS Former 7-1-74 to 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Apr.
George and Betty Sell Homes 726 S. Cedar Ottawa, Kansas 66067 (913) 242-5650								
Ottawa Cedar House 307 S. Cedar	II	MR 6	2	2	0	2	0	0
Mrs. Likes Home 221 E. Third	II	MR 15	0	3	0	3	0	0
Our Home 726 S. Cedar	II	MR 20	1	21	0	21	0	0
Vinco Manor 604 S. Cedar	II	MR 15	0	11	0	11	0	0
Willowbranch 604 S. Willow	II	MR 3	2	0	0	0	0	0
HOMES - PARSONS AREA								
Freda Residential Center 810 Galena Avenue Galena, Kansas 66739 (316) 783-1366	II	MR 14	3	5	0	5	1	0
Greenlawn Residential Center 311 E. 7th Galena, Kansas 66739 (316) 783-1368	III	MR 15	0	1	0	1	0	0
HOMES - PITTSBURG AREA								
Kinder Residential Home 310 W. 10th Pittsburg, Kansas 66762 (316) 231-2436	I	MH/MR 2	1	1	0	1	0	0
Marcum Adult Residential Home 605 E. Perry Arma, Kansas 66712 (316) 347-4263	I	MH/MR 3		0			0	

MR - Mental Retardation A - Alcohol Abuse
MH - Mental Health D - Drug Abuse
CP - Cerebral Palsy

REPORT OF REINTEGRATION CLIENTS IN
CERTIFIED ADULT RESIDENTIAL HOMES
AS OF APRIL 31, 1976

HOMES - PITTSBURG AREA (Continued)	#LEVEL	TYPE-CAP.	VACANCIES	REINTEGRATION CLIENTS Former 7-1-74 to 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Apr.
SEKAN Comprehensive Mental Health Services, Inc. Crawford County Halfway House for Alcoholics 5th floor, Professional Bldg. Independence, Kansas 67301 (316) 331-0444								
Crawford County Halfway House for Alcoholics 609 E. Seventh Street Pittsburg, Kansas 66762	III	A 22	19	1	0	1	0	0
HOMES - PRATT AREA								
Chikaskia Area Training Center, Inc. Box 201 Medicine Lodge, Kansas 67104 (316) 886-3333								
816 No. Oak	II	MR 8	2	3	0	3	2	0
HOMES - SALINA AREA								
Continuing Care, Inc. P. O. Box 1975 Wichita, Kansas 67201 (316) 262-0177								
Salina Crawford Home 660 S. 2nd Street	III	MR 14	0	9	0	9	0	0
Salina Manor 134 N. 9th Street	III	MR 15	0	6	0	6	0	0
Santa Fe Apartments 726 S. Santa Fe	III	MR 12	2	10	0	10	0	0
Republic Valley Home(Bates) Republic, Kansas 66964 (913) 361-4164	II	MR 15	7	7	2	9	0	0
Smith Residential Center 660 So. Santa Fe Salina, Kansas 67401 (913) 823-3645	II	MH/MR 15	0	2	0	2	0	0

R - Mental Retardation A - Alcohol Abuse
H - Mental Health D - Drug Abuse
P - Cerebral Palsy

REPORT OF REINTEGRATION CLIENTS IN
CERTIFIED ADULT RESIDENTIAL HOMES
AS OF APRIL 31, 1976

OMES - TOPEKA AREA	#LEVEL	TYPE-CAP.		VACAN-CIES	REINTEGRATION CLIENTS Former 7-1-74 to 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Apr.
ottonwood, Inc. 801 West 31st awrence, Kansas 66044 913) 842-0550									
Cottonwood House 2421 W. 31st	III	MR	8	0	5	0	5	0	0
Bess Stone Home 745 Ohio	III	MR	7	0	8	0	8	0	0
South Ridge Apartment Living 1704 W. 24th Street	III	MR	9	0	19	0	19	4	3
Whitcomb Home 645 Connecticut	III	MR	9	0	11	0	11	4	0
entral Plains Comprehensive Drug Rehab.Center, Inc. ox 19087 opeka, Kansas 66619 913) 862-0108									
2826 Baker Drive	III	D	12	4	0	0	0	0	0
2828 Baker Drive	III	D	14	6	0	0	0	0	0
2830 Baker Drive	III	D	12	4	0	0	0	0	0
elp Unite Human Relations,Inc. 16 Lane opeka, Kansas 66604 913) 233-5571	III	CP	5	0	2	0	2	0	0
ospitality House 035 No. Monroe opeka, Kansas 913) 235-0791	II	MH	15	0	11	1	12	0	0
orthside Residential Home 023 Eugene opeka, Kansas 66608 913) 234-6588	II	MH/MR	15	2	7	2	9	0	0
heltered Living, Inc. 216 Fillmore opeka, Kansas 66604 913) 357-4198									
1216 Fillmore	III	MR	12	2	2	1	3	0	0
501 Buchanan	II	MR	9	1	4	0	4	0	0

MR - Mental Retardation A - Alcohol Abuse
MH - Mental Health D - Drug Abuse
CP - Cerebral Palsy

REPORT OF REINTEGRATION CLIENTS IN
CERTIFIED ADULT RESIDENTIAL HOMES
AS OF APRIL 31, 1976

HOMES - TOPEKA AREA (Continued)	#LEVEL	TYPE-CAP.		VACAN-CIES	REINTEGRATION CLIENTS Former 7-1-74 to 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Apr.
Sheltered Living, Inc. (Continued)									
Apartment #1 2045 MacVicar	III	MR	3	0	0	0	0	0	0
Apartment #2 5200 W. 20th St. Terr.	III	MR	3	0	0	3	3	0	0
HOMES - WICHITA AREA									
Pennington's Residential Home 8401 N. Broadway Valley Center, Kansas 67147 (316) 755-1921	III	MH/MR	20	1	14	1	15	0	0
Cerebral Palsy Research Foundation, Inc. 4320 E. Kellogg Wichita, Kansas 67218 (316) 683-5627									
El Dorado Ranch Residential Center Rt. #1	III	CP	12	0	0	0	0	0	0
Respite Care Center Rt. #1	III	CP	15		0			0	
Wichita Urban Residential Center 1515 Bleckley	III	CP	6	0	0	0	0	0	0
Companion Way 631 W. 47th Street South Wichita, Kansas 67217 (316) 524-0192	III	MH/MR	15	2	7	0	7	0	0
Continuing Care, Inc. P. O. Box 19[illegible] Wichita, Kansas 67201 (316) 262-0177									
Broadway Manor 1002 South Broadway	III	MR	12	1	5	0	5	0	0
Rebecca House 1838 Wellington Place	III	MR	12	5	2	2	4	0	0
Dee's Inc. 320 E. Central Wichita, Kansas 67202	III	A	40	11	0	0	0	0	0

REPORT OF REINTEGRATION CLIENTS IN
CERTIFIED ADULT RESIDENTIAL HOMES
AS OF APRIL 31, 1976

OMES - WICHITA AREA (Continued)	#LEVEL	TYPE-CAP.		VACANCIES	REINTEGRATION CLIENTS Former 7-1-74 to 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Apr.
risco's Retreat 830 E. 13th ichita, Kansas 316) 686-5875									
1411 N. Erie	III	MR	7	1	6	0	6	0	0
2830 E. 13th	III	MR	8	0	2	0	2	0	0
ansas Alcoholic Rehab. Centers, Inc. formerly Wichita Fellowship Club) 04 W. 18th ichita, Kansas 67203 316) 265-9348									
Alcoholism Rehab. Ranch Rt. #4, Box 164-A Arkansas City, Kansas	III	A	65	0	0	0	0	0	0
Kansas Elks Training Center 619 South Maize Road Wichita, Kansas 67209 (316) 722-1551									
Small Teaching-Parent Homes Coop. 619 South Maize Road	III	MR	100	25	29	3	32	0	0
Mid-Way, Inc. Sedgwick County Assn. for Mental Health 2708 E. Central, Suite A Wichita, Kansas 67214 (316) 268-8251									
301 N. Ash	III	MH	8	1	29	1	30	6	0
303 N. Ash	III	MH	7	3	7	0	7	2	0
1117 N. Market	III	MH	8	2	5	0	5	3	0
Sears Residential Home 2673 S. Holyoke Wichita, Kansas 67210 (316) 685-7102	III	MH/MR	5	3	0	0	0	0	0

REPORT OF REINTEGRATION CLIENTS IN
CERTIFIED ADULT RESIDENTIAL HOMES
AS OF APRIL 31, 1976

HOMES - WINFIELD AREA	#LEVEL	TYPE-CAP.		VACANCIES	REINTEGRATION CLIENTS Former 7-1-74 to 3-31-76	Add'l. Apr.	Total	Moved to Ind.Living Former	Apr.
Terramara, Inc. 2375 West Central El Dorado, Kansas 67042 (316) 321-1660									
Clayton Home 417 Houser Drive	III	MR	3	0	4	0	4	0	0
Dickson Home 617 W. 1st	III	MR	3	0	4	0	4	0	0
Crescent Home 1315 Crescent Drive	III	MR	3	1	2	0	2	0	0
Lawndale Home #1 1634 Lawndale	III	MR	3	0	4	0	4	0	0
Lawndale Home #2 1636 Lawndale	III	MR	3	1	1	0	1	0	0
Lawndale Home #3 1644 Lawndale	III	MR	3	2	0	0	0	0	0
88 HOMES TOTAL				1,128	185	466	29	495	35	7

#Refer to forms SA-4003 Social Services Plan and SA-4006 Fee Schedule

Summary of Vacancies by Type of Home

Mental Retardation	82
Mental Health	14
Mental Health/Mental Retardation	39
Cerebral Palsy	0
Alcohol Abuse	33
Drug Abuse	17

Senator Sowers, Representative Walker and members of the committee: thank you for allowing our organization, Kansans for the Improvement of Nursing Homes, this time to speak to you about proposal no. 32. We do not speak for ourselves alone, but for probably one hundred thousand Kansas citizens, as we are supported by some very large groups, for instance: the National Retired Teachers, the American Association of Retired Persons, the Kansas Association for Retarded Citizens, and others.

Our organization has two objectives, primarily. The first is, to get the facts about nursing homes before the public. We, the public, have family members in nursing homes; we, the public, will go to nursing homes if we live long enough; we, the public, help to pay for over half the residents in Kansas nursing homes with our tax money. So we, the public, have a right to know the truth and to make it known.

Our second and equally important objective is to speak for the residents of Kansas nursing homes,--to act as their advocate.

We are not concerned with getting along with state agencies or with the nursing home professionals. We must tell the truth as we see it, and if the facts alienate an agency or the nursing home profession, that cannot be helped. If we are shown to be in error on any question of fact, we will apologize. But if we hurt some one's feelings by telling the truth, too bad.

I will outline briefly the KINH position on the KDHE rules and regulations.

First, we feel there is little point in having regulations for adult care homes if no one knows about them,--not the aides who are caring for the residents, not the residents, and not the families and friends of the residents.

We ask that the basic regulations on care of the residents be extracted from the rest, and be put onto a large placard in large print, and posted on the wall of every nursing home lobby in Kansas. The cost would be small, the benefits immense. We also ask that leaflets containing these basic regulations be available in every doctor's office, every health department, every church and every library.

The way things have been up to now, ninety-nine percent of the people of Kansas don't even know there <u>are</u> any regulations. They don't even know what agency is responsible for monitoring and licensing nursing homes.

The value of the KDHE regulations, no matter how excellent, is vitiated if no one is going to see them except KDHE, some thirty-five county health departments, and the nursing home professionals.

And KINH also feels that regulations are useless if they cannot be enforced. We think that licensure and certification of Kansas nursing homes is a large and important task. So we ask that KDHE appoint one qualified health professional whose sole responsibility would be just this: the licensure and certification of nursing homes. If it is done as it should be done, it would certainly be a full-time job.

NH feels that ignorance of the law is not a valid excuse. If you are stopped for speeding, you are not given two--or four--or six weeks to correct this deficiency in your driving. You get a ticket, and generally, you pay the fine. That's the way it should be, and that's the way it is.

So KINH suggests that when a nursing home is in violation of a state regulation, a ticket should be issued at once and generally, a fine should be paid.

If the nursing home is given two weeks--or four weeks--or six weeks--to correct that deficiency, that means that for two weeks--or four weeks--or six weeks-- the residents have no social activity program,--or sleep in filthy sheets,--or have insufficient meals. Leniency to the nursing home operator means misery for the residents.

When we are stopped for speeding, it is duly reported in the local newspaper. But isn't it more important for the public to know that such and such a nursing home is in violation of such and such a state ordinance? KINH feels that all such violations should be reported to the media as a matter of course. If this is not done, the public's right to know is being overlooked.

And our last point about regulations is this: if our new state regulations contain all the Federal regulations plus any that KDHE wishes to add, Kansas taxpayers will save a mint of money. The way things are now, either there are two separate inspections of a home by two different area nurses from KDHE, or there are two

separate inspections by the same area nurse from KDHE, one being for licensure and one for certification.

Obviously, this is a waste of time and money. One inspection would accomplish both licensure and certification for Federal regulations (this last being necessary for a home to accept Medicaid residents, and so far as we can find out, there is no nursing home in the state which is licensed but not certified).

Inserts

KINH feels that these are most reasonable requests and that if they are met, everyone would benefit: all residents of Kansas nursing homes, and all citizens of Kansas.

We understand that the new regulations will call for the KDHE aide training program, which Sessa Branson will discuss.

We are fortunate in having a young lady who worked for six months as an aide in a nursing home recently, here with us today, should the members of the committee care to ask her any questions.

KINH hopes that the new regs will sharply delineate an aide's proper duties: whether she is to cater to occupy her time catup for the residents, who so desperately need it, or whether she must fill a great part of her time with laundry and ~~trying~~ to cleaning Sunday messes off the floors. This is an aura of chaos and confusion at present.

Attachment J

June 24, 1976

To: Members of Interim Committee
on Health and Welfare

From: Jessie Branson, Member
Steering Committee for Kansans for
Improvement of Nursing Homes

Re: Adult Care Home Study

KINH wishes to report on our studies during the past year and to identify areas of concern which relate to the level of care in adult care homes in our state.

STUDIES CONDUCTED by KINH members during the past year -

1) Monitoring -

a) Conducted a three-day tour in one area of the state with eight counties involved. 14 adult care homes and one "residential home" were monitored.

b) Conducted a two-day tour in another area of the state with four counties involved. 10 adult care homes and two "residential homes" were monitored.

c) Three adult care homes in two counties were monitored at other times during the year.

General findings from monitoring activities -

A total of 27 homes were monitored. Some were homes on which we had received complaints; the remainder, approximately half, were picked at random. Entrance was refused at one adult care home. Conditions varied considerably. Four of the adult care homes could best be described as a horror, with numerous violations and inadequacies cited in facility, staffing and program. Some homes appeared clean or new but were lacking in program. Most were lacking in rehabilitation programs (except "on paper"). Some homes were in a state of disrepair. In our judgement two adult care homes appeared exceptionally well run, well staffed, well supervised, and the programs (including dietary) were for the most part adequate, and the facility was clean and attractive both interior and exterior.

2) County Health Department Visits -

Nurses and/or Health Officers in 12 County Health Departments were interviewed and questioned about the homes in their respective counties. Four of the HD's are "participating" counties.

3) Input from members of KINH and from citizen organizations which are supporting members of KINH

4) Communication with state agencies -

KINH has corresponded with and has held conferences with various state agency personnel including KSDHE, SRS, The Ombudsman, Assistants to the Attorney General, and Voc Ed. State agency personnel have been invited to participate in and to speak at KINH meetings. Federal agency personnel has also been conferred with and invited to participate in our meetings.

AREAS OF CONCERN

1) Aide Training

KINH is pleased that the SDHE has developed and will be presenting to the legislature for approval a proposal for aide training. We support, in particular, the following recommendations included in the proposal:

a) The curriculum

b) Designation of the State Department of Education as the responsible agency for administering the program

c) Designation of Registered Nurse as teachers of the course

KINH would urge, however, that the Health Department be sufficiently staffed to monitor compliance by adult care homes in the required aide training program.

2) Revision of State Regulations

(See Mrs. Cerf's recommendation)

Need for one inspection for licensing and certification. Much confusion over the overlapping of the existing two inspections.

3) Need for sufficient Health Department staff - Local and State -

In at least four local, participating County Health Depts. we have been informed by the Public Health Nurses responsible that:

a) there is not sufficient staff to make needed interim visits to the homes and to report on these visits

b) when they do follow up on complaints, make an interim visit and find the complaint justified, and file a report with the State HD, there is no response and no support from the State

c) there is little or no communication with the State

d) some participating local HD's have lost interest in checking on nursing homes because of the lack of cooperation with the State

4) Inappropriate placements

We are finding increasing numbers of mentally retarded and mentally ill (not geriatric) residents in adult care homes. Increasing numbers of these individuals released from state institutions are being placed in adult care homes. Rarely have we found programs suited to their needs - a sheltered workshop or work activity program in the community. Personnel in adult care homes are not trained for the care of these individuals. KIMH feels strongly that such inappropriate placements are an injustice to both the mentally handicapped and to the geriatric residents living in these homes.

In addition we are seeing the development in communities the so-called "residential homes" where mentally handicapped are housed. In several instances we have found these homes to be old, run-down, two-story frame houses , and the staff and community programs inadequate to meet the needs of these individuals.

5) Mechanism for dealing with homes in which violations occur and persist