Kansas Legislative Research Department   October 11, 1976

M I N U T E S

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

September 22-23, 1976

Members Present

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

Staff Present

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

Others Present

Jack Roberts, Blue Cross-Blue Shield, Topeka
Pauline Bork, Department of Health and Environment, Topeka
Harriet Nehring, Kansans for the Improvement of Nursing Homes, Lawrence
Jessie Branson, Kansans for the Improvement of Nursing Homes, Lawrence
Katie Pyle, Kansans for the Improvement of Nursing Homes, Topeka
Carl Hawkins, Department of Social and Rehabilitation Services, Topeka
Robert Harder, Department of Social and Rehabilitation Services, Topeka
William Newman, Department of Social and Rehabilitation Services, Topeka
C. Blume, Department of Social and Rehabilitation Services, Topeka
Jack J. Shandy, Mid America Nursing Centers, Wichita
Charles Wurth, Mid America Nursing Centers, Wichita
Larry Fischer, Kansas Health Care Association, Coffeyville
Wes Worthington, Kansas Health Care Association, Mound City
Judy Runnels, Kansas State Nurses Association, Topeka
Doug Johnson, Kansas Pharmaceutical Association, Topeka
Gary Quick, Good Samaritan, Hays
Stewart Entz, Kansas Association of Homes for the Aging, Topeka
David Slack, Presbyterian Manors, Lawrence
Ken Keller, Good Samaritan, Hays
Rodney Gage, ALAFERN, Russell
James Mankin, Department of Health and Environment, Topeka
Richard Swanson, Department of Health and Environment, Topeka
Richard Priestly, Department of Health and Environment, Topeka
Donna Tarbutton, Kansas State Nurses Association, Maple Hill
Shirley Edgerton, Kansas State Nurses Association, Eskridge
Gary Robbins, Kansas State Nurses Association, Topeka
Linda Passmark, Department of Family and Child Development, Kansas State University, Manhattan
Richard Brown, Kansas Health Care Association, Topeka
John Jones, Kansas Public Nursing Home Administrators Association, Kansas City
John Hood, ACNHA, Lenexa
Jerry Slaughter, Kansas Medical Society, Topeka
Elizabeth Carlson, Board of Healing Arts, Topeka

Others Present (cont'd)

Ruth C. Dickinson, State Planning and Research, Topeka
Roberta D. Thiry, Kansas State Nurses Association, Lawrence
Marvin H. Ewart, Bethel Home for Aged, Newton
Mary J. Wiersma, Kansas Farm Bureau, Manhattan
Carl Schmitthenner, Kansas Dental Association, Topeka
Lowell Wiese, M.D., Department of Health and Environment, Topeka

September 22, 1976

The meeting was called to order at 10:00 a.m. by the Chairman, Senator Wesley H. Sowers. After Committee discussion, the minutes of the July 14 and 15 meeting were corrected to change the spelling of the name of the first person in the list of those in attendance and to make an editorial change on page 8. A motion was made and seconded to approve the minutes of the July 14 and 15 meeting as amended. Motion carried.

Subcommittee Report. Representatives Mike Johnson and Sharon Hess reported on visits to adult care homes which had been made subsequent to the July meeting.

Representative Johnson noted that surveyors feel they would have better cooperation from nursing home administrators if: (a) they could visit the homes more frequently so the evaluation became more than policing; (b) they received copies of the reports sent by the Departments of Social and Rehabilitation Services and Health and Environment to nursing home administrators; (c) they were not in the position of asking administrators to meet federal requirements for special services when they are not in need of such specialists; and (d) they could notify the administrator when they would be at the home to check the paper work.

Representative Johnson noted that the administrators of the homes he visited stated the 50¢ co-pay for prescriptions was not the problem they had thought it would be.

Representative Hess noted the surveyor she accompanied also felt visiting the homes only once a year creates a problem although a nurse from the Wichita - Sedgwick County Health Department makes follow-up visits. There are some federal regulations the public health nurse cannot enforce because of inconsistencies between state and federal regulations. Representative Hess stated the administrator pointed out the following problems: getting qualified aides; aide's wages; difficulty in getting residents involved in activities; an allegation that some families or guardians are keeping the $25.00 pass-through personal funds which Medicaid patients should receive; publicity about a very few bad homes reflecting on the total industry; the low daily rate paid by the state; and the need for training in geriatrics for home administrators. The surveyor felt that administrators or owners are willing to spend money to comply with regulations but they also have to work with a board of directors and are responsible to investors. She also expressed the belief there is a need for more aide training in the psychology of handling older people, and for aides, nurses and physicians in geriatrics.

Representative Johnson presented the following suggestions for consideration: (1) state rules and regulations to be the same as federal rules and regulations; (2) consider further the problem of complying with patient-staff ratios, especially on the 11:00 p.m. to 7:00 a.m. shift; and (3) announcing the visit to review the home's records, but make an unannounced visit for the rest of the inspection.

In answer to a question, Dick Swanson, Department of Health and Environment, stated that for the Medicaid Survey, staff in the Department put information and comments from the form filled out by the surveyor on a sheet which is sent to the home administrator. This sheet is not sent to the surveyor until just before the next visit. After discussion, Mr. Swanson agreed to initiate a procedure to mail the sheet to the surveyor at the time it is sent to the administrator.

In answer to a question, Mr. Swanson stated that if a home is not in compliance, the time lapse before another visit is made depends on the deficiency and the plan submitted by the home to correct it.

Proposal No. 32 - Nursing Homes

Mrs. Jessie Branson, Kansans for the Improvement of Nursing Homes, presented a written statement relating to site visits. (Attachment A) In answer to a question, she stated they had not sent a copy of this report to the Department of Health and Environment or the Department of Social and Rehabilitation Services but they would do so.

Dr. Mankin, Department of Health and Environment, presented a written report on the hearing on proposed rules and regulations for the licensure of adult care homes and a summary of proposed changes. (Attachment B) In answer to a question, he stated the state regulations are more specific than federal regulations and include some additional requirements such as staffing ratios and aide training requirements.

Larry Fischer, Kansas Health Care Association, referred to the packet of material given to the Committee previously, noting the Association is in the process of updating the fiscal impact statement showing the effect of the proposed rules and regulations. He noted the difficulty of estimating the fiscal impact of requiring aide training since some aides will have taken other courses, some will test out, and some will complete the training prior to employment.

In answer to a question, Department of Health and Environment staff stated they do not have sufficient personnel to make visits in a timely manner or to provide help and consultation to homes.

Mrs. Petey Cerf, Kansans for the Improvement of Nursing Homes, presented a written statement, "Suggestions for Raising the Level of Care in Kansas Nursing Homes." (Attachment C)

The meeting recessed for lunch at 12:20 and was reconvened by the Chairman at 1:45 p.m.

Dr. Mankin, in response to KINH suggestions, stated the Department supports the concept of a fine system but feel they also need the provisional license to cover some special cases. Licensure reports are available in accordance with the law, and certification reports are available in the local Social and Rehabilitation office. Only four local health departments do total inspections. Others participate to some extent. Some have elected not to participate. Publishing deficiencies in the newspaper is a sensitive point and indications are that even bad publicity does not affect the occupancy rate in a home.

In answer to a question, staff noted HB 2702, authorizing the Department of Health and Environment to levy fines against nursing homes, was held in the House Public Health and Welfare Committee primarily because of the procedural sections of the bill.

Stewart Entz, Kansas Association of Homes for the Aging, made the following points: (1) a Senate Committee has issued a report (Moss Report) suggesting deleting federal regulations as they now exist; (2) rules and regulations tend to follow a medical model and tend to ignore the social component of care which should also be given consideration; (3) changes in rules and regulations do have an impact on the cost of care, which must be charged to the resident, the state, or the federal government; (4) the industry needs to develop a good common accounting system; and (5) before any changes are made, consideration needs to be given to the impact on the patient as well as the impact on the state.

In answer to a question, Mr. Entz stated staffing patterns, staff training provisions, and physical facility requirements have a direct impact on patient costs. Few facility requirements increase the cost of new construction.

Mr. Entz made the following remarks in answer to questions. An advisory council to the Department of Health and Environment would be helpful in establishing ongoing communication and in developing workable solutions to short and long-range problems. A fine system is good in theory, but the cost may have to be passed on to the resident. Once the state has established the level of care to be provided and is willing to pay for this level of care, then it is reasonable to say homes must be in compliance. There has to be an incentive for compliance. Mr. Entz noted he did not feel that reducing the six-month period for a provisional license would improve patient care and would not take into account the time it takes to comply after being cited.

Charles Wurth, Mid America Nursing Center, stated he is in agreement with the proposed aide training requirements but is concerned over implementation which will decrease an already small job market. He suggested the home have the option of offering the course if their instructor and setting are approved by the Department of Education. Self-instruction under proper supervision and testing is another alternative to consider. Supervision by the nurse for whom the aide will be working has advantages and should be considered for the clinical part of the training.

Dr. Mankin and Mr. Swanson reviewed the implementation program stressing aides can test out the flexibility of the program and the fact that if an aide has signed up for a course within three months after starting work, the responsibility is then on the program to provide the training.

In answer to a question, Mr. Wurth stated he felt both a fine system and a provisional license system were needed.

David Slack, Presbyterian Manor, Lawrence, Kansas, stated the Manors are nonprofit homes funded by charges to residents and gifts. Only 10 percent of those in the Newton home receive Medicaid. Their charge to a resident for ICF care on a semi-private basis is $510. Their cost is $528. The difference is covered by gifts. Medicaid pays $15.64 per day but their cost is $17.33 per day. The for-profit home has to make up this difference from profits. He noted that a 10¢ increase in the minimum wage would cost each of their residents $10.00 per month. He recommended a cost-related reimbursement which would be different for each type patient or care.

Dr. Robert Harder, Department of Social and Rehabilitation Services, stated, in answer to a question, that implementing the staffing regulations could have a significant impact on Medicaid costs. At the Chairman's request, Dr. Harder will send the Committee a memo outlining the cost projections. (Attachment D)

In answer to a question, Dr. Harder stated the Department conducts periodical medical reviews and utilization reviews. As of July 1, 1976, the medical review staff was increased to 27 for a total caseload of 10,000 to 10,500.

In answer to questions, Dr. Harder stated that federal regulations state a facility must arrange for services needed by a patient. If the facility cannot arrange for these services they cannot accept the patient or they must transfer the patient. Most homes can live within these guidelines. Two types of specialist services are offered -- (1) consultation or training to staff and (2) direct service to the patient. The first is a valid cost and is reflected in the daily rate.

In answer to a question, Dr. Harder stated that at the present time there is no provision for reducing payments to homes with a provisional license. If a fine is imposed and the certification remains valid, it would probably not be a problem. However, a fine implies noncompliance. He stated the Department could send an inquiry regarding this to the regional office of HEW.

Wes Worthington, Kansas Health Care Association, presented a written statement concerning the Title XX program. (Attachment E)

Dr. Harder pointed out that Title XIX is a medical program and Title XX is a social service program. The federal government will not pay for medical services under the Title XX program, and this program does not require aides with a medical background or nurses. The Department does not have a policy to "depopulate" nursing homes. Their policy is to work with the individual in finding the setting most appropriate for him. However, the individual makes his own choice insofar as he can. There is a larger match for the Title XX program but there is a top limit on the federal funds allocated to the state, unlike Medicaid.

Larry Fischer, Kansas Health Care Association, expressed concern about a solution to the problem of pass-through costs and the problem of getting people to the proper level of care. He suggested the Committee consider defining "reasonable charges" to give SRS the latitude to make pass-through provisions. He also suggested that Title XX homes be required to meet the Life Safety Code requirements.

O.J. Jones, Kansas Health Care Association, suggested the following as an alternative incentive for compliance, "Give a home 60 days to comply and, if they fail to do so, withdraw the provider number so the home cannot receive payments for Medicaid patients."

Referring to the chart attached to the KINH statement (Attachment A), a Committee member stated he was interested in having the Department of Health and Environment compare this chart with the surveyor's reports for these homes and show this comparison on a chart. Mrs. Branson agreed to provide the Department with the names of the homes. The Chairman suggested that Representative Littlejohn follow through on this with Mr. Swanson.

Shirley Edgerton, Kansas State Nurses Association, briefly outlined their concerns relative to nursing care in nursing homes. The Chairman asked her to prepare a written statement and send it to the Committee.

Gary Robbins, Kansas State Nurses Association, stated they support the concept of an advisory council for nursing homes. He also noted they are looking at how gerontology can be put into nurse training programs.

The meeting was adjourned at 4:00 p.m.

September 23, 1976

The meeting was called to order by the Chairman.

Minutes. A motion was made and seconded to approve the minutes of the August meeting. The motion carried.

Proposal No. 32 - Adult Care Homes

Marvin H. Ewart, Bethel Home for the Aged, Newton, Kansas, presented a written statement outlining the projected cost to their home to comply with the aide training regulations. (Attachment F) He suggested Medicaid reimbursement be made on the same basis as for hospitals. He noted that payment at the 75th percentile penalizes homes doing a good job.

Dr. Lowell Wiese, Department of Health and Environment, presented facts relative to present training and the proposed aide training noting the cost to the home is about the same for each program.

In answer to questions, Dr. Wiese stated they have notified homes they will not penalize them for insufficient aides if some are taking an aide training course. The Department of Education may have to offer the course for less than ten people in some parts of the state.

Proposal No. 33 - Medically Underserved Areas

The Chairman noted the handouts given to the Committee. (Attachments G,H,I)

Mary Wiersma and Representative Littlejohn reported on the "Health Days" in Kansas City and Wichita noting communities learned they need to put together a better package and the importance of talking to wives.

The Chairman summarized suggestions which had been made to help solve the problem of maldistribution of health care providers as follows:

I. Consider mandating collection of data that will be valuable in determining need. Such data to be on a computer.

II. Consider ways to encourage providers to go to underserved rural areas.

   A. Scholarship or loan forgiveness program.

   B. Students who agree to serve in an underserved area for a specified period be charged a normal tuition. Others to be charged the full cost to the state which is about $20,000 per year.

   C. University of Guadalajara program which does not give an MD degree until the person has served in an underserved area for a specified time be adopted.

   D. Offer the first 50 slots in primary care specialties to those coming from underserved areas with special consideration given to those agreeing to return to such areas.

   E. Lower admission requirements.

III. Consider more fiscal support for primary care residencies by funding additional slots or by decreasing the number of specialty residencies and increasing the number of primary care residencies.

IV. Encourage implementation of the Farm Bureau program which has been carried out in Illinois with some success.

Dr. Wiese, Department of Health and Environment, stated he felt it would be best not to enact any laws now because of the changes being made by the Medical School and the newness of the HSAs. He suggested a legislative recommendation for more aggressive recruitment programs.

In answer to a question, Dr. Wiese stated emphasis can be put on primary care programs but it should not be done at the expense of the specialty departments. In the discussion it was noted that the Medical School probably should be moving toward more slots for family practice leaving enough slots in the specialties and subspecialties for depth. Teaching should be geared toward the needs of students, both family practice and specialties. If the emphasis is to be on students going to rural areas to practice, then students should be recruited from these areas.

In answer to a question about the development of training programs for ancillary care, Dr. Wiese stated they are working on a program proposal in this area. It was noted that the Kansas Medical Society, Kansas State Nurses Association and the universities offering physician extender programs have not been included in the development of this proposal.

Dr. Wiese noted some states are taking steps to allow people such as nurse practitioners more independence. He also noted that some medical schools have reduced the pre-med program to three years and some have gone to a six-year program combining pre-med and medical school and offering only an MD degree.

The Committee recessed for lunch at 12:10 p.m. and the Chairman reconvened the meeting at 1:45 p.m.

A motion was made and seconded directing staff to draft a bill incorporating the concept of 1975 SB 355, updating language as necessary, making the medical and osteopathic allotments interchangeable if not used by the specified group, synchronizing the date money is available with the date students are eligible for admission, and limiting the bill to three years. The motion carried. After discussion, the consensus was to leave the maximum amount at $6,000 for the present.

A motion was made and seconded directing staff to draft a resolution recommending that for a limited time the KU Medical School give special consideration in recruitment and admissions to the size community a student is from (such consideration to favor rural areas) and that the Medical School notify schools of the addition of this criteria. Motion carried.

A motion was made directing staff to draft a resolution urging the Medical School to expand recruitment and placement programs including providing information and consultation to communities and urging them to draw upon information from other agencies, with specific mention of KDED. The motion was seconded and carried.

The Chairman noted that the Farm Bureau will have a progress report on their proposed scholarship program for the Committee by November 1. Comments about the program can be included in the Committee report.

He also noted Dr. Wiese had told him the Department of Health and Environment would accept the responsibility for working with Drs. Kugel, Dykes and Reed to reach an agreement on a data program. The Department will be willing to undertake and incorporate such data collection in their computer program. A motion was made and seconded that Dr. Wiese be asked to report promptly to the Committee staff the data base agreed on and that staff be directed to draft a resolution recommending the establishment of this data collection program by the Department of Health and Environment, including an outline of the data base agreed on. Motion carried.

A motion was made and seconded directing staff to draft a resolution recommending that primary consideration be given to funding residencies in primary care (family practice, general internal medicine, general pediatrics, and general OB/GYN) with a goal of 50 percent of state-funded residencies being in primary care. The motion carried.

A motion was made and seconded directing staff to draft a resolution urging the Medical School to consider the feasibility of shortening the pre-med program or of combining the pre-med and medical school program into a six academic year program offering an MD degree. The motion carried.

Developing a model rural health center as suggested in paragraph ten of Dr. Dykes letter was discussed. A motion was made and seconded directing staff to draft a resolution commending the Medical School for taking steps to develop a model rural health center to be used for family practice residents and as a site for continuing education programs and urging them to develop this program as outlined in paragraph ten of Dr. Dykes letter. The motion carried.

Reference was made to Vol. II of Dr. Jack Walker's report dealing with legislation for health services and a plan to establish regional health centers. Consideration was given to urging HSAs to undertake the development of regional health centers as a part of their task.

Staff was asked to draft a Committee report based on Committee minutes. Specific points to be included are: extending the use of ancillary personnel along with a need to clarify their role; inclusion of ancillary personnel in third party payments; substantial testimony indicated few communities are doing a good job of recruitment; outline of changes that need to take place to develop an effective recruitment program such as a change in community attitudes; note that testimony indicates doctors will probably not go into solo practice in small communities.

Proposal No. 34 - Safe Drinking Water Act

Staff reported the Department of Health and Environment recommends the Kansas statutes be amended to comply with the federal requirements in order that the state qualify to administer safe drinking water standards. This would mean a better program with less state funding than would be necessary if the state does not comply. Staff noted that if the state does not administer this program, the federal regulations will still be applicable.

Staff was instructed to draft a bill for Committee consideration showing the amendments necessary for compliance.

October Meeting

The next meeting of the Committee will be October 13 and 14, 1976. Adult care homes will be discussed on October 13.

By consensus the Chairman is to ask the Legislative Coordinating Council for permission to meet on November 3 and 4.

The meeting was adjourned at 3:10 p.m.

Prepared by Emalene Correll

Approved by Committee on:

10/14/76
date

Attachment A

NURSING HOME CARE IN KANSAS

STATEMENT TO LEGISLATIVE COMMITTEE ON HEALTH AND WELFARE

Progress Report on Monitoring

By Kansans for Improvement of Nursing Homes

September 22, 1976

In April, 1976, Kansans for Improvement of Nursing Homes, the Committee on Monitoring, launched a project to carry out site visits on nursing homes in selected areas of the state. The purpose of the project is to make on-site observations of conditions which exist, to determine quality of care, and to report findings to responsible state officials and to the legislature.

To date, a total of 26 nursing homes have been visited. Trips have been made to South Central, Southwest, Southeast, and North Central Kansas. KINH received complaints on approximately 50% of the homes visited; the remainder were selected at random.

On each visit the team consists of two or three members of KINH. The chairman of the Monitoring Committee, a registered nurse, participates in each visit.

Visits are unannounced. Upon arrival a request is made to speak with the administrator and/or the director of nursing. Members of the monitoring team identify themselves and the organization (KINH), and describe the purpose of KINH. Questionnaires are used, and additional comments and observations are recorded. In addition to the administrator and/or the director of nursing, team members also visit with aides and other employees and with the residents and their relatives whenever possible.

Entrance beyond the administrator's office was refused in one home - the home which required the greatest travelling distance and about which the greatest number of complaints had been received. In four homes a satisfactory assessment could not be made due to lack of cooperation by the administrator.

Findings in the KINH study thus far indicate that there is an alarmingly high percentage of nursing homes in Kansas which fail to meet minimal standards of acceptability by concerned citizens. We believe that this should be cause for deep concern to those charged with the public trust of protecting our citizens against such abuses.

Please refer to the attached chart which documents findings of the KINH survey to date.

NOTE:

1a = Administrator refused to allow tour of facility or to give any information

2a = Administrator answered limited number questions about home, evaded questions, and prevented a satisfactory tour of home

? = Unable to determine

xx = particularly severe deficiency

Complaints - Complaints are screened: nurses - local PHN, KINH members who are nurses; multiple complaints from family, employees, etc. on a given home; legislator; health professionals

VIOLATIONS and DEFICIENCIES - please see pages 3 and 4 for numbered list

SUMMARY

KINH believes that findings to date from the monitoring endeavor have been extremely enlightening. These findings, documented in the chart attached, reflect patterns in deficiencies as well as a high incidence of deficiencies and violations. The findings indicate that the following are critical points of concern:

1) Lack of adequate inspection and enforcement -

   a) Of 26 homes monitored - 4 homes with 10 or more deficiencies or violations - all 4 homes under full licensure and certification

   b) Of 26 homes monitored - 7 homes with 6 to 10 deficiencies or violations - all under full licensure and certification

2) Nurse aide problem - understaffing, under paid, not trained

3) Inappropriate placement of non-geriatric mentally handicapped in nursing homes

4) Lack of rehabilitation programs

5) Lack of space and equipment for rehabilitation programs and other services

6) Physician problem - lack of participation

7) Administrator problem - lack of competent administration

VIOLATIONS AND DEFICIENCIES

Following is a list of violations and deficiencies observed and recorded. The numbers at left correspond with those under the heading VIOLATIONS and DEFICIENCIES on the chart. Each column checked on the chart indicates that one or more of the deficiencies included in the corresponding category was cited.

1) Dirty - dirt and litter on floors; soiled linen on floors; dirty, dusty, scurry bedside tables and bed frames; wax build-up on floors and counters; dirty walls; soiled woodwork, especially around doorways; bathrooms dirty - stench - smudges of feces on walls/floor

2) Call bells lacking, not within reach, or present only for a few residents; hand bells, whistles, etc. used in lieu of push buttons; call bells not working

3) Patients "hanging out" of geriatric chairs; not aligned or well positioned in geriatric chairs, beds; periods of time in geriatric chairs too lengthy; ambulatory (non-geriatric MI) restrained to room; resident (MR) restrained in chair with strips of sheets

4) Strong urine odor - upon entrance, in hallways, in residents' rooms, worst in bathrooms

5) Unemptied urinals, bed pans, commodes with stale, concentrated urine on bedside tables, floors of residents' rooms and bathrooms; unemptied bedpans with feces on bed or bedside chair

6) Facility and equipment in state of disrepair - faucets leaking, window shades stained, torn; cupboard doors hanging loose; floor tiles loose; privacy screens lacking or not working; construction flaws (floors bumpy, not level, hazardous, etc.); walls, woodwork, trim in need of repair, paint

7) Facility dreary, drab, dark, rooms dingy; exterior of building unattractive; grounds unattractive, littered, very few or no plantings; not pleasantly situated

8) Unsatisfactory, inconvenient floor plan or arrangement of rooms, wings; converted from old school building or other old building with additions of wings to old parts, etc. narrow hallways; no toilets or lavatories in or connected to residents' rooms

9) Service rooms and equipment inadequate/non-existent - service rooms too small; P.T. room non-existent; activity room non-existent; P.T./activity rooms poorly equipped or not equipped; P.T. room not used; service rooms combined - dirty/clean laundry, dirty/clean linen, dirty/clean utility, utility/ laundry/janitor, P.T./activity, P.T./storage of wheel chairs, walkers, etc., linen closet/storage of wheel chairs, walkers, etc.; Oxygen tanks stored in various service rooms

10) Very limited or no rehabilitative program

11) Physician problem - difficulty getting physicians to visit routinely or for emergencies; nurses write orders; "P.A." used (qualified??) for perscriptions; nurse talks to physician on 'phone in lieu of physician making required Medicaid, Medicare visit

12) Beds untidy, soiled; residents appear not well groomed or clean

13) Food unappetizing; trays with cold, stale food sitting at bedside

14) No drinking water at bedsides

15) Nurse aide problem - not enough aides, aides appear rushed; not supervised; poorly paid; untrained; high turnover; untrained aides giving medications; not well groomed; unprofessional

16) Residents generally appear sluggish, drowsy, in stupor - over drugging? or appear generally very subdued

17) Administrator problem - administrator confused, unable to answer questions; disorganized; complains of being overworked; not licensed; co-administrators; administrator bitter toward owner, unhappy; long absences

18) Fire exits barred; fire safety questioned; narrow hallways; no sprinkler system

19) Charges extra fees over flat rates for services such as feeding, bathing, bed care

20) Uses aides for laundry

21) Uses MR/MI residents for laundry, kitchen work, etc. without paying

22) Scanty supply of wash cloths, towels or soap in bath-rooms, at bedsides; short supply linens in linen room

KINH MONITORING STUDY

DATA								VIOLATIONS								DEFICIENCIES																
HOME	Type Home	No. Beds	No. Medic-aid	Approx. No. MR/MI	Chain	Complaints	[illegible] lic./cert.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Total	[illegible]	
	S	100	80	?			yes							X	XX	X	X	X		X		X			X	X				[illegible]		
B	I	45	35	4-9			yes	X	X		X		X			X	X	X			X	X		X						10		
C	I	100/76	52	3	X		yes									X	X	X		X		X							X	6		
D	S?	50	14	4-9			yes									X	X	X				X								4		
E	I	100/60	35	20+	X	X	Prov.								X	X	X	X				XX		X						6		
F	I	50	25	25		X	yes	X	X	X	XX	XX	X	X	X	X	XX	X	X	X	X	XX				X	X	X	X	19		
G	I	60	36	6-8			yes											X									X			2		
H	I	81	81	81		X	Prov.	X	X	X			X	XX	XX	X	XX	X	X	X	X	X			XXX		X	X		16		
I	I	50	?	0			yes			X						XX	XX	X				X	X	X						7		
J	I	96/85	26	0	X		yes									X		?			X	X				X				4		
K	I	60	45	5	X		yes	X							X	X	X	X				X						X		7		
L	I	100	55	25	.	X	yes	X	X	X	X	X	X			X	X	X	X	X		XX		X		X		X	X	16		
M	I	64	48	2	X		Prov.						X			X	X	X				X		X						6		
N	I	36	23	5		X	yes		X	X		X			XX	XX	XX	X				X		X	X					10		
O	I	46	42	44	X	X	Prov.		X	X			X	X	X	XX	XX	X		X	X	X	X	X	X			X		15		
P	I	41	?	3			yes									X	X					X		X						4		
Q	I	50	32	1	X		yes				X					XX	X	X				X		X			X			7		
R	I	32	27	4		X	yes		X				X	X	X	XXX	XX	X				X		X	X		X	X	X	13		
S	I	100	50	0?	X	X	yes			X	X					X	X	X				X	X							7		
T	I	53/45	30+	10	X	X	yes		X	X						XX	X	X				X			X					7		
U	I	100/70	60	25	X	X	Prov.	XX			X		X			X	X	X	X	X		XX		XX				X	X	12		
V	S	100			X	X	yes	X						X		X						X		X						5		X
W	I	50	15	1-3			yes															X		X	X	X				4		X
	I	100/40	?	1-3	X		Prov																							0		X
Y	I	46/36	25	?	X	X	Prov															X								1		X
Z	I	49				XX	yes															X		XX						[illegible]		[illegible]

OFFICE COPY
Attachment

DEPARTMENT OF HEALTH AND ENVIRONMENT

Topeka, Kansas

September 13, 1976

MEMORANDUM

TO: Dwight F. Metzler, Secretary

FROM: Joe M. Marshall, Hearing Officer

SUBJECT: Report on Hearing on Proposed Rules and Regulations for the Licensure of Adult Care Homes (28-33-1 through 22, 28-39-30 through 50, 28-39-60 through 75, and 28-39-90).

This hearing began at approximately 11:00 A.M. on September 8, 1976, in the auditorium at the Topeka-Shawnee County Health Department, 1615 West Eighth Street, Topeka, Kansas. There was a total of 123 persons in attendance. Representing the Kansas Department of Health and Environment were Dr. Lowell Wiese, Dr. James Mankin, Mr. Richard Swanson, and Mrs. Patricia Casper.

Several statements were presented orally and/or in writing, many questions were asked, and many comments were made. If there was one main theme of the comments and questions received, it was that the adult care homes would be glad to provide almost any required additional services if they knew that those additional services would be paid for. A recurring question was whether we felt that the Department of Social and Rehabilitation Services would increase their payments to cover the additional costs of new requirements (training for aids, etc.). One Adult Care Home Administrator who is also a C.P.A. supplied detailed cost estimates of those additional requirements.

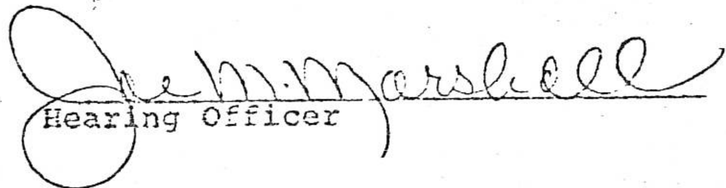
I have listened to the comments made by various interested persons appearing at the hearing and I have reviewed the suggestions offered by representatives of the various groups who met with department staff prior to the hearing. Accordingly, I submit the following recommendations regarding the proposed adult care home regulations as they appear in the draft dated August 12, 1976 and the amended sections dated August 17, 1976.

I recommend that all changes, additions, or modifications to these regulations resulting from meetings with providers

and staff, as described on the attached sheets 1 through 6 and as coded "A", be adopted. I also recommend that those changes coded "B" not be adopted. On sheets 7 through 9 I have made specific recommendations regarding those items coded "B" as well as additional recommendations that resulted from the various comments during the hearing itself. I have not attempted to comment on "housekeeping" changes to clear up inconsistencies, etc. These were noted by staff and will be dealt with accordingly.

I recognize that third party payment may be a controversial element in the adoption and enforcement of some aspects of these regulations. However, it must be kept in mind that the Department as the licensing agency has a primary responsibility to the resident as mandated under K.S.A. 39-924.

Attached at the back of this report is a 4-page booklet containing a resume of comments made by persons who attended the hearing. Clipped to that booklet are written statements submitted to the Hearing Officer at the time of the hearing.



Hearing Officer

JMM:jla

Attachments

A <u>1 (Q) and 30 (P)</u>

The definition of full time changed to "a work week of not less than 30 hours."

A <u>3 (N) and 33 (N)</u>

The first sentence amended to read: "All incoming mail shall be promptly delivered to the resident intact and unopened unless contra-indicated by the resident's physician in writing for medical reasons."

A <u>18 and 46 (A)(1)(h)</u>

First sentence amended to read: "Visual privacy shall be provided for each resident in multi-bed rooms with permanently mounted ceiling hangers and curtains or free-standing folding screens."

A <u>18 and 46 (A)(2)(c)</u>

Delete requirement for nurse's locker room and lounge.

A <u>18 and 46 (A)(2)(e)</u>

Delete requirement for sterilizer in each nursing unit; require at least one sterilizer in each facility unless sterile disposables are used or there is an agreement with a licensed medical facility for sterilization service.

A <u>19 and 47 (A)(23)</u>

Sentence amended to read: "Paper towel dispenser and waste receptacles shall be provided at all handwashing fixtures except those located in resident care areas."

B <u>18 and 46 (K)(2)(o)</u>

Delete requirement for self-dispensing icemaking facilities.

A <u>18 and 46 (L)(1)(f)</u>

Sentence amended to read: "Laundry rooms shall not open onto nursing unit."

A <u>6 (L)(1)(b) and 40 (E)(1)(b)</u>

Sentence amended to read: "The administrator shall be responsible to see that . . . is functioning correctly."

A 30 (S)

Change definition to read: ". . . a person who is licensed to practice practical nursing in Kansas under the Nurse Practice Act."

A 1 (DD)

Change definition to read: "Resident - any person admitted to an adult care home for observation, treatment, or care of illness, disease, injury, or other dependency."

A 1 (K) and 30 (K)

Amend definition of dietitian to read: ". . . a person who has received . . . approved by the American Dietetic Association and is a registered dietitian or is registration eligible, pending successful completion of the examination within a period of one year."

A 1 (V) and 30 (W)

Amend definition to read: ". . . any unlicensed person who has satisfactorily completed a state-approved training program in medication administration."

A 1 (X) and 30 (Y)

Amend definition to read: ". . . any unlicensed person who has satisfactorily completed a state-approved training program for nursing home aides."

A 6 (K)(1)(a) and 40 (D)(1)(a)

Amend to read: "All unlicensed employees who provide direct individual care to residents exclusively or in addition to other duties shall complete a . . . to continue employment."

C 1 (EE) and 30 (FF)

Add following to definition: ". . . or; has satisfactorily completed the Kansas Activity Director's Program."

A 2 (A)(5) and 31 (A)(5)

Amend first sentence to read: "Two copies of final plans and specifications will be submitted to the licensing agency and approval to commence construction will be granted upon review of these documents according to a prearranged time schedule."

A 2 (G)(2) and 31 (G)(2)

Amend first sentence to read: "A notification of a change of administrator received during the term of the license shall be accompanied by a fee of fifteen dollars ($15.00).

A 3 (A)(1)(a) and 33 (A)(1)(a)

Amend sentence to read: "The health care, safety, social, psychological, and self-esteem needs of the resident."

A 3 (B) and 33 (B)

Amend section as follows:

(1) The facility shall have an advisory committee consisting of a physician, a nurse, a religious advisor, and other local citizens who will give advice and counsel to the administrator on matters of resident and community interest.

(2) The committee shall meet as often as necessary but not less than once every six months. Minutes of each meeting shall be kept on file in the facility.

A 3 (E) and 33 (E)

Add the following as (5): "The facility shall not accept or shall discharge a resident requiring, according to attending physician's orders, the services of an unavailable qualified consultant."

C 6 (A)(3)

Amend the sentence to read: "Licensed nursing personnel shall be required for all tours of duty."

C 40 (B)(1)

Amend the sentence to read: "Licensed nursing personnel shall be required during the day tour of duty."

B 6 (A)(7)

Amend the sentence to read: "Resident care provided by resident care personnel shall be a minimum average of 2.0 hours per resident per 24 hours. Resident care personnel shall not include employees whose primary duties are administration, dietary, housekeeping, maintenance, or consultation."

B 40 (B)(2)

Amend the sentence to read: "Resident care provided by resident care personnel shall be a minimum average of 1.75 hours per resident per 24 hours. Resident care personnel shall not include employees whose primary duties are administration, dietary, housekeeping, maintenance, or consultation."

C 6 (A)(6) and 40 (B)(4)

The paragraph shall be amended to read: "The licensing agency, after consultation with the administrator and selected members of the advisory committee to include the health professions membership, may require an increase . . . of the residents."

A 3 (F)(4) and 33 (F)(4)

Amend first sentence to read: "Upon admission or within 48 hours of admission, referral information must be made available."

C 42 (A)(2)

Amend the first sentence to read: ". . . at least quarterly on methods . . ."

C 42 (B)(2)(h)

Amend the sentence to read: "The brand name or corresponding generic name and the distributor's name and the strength unless otherwise specified by the prescriber."

A 14 (A)(1) and 43 (A)(1)

The following shall be added as a third sentence: "All resident records shall be the property of the facility."

A 43 (D)(2)

Omit the following: "In a skilled nursing home."

A 43 (E)

Change all references of "nurse's" to "nursing."

A 17 (B)(2) and 45 (B)(2)

Amend the sentence to read: "A record shall be maintained of each fire drill to include date and number of residents and employees participating in the drill."

A 3 (F)(7) and 33 (F)(7)

Amend first sentence to read: "A resident who becomes mentally disturbed or whose social or medical condition changes after admission and who may . . ."

C 3 (F)(9) and 33 (F)(9)

Change the paragraph to read in part: ". . . in the opinion of the attending physician or the administrator . . ." and "The physician or the administrator must document . . ."

B 3 (J)(23) and 33 (J)(23)

Omit this requirement since it conflicts with the ability to provide "unit dose" medication system.

A 4 (A)(10)

Change the sentence to read: "Every resident's total program of care (including medications and treatments) shall be reviewed, evaluated, and updated as necessary by all professional personnel involved in the care of the resident."

C 6 (K)(1) and 40 (D)(1)

The following shall replace (a) and (b) and will appear under "(1) Education":

> All unlicensed employees who provide direct individual care to residents exclusively or in addition to other duties shall, at the time of being employed, be enrolled in an educational program approved by the Kansas Department of Health and Environment and which shall be conducted in a location by an instructor acceptable to the Kansas Department of Education in order to insure that the aides are capable of rendering high quality nursing care to residents. This training program shall include both didactical and clinical instruction. Each newly employed aide shall complete this course within six months of the date of employment and produce evidence of satisfactorily completing the course of instruction."

A 18 (K)(2)(j) and 46 (K)(2)(j)

Delete words "and storage areas."

A 21 (E)(2)(e) and 49 (E)(2)(e)

Delete the requirement for bedpan flushing devices.

A 2 (B)(3) and 31 (B)(3)

The following shall be a second sentence to this section: "All facilities holding a current license on December 31, 1976, and found to be in compliance with the requirements of the applicable fire safety standards and the American National Standards Institute as they relate to the physically handicapped shall be permanently waivered from compliance with changes in physical plant requirements contained in these regulations if they do not adversely affect in a substantial way the health and safety of the residents."

28-39-6 (K)(1)(a) and 28-39-40 (D)(3)(a)

Delete the following paragraph:

(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 complete the program in order to continue employment.

Substitute the following paragraph:

(a) All unlicensed employees who provide direct individual care to residents exclusively or in addition to other duties shall, within 30 days following employment, be enrolled in the next available educational program approved by the Kansas Department of Health and Environment and which shall be conducted in a location by an instructor acceptable to the Kansas Department of Education in order to insure that the aides are capable of rendering high quality nursing care to residents. This training program shall include both didactical and clinical instruction. Each newly employed aide shall complete this course within six months of the date of beginning the course and produce evidence of satisfactorily completing the course instruction.

28-39-6 (A)(7)

Delete the sentence which reads:

(7) Nursing home aide care for each 24-hour period for each resident shall be a minimum of 2.0 hours.

Substitute the following:

(7) Direct individual resident care provided by resident care personnel shall be a minimum average of 2.0 hours per resident per 24-hour period. Resident care personnel shall not include employees whose primary duties are administration, dietary, housekeeping, maintenance, or consultation.

28-39-40 (B)(2)

Delete the sentence which reads:

(2) Nursing home aide care for each 24-hour period for each resident shall be a minimum of 1.75 hours.

Substitute the following:

(2) Direct individual resident care provided by resident care personnel shall be a minimum average of 1.75 hours per resident per 24-hour period. Resident care personnel shall not include employees whose primary duties are administration, dietary, housekeeping, maintenance, or consultation.

28-39-3 (J)(23) and 28-39-33 (J)(23)

Delete this sentence which reads:

(23) The resident shall have the right to choose his own pharmacy for purchase of medications and where other goods and services for that individual's personal use are to be purchased.

Substitute the following:

(23) The resident shall have the right to choose his own pharmacy where goods and services for personal use are purchased except for prescription medications when the facility provides a "unit dose" or similar medication distribution system.

28-39-40 (B)(1)

Delete the following sentence:

(1) Licensed nursing personnel shall be required during the day tour of each nursing unit.

Substitute the following:

(1) There shall be licensed nursing personnel on duty at each nursing unit during the day tour of duty and a designated "charge person" on duty at all other times.

28-39-3 (P)

Add the following paragraph to this section:

(P) All current regulations under Nursing Services relating to personal hygiene, rehabilitative nursing care, and supervision of resident nutrition shall be posted in a conspicuous location in the facility where they can be observed by both residents and visitors.

28-39-33 (P)

Add the following paragraph to this section:

(P) All current regulations under the section entitled HEALTH SERVICES relating to personal hygiene and the entire section entitled REHABILITATIVE SERVICES shall be posted in a conspicuous location in the facility where they can be observed by both residents and visitors.

PUBLIC HEARING - ADULT CARE HOME LICENSING REGULATIONS

September 8, 1976

Topeka-Shawnee County Department of Health Auditorium

The following is a resume of comments made by persons who attended the hearing. Participants may have commented at various times but their remarks are combined under their name and address.

William Tevington, Kansas City

He submitted a written statement regarding the increase in labor costs and building construction costs that would occur if ICF standards were adopted. He also suggested that regulations allow waiver of new construction requirements if final plans and specifications were approved prior to December 31, 1976.

Clarence Madsen, Hiawatha

He was not familiar with aide training requirements and asked for clarification. No changes were suggested.

Marge Gehring

She questioned the type of exam for experienced aides to "quiz out" and suggested that there be continuing education requirements for aides who become certified, similar to present requirements for RNs and LPNs.

Jeannine Grubbs, Topeka

She questioned the need to make any time requirements regarding physician visits to the facility and suggested that any reference to time frames be deleted and the words "as necessary" substituted.

Marian Weaver, Osawatomie

She suggested that the requirement for an advisory committee is a duplication of effort of "utilization review" committee and should be deleted.

Wes Worthington, Mound City

He questioned whether the state was fully aware that the proposed regulations would increase the cost of resident care and would the Department of Social and Rehabilitation Services be willing to increase Medicaid reimbursement to meet these costs. He also questioned the proposed requirement that the surveyor be given the authority to require an increase in resident care staff if the situation warrants.

Ross Martin, Topeka

He suggested that a definite time frame be included in the regulations for the approval of plans and specifications for proposed projects. He was willing, however, to accept the words "according to a prearranged time schedule" as being satisfactory.

Ferrill Williamson, Wichita

He reiterated the cost impact of the proposed regulations that was brought up by Mr. Worthington.

Jesse Branson, Lawrence

She submitted written recommendations as representing Kansans for Improvement of Nursing Homes. These recommendations are attached. She described the recommendations and put particular emphasis on the following:

(a) KINH suggests that only geriatric mentally retarded persons be admitted to nursing homes.

(b) KINH requests that all deficiencies found by state surveyors be published in a local newspaper.

(c) KINH requests that all rules and regulations relating to resident care be conspiciously posted in the nursing home.

Larry Fischer, Coffeyville

He submitted a written statement regarding the increase in employee costs if health care personnel-resident ratios are adopted and the increase in construction costs if proposed environmental standards are adopted. These written comments are attached.

Thomas C. Wentz, Newton

He supported staff recommendation to include in the designated responsibility of the home "social, psychological, and self-esteem needs of the resident." He questioned the method to be followed by the state in evaluating homes such as his (Presbyterian Manors) which provide various levels of care.

Shirley Edgerton, Eskridge

She submitted a written statement which is attached. In general, her statement suggests the following:

(a) The ICF have a "director of nursing" instead of a "health services supervisor."

(b) The ICF have an RN consultant for eight hours per week in lieu of four hours per week as proposed in regulations when health services supervisor is an LPN.

(c) She suggests ratios to be "health care personnel" instead of just "aides." The inclusion of aides would discourage use of licensed persons.

Kay Kent, Lawrence

She submitted a written statement which is attached. These comments consist primarily of "housekeeping" language, suggestions for clarification of terms, etc. There are no suggestions of fundamental additions or modification.

Petey Cerf, Lawrence

She requested a clear definition of "nurse aide" and that it be required that the nurse aide confine her duties to resident care.

Andrew Johnson, Madison

He suggested that resident's mail be withheld and opened if permission is granted by resident's guardian.

Henry Steinhaus, Prairie Village

He made an oral presentation regarding nursing homes and their ability to meet their responsibility in caring for their residents. The remarks were made to suggest that licensing standards should not set ratios between resident care personnel and residents.

Marion Ewert, Newton

He requested a clarification regarding staff opposition to changes requested by providers in aide training requirements. A discussion with Dr. Wiese resulted in staff approval of change when a minor change of language was made. He also suggested that laundry water temperature requirement be lowered from 180°F. to 160°F. to accommodate no-iron fabrics.

Charles Wurth, Wichita

He made comments regarding the apparent problems connected with the method of training aides as proposed by the Department of Education. He commented on excessive turnover in employment and the possibility of numerous aides being absent from duty during training, etc. He also suggested a further change in wording of aide training requirement that was acceptable to Dr. Wiese. Later he inquired if regulations were contemplated for facilities for the mentally retarded. Staff answered that such regulations were not being proposed.

Stu Entz, Topeka

He continued discussion of wording of aide training requirement which resulted in proposing the following:

6 (K)(1), 40 (D)(1), and 65 (B)(2)(a)

All unlicensed employees who provide direct individual care to residents exclusively or in addition to other duties shall, within 30 days following employment, be enrolled in the next available educational program approved by the Kansas Department of Health and Environment and which shall be conducted in a location by an instructor acceptable to the Kansas Department of Education in order to insure that the aides are capable of rendering high quality nursing care to residents. This training program shall include both didactical and clinical instruction. Each newly employed aide shall complete this course within six months of the date of beginning the course and produce evidence of satisfactorily completing the course instruction.

He also asked if all environmental requirements would be the same for Residential Care Facilities as for Intermediate Care Facilities. Staff answer was "yes." He also expressed publicly appreciation to the Department for the opportunity of all concerned to have the opportunity to review and comment on the proposed regulations.

Harold D. Martin, Mulvane

He asked if the regulations were designed to provide any difference in requirements between a small nursing home (he has a 23-bed facility) and a large home. Staff responded that requirements were the same regardless of capacity.

Attachment

Kansans for Improvement of Nursing Homes

September 22, 1976

SUGGESTIONS FOR RAISING THE LEVEL OF CARE IN KANSAS NURSING HOMES

KINH suggests that raising the level of care in adult care homes (nursing homes) can be effected by:

I. Action by the Legislature
   - A. Establishment of a system of fines for violations of KDHE
   - B. Outlawing Provisional Licenses for nursing homes with deficiencies.

II. Action by the Kansas Medical Society
   Establishment of a plan to insure adequate medical supervision for all nursing home residents.

III. Action by the Kansas Department of Health and Environment to Eliminate Tilt Towards the Nursing Home Industry.
   - A. By adopting KINH suggestions for changes in proposed regulations (see Branson critique of July 13, 1976)
   - B. By informing the news media about violations, naming the offending nursing homes.
   - C. By making licensure reports available to the public in compliance with the law.
   - D. By improving communication with local health departments and improving enforcement of regulations.
   - E. By appointing a qualified health professional whose sole responsibility would be supervision of adult care program.

I. Action by the Legislature

A. Establishment of a system of fines for violation of KDHE regulations. KINH suggests that the Legislature establish a system of graduated fines for violations of KDHE regulations. The importance of such a system to the level of care in nursing homes cannot be exaggerated, as at present KDHE has no tool to compel compliance with regulations other than revocation of the home's license. Because a nursing home cannot be built without a Certificate of Need, precluding any competition in the area, it is generally impossible to find beds for displaced residents without sending them out of county, should a home's license be revoked. Naturally, authorities are reluctant to revoke the license. KINH supports a system of fines as a most necessary tool.

B. Outlawing Provisional Licenses. At present, a nursing home with serious deficiencies may be given a provisional license by KDHE, two concurrent provisional licenses being the limit allowed. KINH feels that provisional licenses encourage substandard conditions. We suggest that they be discontinued, as it is clearly not in the residents' interests to

live under substandard conditions which may endure for as long as a year.

KINH finds no valid excuse for a nursing home to permit substandard conditions. Industry spokesmen may imply that deficiencies cannot be remedied because of the expense involved, but available evidence does not support this contention. (See below: Elimination of tilt towards the nursing home industry.)

II. Action by the Kansas Medical Society.

Establishment of a plan to insure adequate medical supervision for all Kansas nursing home residents. Improving the level of care in Kansas nursing homes calls for a definitive plan of action by the Kansas Medical Society; a plan which is long overdue. The gross lack of medical supervision in nursing homes is both shocking and inexcusable.

III. Action by the Kansas Department of Health and Environment to Eliminatte Tilt Towards the Nursing Home Industry.

KINH finds that all available evidence indicates a healthy financial picture for the nursing home industry.

First, it is not difficult for the owner to spend less per day on each resident than the fee charged per day. In a fifty bed home, saving a dollar a day per resident (the average fee charged being twelve dollars a day) would mean fifteen hundred dollars a month net profit.

Second, the owner may utilize to his advantage the cash flow resulting from the depreciation allowance, and I quote from Dr. David Shulman's "Reorganizing the Nursing Home Industry", section on depreciation and cash flow: "As long as the depreciation is larger than the amortization of principal, the nursing home is generating cash flow in excess of net income. Cash flow can thus be positive even while net income may be negative . . . . our typical nursing home bed generates cash at the rate of 29 cents per dollar of investment. This is considered a very high return in both real estate and non-real estate circles. This high return accounts for the large amount of capital attracted to the industry and thus for the industry's growth."

Third, nursing home ownership may hold interests in the companies from which it obtains goods and services for the homes it controls. The mark-up on these goods and services when sold to the nursing home may be considerably inflated, and may therefor provide another very substantial source of profits to the owners.

It is interesting to note that at least one of the three largest nursing home corporations in Kansas has increased its profits by over forty percent in the last year.

Therefore, KINH finds no reason to tailor the regulations to the industry's demands for fear the industry will wither on the vine. We suggest that KDHE tilt towards the twenty-three thousand nursing home residents who are in need of improved care, and towards all Kansans.

A. By adopting KINH suggestions for changes in proposed regulations (See Branson critique of July 13, 1976)

At the KDHE public hearing on the proposed regulations on September 8th, Mrs. Branson read a KINH statement which summarized suggestions KINH has made in the interests of nursing home residents. To date, KINH suggestions have been ignored, with perhaps one or two minor exceptions, whereas the industry's suggestions have been given much attention by KDHE.

KINH asks: why this tilt towards the industry?

Assuming it is appropriate to ask those who are being regulated for suggestions on the regulations (an assumption some might be reluctant to make), surely consumers' suggestions should carry more weight than the industry's.

The KINH statement of September 8th includes suggestions for:

1) Eliminating the use of ambiguous language to make enforcement possible.
2) Not allowing the admission of non-geriatric, mentally handicapped persons to homes which house geriatric residents (except under carefully stipulated conditions.)
3) Employing the ratio for nursing aide time per resident recommended in the recent Mid-America Health Systems Agency's report.
4) Requiring a "Charge Person" for Intermediate Care Facilities.
5) Not permitting co-administrators, and stipulating the amount of time the administrator is allowed to be away from the home.
6) Posting selected regulations on residents' rights and care, along with the request that observers of violations notify the local health department; name, address and phone number of the department being supplied.

This statement of September 8th summarizes suggestions KINH has made many times over since January, 1976. We have received no communication from KDHE about our suggestions. However, KDHE has held several conferences with the industry and has embodied many of their suggestions in the proposed new regulations.

KINH asks: why this tilt towards the industry?

B. By informing the news media about violations, naming the offending nursing homes. As well as our request to post KDHE regulations, KINH has suggested repeatedly to KDHE that the news media be informed of nursing homes with violations. Posting the regulations on nursing home walls and releasing information to the media call for little, if any, funding; and would be most effective in raising the level of care in nursing homes. And the thick cloak of secrecy which the industry maintains over substandard care homes would be partially lifted, to the benefit of all Kansans.

Because KINH has had no response from KDHE on these two suggested procedures, Mr. Richard Swanson was asked at the September 8th hearing if he knew of any reason why they should not be adopted. His answer was: "It is sensitive."

Again, KINH asks: why this tilt towards the nursing home industry?

How can members of the public make an intelligent and informed choice between nursing homes if they are kept in the dark about violations? And how can nursing home residents and their families learn of the regulations so important to their welfare unless they are posted in the nursing home? And how can they know where to register complaints unless this information is posted?

Why should Kansans kow-tow to the nursing home industry?

C. By making licensure reports available to the public in compliance with the law. Mr. Swanson tells us that of the ninety local health departments in Kansas, thirty-six participate in the KDHE adult care home program.

During the summer months, Mrs. Nehring undertook for KINH a study of these participating local health departments, visiting thirty-two of the thirty-six; in each case, she interviewed either the public health nurse supervising the nursing home inspection program, or the nurse who actually functions in the program. She divided her study into two parts. The first part addressed the impact on local health departments of Senator Booth's bill which was passed into law by the 1975 Legislature. The intent of this bill is to make available to members of the public all filed reports relating to the licensure of adult care homes, particularly the names of the care homes mentioned in the reports.

KINH discovered several months ago that these reports were seldom available to the public and we wrote Mr. Metzler about it. He replied, and I quote from his letter dated June 14, 1976: "In response to your request about KSA 39-934, we did notify the local health departments that have licensure reports in their files that they were obligated to make their contents available to the public."

But Mrs. Nehring was able to see copies of the licensure reports in only ten of the thirty-two participating departments. The fact that KDHE has failed to make all licensure reports available to the public is not in compliance with the law; and this failure is most helpful in maintaining the cloak of secrecy over substandard nursing homes. KINH asks: why this tilt towards the nursing home industry?

We have been discussing the thirty-six "participating" health departments. KINH feels that the intent of Senator Booth's bill is to make filed reports available to the public in every one of the ninety local health departments, not just in thirty-six. Therefore KINH has requested KDHE to see that this be done. Mr. Metzler replied (and I quote from his letter of June 14th, 1976): "It did not seem necessary to notify those departments that have no such information. We are most willing to have this information available to interested persons and will do what we can to see that it is placed in a strategic location."

It seems that KDHE did not find the fifty-five other local health departments strategic locations, as the licensure reports are not available there; nor have these departments received any word from KDHE about the change in the law effected by Senator Booth's bill.

Again, KINH asks: why this tilt towards the nursing home industry?

D. By improving communication with local health departments and improving enforcement of regulations. The second part of Mrs. Nehring's study addressed itself to assessing the authority and responsibilities of local health departments.

KDHE spokesmen have emphasized the importance of working with local health departments to the nursing home program. I quote from Mr. Swanson's memo of January 12, 1976, directed to "All County Health Officers, Nurses, and Sanitarians: . . . It has long been the policy of the state licensing agency to encourage the active participation of local health departments in the licensure program. We feel that the most productive approach toward maintaining the 'day to day' success of a facility in meeting licensure standards is through the involvement of the local health department. Local nurses and sanitarians can work more effectively in their own communities than can state surveyors based miles away."

But Mrs. Nehring's study shows that of the thirty-six participating health departments, few are involved in the licensure program. Many of the nurses in these departments did not know the difference between licensure and certification. They told Mrs. Nehring that they had received no direction from KDHE and have no idea what is required of them.

KINH asks: why not?

Enforcement problems. According to Mrs. Nehring's study, eighteen of the participating local health departments reported serious deficiencies in nursing homes, and requested help from KDHE. Three departments received support and cooperation from KDHE. Fifteen did not. A typical comment made to Mrs. Nehring was: "A short time ago we were having severe problems with nursing homes; I received no help, nor even any response from the State Health Department."

KINH asks: why not?

Because Mrs. Nehring's study covered only participating health departments, KINH made a test call to Dr. Terry Hunsberger, the Health Officer of Finney County, a non-participating county. We asked him for his experiences with KDHE and the nursing home program. Dr. Hunsberger has strong feelings on the subject, and we have his permission to quote him: "In one home, the stink knocks you down when you go in there. The patients in wheelchairs look like they are going to fall out. There is no one to assist in feeding." Dr. Hunsberger complained of the many violations observed in this home to the area state surveyor many months ago, specifically asking for feedback. He got none. Dr. Hunsberger says he is fed up, and he wants to know why no one is doing anything about this home.

So does KINH.

E. By appointing a qualified health professional whose sole responsibility would be supervision of adult care program. KINH feels that all available evidence indicates little communication between KDHE and local health departments, in spite of Mr. Swanson's assessment of its importance. Because we agree with Mr. Swanson about the importance of such communication to the level of care in nursing homes, KINH repeats the request for the appointment of a qualified health professional to supervise the nursing home program across the state. KINH believes this is obviously a full time job. It may cost money, but KINH thinks that Kansans deserve the best.

It's time for KDHE to tilt towards Kansans, and towards the twenty-three thousand nursing home residents.

Attachment B

FO 5
520-

To Ms. Emalene Correll, Res
Associate, Room 545, State
House

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MEMORANDUM

FROM: Dr. Robert C. Harder, Secretary RCH

RE: Special committee on Public Health and Welfare meeting, September 22, 1976

DATE: September 24, 1976

This is in response to your request for material presented at the referenced meeting.

1. PERIODIC MEDICAL REVIEWS

   Periodic Medical Reviews presently conducted by the Medical Services Section staff are a short notice inspection of the quality of care provided to Medicaid recipients. These inspections are performed at least annually in all nursing homes participating in the Medicaid Program. Distribution of the inspection results is to the local Social and Rehabilitation offices in which the facility is located, Area Social and Rehabilitation office, the facility, the Utilization Review Committee for the facility and the State Department of Health and Environment. The local office provides follow up on the deficiencies identified during the Periodic Medical Review inspection within 30-45 days of the receipt of inspection results. These Periodic Medical Inspection teams consist of one Registered Nurse, one Social Worker and in all skilled facilities a physician position. The physician services are on call if required during inspections of Intermediate Care facilities.

2. UTILIZATION REVIEW

   Federal regulations require that each nursing home participating in the Title XIX program conduct a Periodic Utilization Review. The periodicity of the review is: Intermediate Care Facility, at least every six months. Skilled facility every 30 days for the first 90 days thereafter. Utilization Reviews are conducted by one or more physicians with Registered Nurse support. The object of Utilization Reviews is to insure that the patient is receiving the proper level of care consistent with his physical condition.

3. EDUCATIONAL SEMINAR--COST-RELATED REIMBURSEMENT

   The Department of Social and Rehabilitation recognizes the need for proper utilization of cost studies by nursing home facilities to insure proper reimbursement rates established consistent with reasonable cost expenditures by the facility. Along these lines, the Department of Social and Rehabilitation Services intends to contract for an educational seminar to be provided to the nursing home industry through the state at the department's expense. This effort is being planned for the early calendar year 1977.

4. LIMIT ADJUSTMENT FOR THE HEALTH CARE COST CENTER

The department, having recognized the efforts of the State Department of Health and Environment to improve the quality of care provided in nursing homes, is in the process of evaluating raising the present percentile limitation on the health care cost center within the department's cost related reimbursement system. To date a budgetary impact of such action has not been developed.

5. MEDICAL SERVICES STAFF INCREASE

Effective with Fiscal Year 1977, July 1, 1976, the Medical Services Section was allowed to increase their medical review staff by 13 additional reviewers. It is projected that this additional staff, the Medical Services Section will be able to provide more consultation to the nursing homes during the inspections and follow-up when it is deemed appropriate by the team. The department has already received several letters from nursing homes expressing appreciation for the effort of the teams in providing assistance during inspections.

6. CERTIFICATE PROGRAM

The Department of Social and Rehabilitation Services has developed a program of a certificate to be delivered to a Nursing Home Facility that will be available for Public Display and will attest to their certification within the Kansas Medical Assistance Program. This program will become active as rapidly as the materials can be procured and will be a function of the Medical Services Section.

7. STAFFING RATIOS

The new Health and Environment rules and regulations include staffing ratios of Health Care personnel per patient at the following levels.

ICF - 1.75 hrs/patient day

SNF - 2.0 hrs/patient day

It appears that approximately 181 of the ICF's and 8 of the SNF's would need to add approximately 8 minutes/patient day of Health Care personnel to meet these ratios. This eight minutes equates to 30¢ per hour at the current minimum wage and a first year fiscal impact to the Nursing Home industry is estimated to be $2,450,000 and the state's share of that impact is estimated at $1,320,000.

(The computation of $5,000,000 for Mrs. Cerf's $1.30 per patient day proposal was reached by $1.30 x 10,700 patients x 365 days.)

cc: Senator Sowers
Mr. Dwight Metzler
Dr. Lowell Wiese

Attachment D

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 substandard 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.

We furthermore recommend that all nursing homes licensed by the Department of Health and Environment Adult Care Home Section, be permitted to provide services for recipients of Title XX funds and Supplemental Security income.

Attachment E

NURSE AIDE TRAINING
Bethel Home for Aged
Newton, Kansas

September 23, 1976

Cost of training nurse aides as required by the proposed rules and regulations for licensure of adult care homes

72 residents - Average occupancy January-June, 1976 - All residents in home

63 residents - Average occupancy January-June, 1976 - Residents receiving nursing care

21.1 - Nurse aide staffing full-time equivalent (FTE)
2.0 - LPN staffing FTE
2.6 - RN staffing FTE (Excluding full-time director)

25.7 - Total nurses on staff FTE

2.06 - Total nurse hours per resident per day

Cost of personnel giving nursing care, excluding director

Wages $6.53 per res/day - All 72 residents
$7.46 per res/day - 63 nursing care residents

Wages plus employee benefits* (Benefits = 15 percent of wages)
$7.50 per res/day - All 72 residents
$8.58 per res/day - 63 nursing care residents

*Health insurance, unemployment insurance, workmen's compensation, pension, etc.

Cost of mandatory nurse aide education

33 nurse aides employed = 21 nurse aides FTE
62.5 percent turnover rate = 54 nurse aides annually
$2.51 per hours = nurse aide current average wage

5 percent = projected cost of living increase in wage rate January 1, 1977, and January 1, 1978

15 percent = employee benefits

$3.04 per hour = projected 1977 nurse aide wage including benefits

$3.19 per hour = projected 1978 nurse aide wage including benefits

$3.35 per hour = projected 1979 nurse aide wage including benefits

$10,397 = Cost in 1977. 70 percent of 54 aides = 38 aides
X 90 hours in course = 3,420 hours
X $3.04 = $10,397.

$ 4,594 = Cost in 1978. 30 percent of 54 aides = 16 aides
X 90 hours in course = 1,440 hours
X $3.19 = $4,594.

$ 3,015 = Cost in 1979. 21 new aides due to turnover. Assume that
11 have completed nurse aide course.
10 aides X 90 hours in course = 900 hours
X $3.35 = $3,015.

Average cost per resident per month
for mandatory nurse aide education:

1977 -- $12.00

1978 -- $ 5.32

1979 -- $ 3.40

The above computation does not take into consideration tuition charges, the cost of books, transportation to and from the learning site, and other costs of this nature.

Attachment F G

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT
(P.L. 93-641)

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) was signed into law by President Gerald F. Ford on January 4, 1975. This new federal law, considered by many as the most important single piece of health legislation enacted by Congress in recent years, has vast potential for restructuring the health services delivery system in the United States. The Act was developed in Congress following two years of intensive study of health planning and development activities. The Act creates a single set of structures at the state and regional levels to deal with planning, resource allocation, and regulation in the health field. Since similar activities have been carried out in the past through a variety of organizational structures, considerable realignment of the nation's health planning and development mechanisms is required.

BACKGROUND

None of the content areas in this legislation represent new or unique federal interests. It is the structure in which planning, resource allocation, and regulation will be carried out that differs. A look at the pre-1975 elements may be helpful.

In terms of state planning, four distinct and loosely-related elements had evolved by 1974. One element was state facilities planning authorized under the federal Hill-Burton legislation, first enacted in 1946. A second element was categorical health-related program planning. These included a drug abuse plan, an alcoholism plan, a public health plan, and so forth. Federal law required such plans as a condition for release and expenditure of categorical federal financial support. The third element was the state comprehensive health plan required under Section 314(a) of the Public Health Service Act. This plan was to deal with broader health issues in the state, and although other plans were to be "consistent" with it, it exercised relatively little control over resource allocation. Finally, the 1972 amendments to the Social Security Act instituted a capital expenditure review program (Section 1122) in which the state had to review and approve or disapprove proposed capital expenditures of health care institutions on the basis of "standards, criteria, and plans" adopted in the state.

Organized federally-supported planning efforts at the substate or area level have a shorter history. The first organized support of this type of activity was provided under Section 318 of the Public Health Service Act, passed in 1961. This program provided financial assistance to facility planning agencies which worked closely with the state Hill-Burton planning activities previously mentioned. Successes with the regional facilities planning agency approach led to the adoption of much broader legislation in 1966. The Partnership for Health Act created a new Section 314(b) of the Public Health Service Act, authorizing assistance for areawide comprehensive health planning. Between 1967 and 1974, more than 200 of these "(b)" agencies were established across the country. The vast majority were non-profit corporations. They brought a community's consumer and provider interests together in an effort to develop plans for the organization and operation of a variety of health programs. Although these agencies had "review and comment" responsibilities on a variety of uses of federal funds, they lacked power to secure realization of their plans. The emphasis was on process rather than product, and the planning was not sanctioned through regulatory or quasi-regulatory authority.

The history of federal programs for allocating resources to the health care delivery system has been even more varied. Beginning with formula grant and project grant activities relating to public health in the late 30's, the process was largely a federal-state or federal-institutional relationship. Although the federal-state allocations were governed by the program plans mentioned earlier, direct grants to institutions and organizations were seldom reviewed for consistency with any overall plan. The Hill-Burton program, in 1946, tied allocation of resources for facilities construction to a state plan document, and the facilities planning agencies created under Section 318 also participated in this process.

Two programs created in the late 60's and early

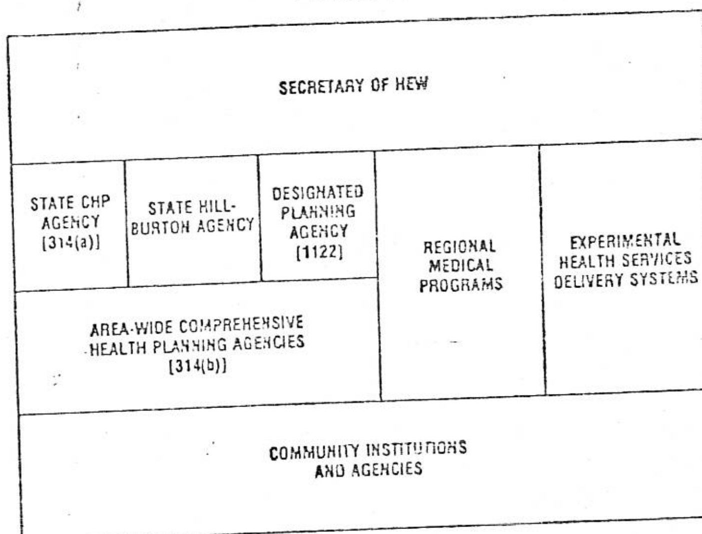
70's adopted a different model for allocating federal resources to specific health programs. The Regional Medical Programs (RMP) legislation followed the Report of the President's Commission on Heart Disease, Cancer, and Stroke, published in December 1964. Initially, the RMPs were to develop cooperative arrangements among health care institutions, medical schools, and research institutions with the goal of bringing the latest advances in treatment of health disease, cancer, and stroke directly to patients. More than 50 RMPs were established across the country, some interstate, some statewide, and others serving a region within a state. In the period between their creation in 1965, and 1974, the program emphasis shifted from specific diseases to primary care, regionalization of health care resources, and improved use of health manpower in underserved areas.

Planning and priority setting in the RMPs was vested in a regional advisory group, and ties to other planning mechanisms as a basis for allocation of the RMP financial resources were very loose. In the nine fiscal years between 1966 and 1974, more than half a billion dollars in federal developmental funds were channeled through the RMP mechanism.

In 1971, another developmental activity was launched by the federal government under the title Experimental Health Services Delivery Systems. A number of community demonstrations were funded by the federal government to assist grantees in the organization and operation of an independent management corporation for health services at the community level. These corporations performed a number of functions similar to both (b) agencies and RMPs, but with an emphasis on the collection of data and the establishment of management information systems for the health segment of the community.

By 1974, a complex of federally supported agencies and organizations, both governmental and non-governmental, had been created to deal with health planning, health resource allocation, and regulation of the health services industry. Figure 1 graphically depicts the elements of the federally-supported structure at the end of 1973.

FIGURE 1



DEVELOPING A NEW APPROACH

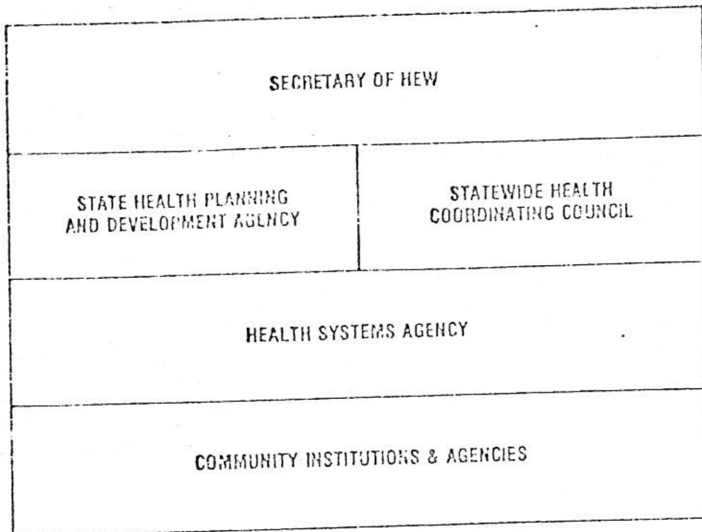
With the legislative authorities for all of these activities expiring at the same time, on June 30, 1974, Congress saw an opportunity to reexamine all of the issues of federal assistance for health planning and development activities. Their stated goal was to provide a more rational system for tying these functions together, while retaining the best features of the predecessor programs. Among the factors which the Congress considered were the following:

— Maldistribution of medical personnel and facilities in many areas of the country.
— Development of duplicative services and excessive beds in health care institutions in the absence of effective planning and control.
— Inaccessibility of health resources and lack of coordination in operation of community health institutions.
— Health care cost inflation, which Congress perceived as a result of excess capacity and inefficiency in utilization of resources.
— The imminence of enactment of national health insurance and the potential negative effect of increased demand in an inefficiently organized and operated system.

The process of developing the new legislation took nearly two years. It included consultation between congressional staffs and a variety of interest groups. Extensive hearings were held in both the House and the Senate. As a part of the developmental process, the House Comm...ee developed a series of principles to guide in the development of new legislation:

— Planning should be done by organizations which represent and incorporate the interests of consumers of health services, providers of the services, and concerned public and private agencies and organizations.
— In order to be effective, health planning must be adequately financed.

FIGURE 2

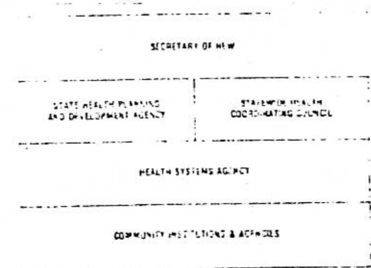


— Effective planning requires a strong emphasis on the implementation of plans, and implementation requires that planning agencies have authority with which to implement the plans.
— The generation of new health resources should be closely tied to health planning.
— If health planning is to be done, it must be good health planning.
— Effective federal, state, and areawide health planning will be possible only if the federal government itself engages in health planning.
— If health planning is actually to improve the peoples health, it must not be limited just to planning for medical care.

It was against this background that the Congress proceeded to develop a new structural approach to health planning and development, one that has been embodied in the National Health Planning and Resources Development Act of 1974.

STRUCTURAL ELEMENTS

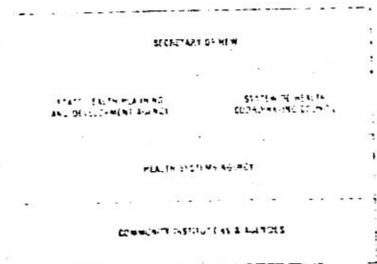
One of the easiest ways of gaining an understanding of the new law is to analyze the structure created at the federal, state, and regional levels under P.L. 93-641. The structural elements are depicted in Figure 2. The Act carefully defines each new element and describes the responsibilities of each.



Description: The Secretary of Health, Education, and Welfare is the principal federal official charged with carrying out the federal portion of P.L. 93-641. In operation, of course, the "Secretary" is represented by central administrations and bureaus of his Department, and by the ten regional offices across the country.

Functions: Among the principal functions of the Secretary in implementation of P.L. 93-641 are:

— Develops, in conjunction with a National Council on Health Planning and Development, and the various state and local agencies created under the Act, guidelines for national health planning policy.
— Establishes, after consideration of plans submitted by the Governors of the states, Health Service Areas throughout the United States.
— Issues regulations governing implementation of the Act.
— Designates Health Systems Agencies in each Health Service Area.
— Provides technical assistance to health planning and development agencies at the state and substate levels.
— Provides financial support to state and substate health planning development agencies.
— Designates state health planning and development agencies.
— Reviews health plans produced by state and substate agencies.
— Approves most federal assistance plans and project grants.

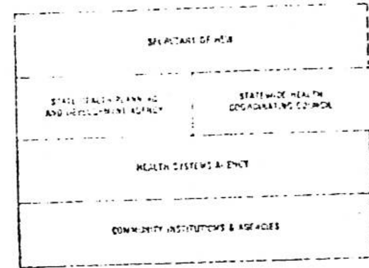


Description: The state health planning and development agency is an agency of state government designated by the Governor to carry out activities mandated by the act for such agencies, and possessing sufficient state statutory authority to do so. Some of the assigned functions may be carried out by other state agencies under agreements between the state health planning and development agency and the delegate agency subject to approval by the Secretary.

Functions: Among the functions of the state health planning and development agency are the following:

— Conducts health planning activities for a state.
— Implements or supervises the implementation of state health plans.
— Prepares a preliminary state health plan document for submission to the Coordinating Council.
— Serves as the designated planning agency for capital expenditure review under Section 1122.
— Administers a state certificate of need program.
— Reviews and makes findings concerning all new institutional health services in the state.
— Periodically reviews and determines whether or not existing institutional health services are appropriate.

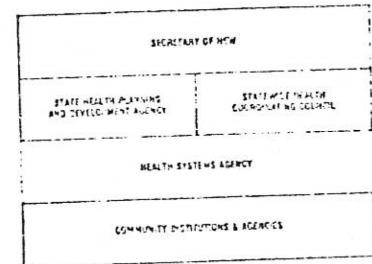
— Coordinates all health data activities in the state.
— Assists the Statewide Health Coordinating Council in its work.
— Administers federally-assisted facilities construction activities.
— Administers an optional rate review and approval program.



Description: The Statewide Health Coordinating Council is a consumer-majority council of citizens. Sixty percent of the members of the Council are selected by the Governor from among nominees of the health systems agencies in the state. The remaining 40 percent are designated directly by the Governor. The Council must have sufficient authority and resources to carry out the functions mandated by the Act.

Functions: The Statewide Health Coordinating Council carries out the following types of functions:

— Reviews and coordinates health planning activities of Health Systems Agencies.
— Prepares and approves a state health plan based on the preliminary state health plan and the Health Systems Plans of the Health Systems Agencies.
— Reviews and comments on the annual budgets of Health Systems Agencies.
— Reviews and comments on annual applications of Health Systems Agencies to the federal government.
— Advises the state health planning and development agency in its work.
— Reviews and approves all state plans and applications for funds made available to the state government under federal health legislation.



Description: The Health Systems Agency is a public agency, or a private non-profit agency, with a consumer majority board or advisory body which carries out the functions mandated for it by the Act in a defined geographic area, the health service area. The agency must maintain a professional staff of not less than five with expertise in administration, the gathering and analysis of data, health planning, and the development and use of health resources.

Functions: The health systems agency functions include the following:

PLANNING FUNCTIONS

— Assembles and analyzes data on health status and health programs in its area.
— Prepares and publishes a health systems plan (HSP) and an annual implementation plan (AIP) for its area.
— Coordinates its activities with other planning bodies in the area.

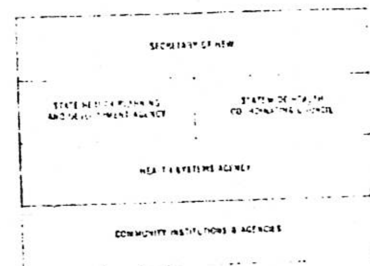
DEVELOPMENTAL FUNCTIONS

— Develops specific activities and projects which support plans.
— Implements plans through technical assistance, and through developmental grants to community agencies.
— Reviews and approves each use of federal funds in its area which support the development of health resources and services in the area.
— Recommends health facilities projects to the state for funding.

REGULATORY ACTIVITIES*

— Reviews and comments to state regulatory agencies on all capital expenditure and new service projects in area institutions.
— Periodically reviews and comments on appropriateness of all institutional health services offered in the area.

*The health systems agency is not a regulatory authority. It reviews and comments to a state regulatory agency on proposals which are subject to regulation.



Description: Community institutions and agencies represent the resources on which the activities of the other components ultimately focus. They carry out the programs which are planned, and utilize the resources which are allocated.

Functions: Among the principal activities of these agencies as they relate to the Act are the following:

— Participate in the governance of the health systems agency serving their area.
— Design and carry out developmental projects.
— Submit proposals and applications subject to review and approval to the health systems agency.

Attachment G-H

STATE OF KANSAS

PRIMARY CARE PHYSICIAN*/POPULATION RATIO

August, 1976

COUNTY	PCP/Pop	COUNTY	PCP/Pop	COUNTY	PCP/Pop
Allen	10/15,343	Greeley	1/2,122	Osborne	1/6,662
Anderson	6/8,651	Greenwood	4/9,483	Ottawa	4/6,380
Atchison	12/19,194	Hamilton	1/3,073	Pawnee	7/8,202
Barber	3/7,245	Harper	9/8,388	Phillips	4/8,386
Barton	21/34,466	Harvey	38/27,225	Pottawatomie	9/12,418
Bourbon	9/15,399	Haskell	1/3,922	Pratt	5/9,954
Brown	5/12,894	Hodgeman	2/2,747	Rawlins	2/4,568
Butler	10/37,918	Jackson	4/11,516	Reno	38/67,844
Chase	1/3,594	Jefferson	5/12,413	Republic	7/8,536
Chautauqua	5/5,130	Jewell	4/6,163	Rice	6/12,295
Cherokee	10/22,055	Johnson	185/231,943	Riley	23/38,349
Cheyenne	3/4,186	Kearny	0/3,306	Rooks	5/7,762
Clark	2/2,898	Kingman	9/10,080	Rush	1/5,405
Clay	7/10,251	Kiowa	2/4,138	Russell	5/9,901
Cloud	13/13,918	Labette	12/24,776	Saline	27/45,421
Coffey	3/8,391	Lane	1/2,904	Scott	3/6,115
Comanche	2/2,898	Leavenworth	18/47,437	Sedgwick	263/333,771
Cowley	26/34,479	Lincoln	2/4,866	Seward	8/16,386
Crawford	22/38,619	Linn	2/8,203	Shawnee	124/171,999
Decatur	1/5,269	Logan	2/3,757	Sheridan	2/3,960
Dickinson	11/23,333	Lyon	22/30,216	Sherman	5/7,980
Doniphan	5/10,266	Marion	10/15,161	Smith	2/6,862
Douglas	38/54,783	Marshall	9/14,165	Stafford	6/6,191
Edwards	3/4,576	McPherson	11/24,109	Stanton	2/2,400
Elk	2/4,175	Meade	2/5,093	Stevens	2/4,407
Ellis	15/23,581	Miami	7/20,571	Sumner	15/23,446
Ellsworth	3/7,146	Mitchell	5/8,083	Thomas	7/7,936
Finney	19/20,711	Montgomery	25/45,634	Trego	4/4,705
Ford	15/23,687	Morris	6/6,944	Wabaunsee	2/6,852
Franklin	15/20,295	Morton	3/3,692	Wallace	1/2,275
Geary	13/24,261	Nemaha	6/12,593	Washington	3/9,758
Gove	4/4,098	Neosho	15/18,531	Wichita	1/3,639
Graham	4/4,868	Ness	3/4,975	Wilson	6/13,315
Grant	4/6,622	Norton	6/7,652	Woodson	2/5,029
Gray	2/4,605	Osage	5/13,567	Wyandotte	183/189,491

*Primary Care Physicians include both M.D.'s and D.O.'s specializing in the fields of General Practice, Family Practice, Pediatrics, and Internal Medicine.

General General

TOTAL PRIMARY CARE PHYSICIANS IN KANSAS: 1,546
TOTAL POPULATION OF KANSAS: 2,277,905

60.3%

PRIMARY CARE PHYSICIAN FACT SHEET

September, 1976

STATE	#PCP	POPULATION	RATIO
Iowa	1,506	2,869,800	1:1906
Kansas	1,546	2,277,905	1:1473
Missouri	2,573	4,763,000	1:1851
Nebraska	939	1,541,000	1:1641

Attachment H

State of Kansas . . . ROBERT F. BENNETT, *Governor*

DEPARTMENT OF HEALTH AND ENVIRONMENT

DWIGHT F. METZLER, *Secretary* Topeka, Kansas 66620

September 21, 1976

The Honorable W. H. "Wes" Sowers
Kansas Senate
State Capitol Building
Topeka, Kansas 66612

Dear Senator Sowers:

In response to your letter of August 31, 1976, I shall attempt to answer your three deceptively simple questions distinctly and forthrightly. First, let me reiterate the questions. Next, let me tell you why I said they are "deceptively simple" and tell you of the qualifications that must surround them. They have no simple answers. I'd like then to give you the best straightforward answers that are available for your questions.

(a) Your three questions pertain to governmental data collection efforts for health:

(1) "...whether the data being collected included meaningful information that will permit valid determination to be made as to the nature, extent of health care services in various areas in Kansas including a meaningful identification of underserved areas;"

(2) "...whether you have data which indicates whether or not our state has a crisis in respect to rendering of health care services and if so please identify and define it;"

(3) "...if on the basis of present data you can identify areas of our state that are underserved by health care provider services, please identify these and indicate the nature of the services in which there is a shortfall."

(b) The qualifications:

"Underserved" is a relative term impossible of definition. If one is in Wichita County and suffers a severe head injury, "underserved" means not having a neurosurgeon within 20 minutes availability, not having a hospital sophisticated enough to respond to the neurosurgeon's needs, not having a rapid emergency evacuation service, etc. In another context, "underserved" may mean having enough physicians but insufficient hospital beds. Again, the term may refer to

dentists, osteopaths, podiatrists, optometrists, physical therapists, nurses, public health services and a host of other factors related to total health care. The physician alone is like the airline pilot who, however skilled, is useless without an aircraft, mechanics, flight attendants, and a host of other things that make an airline run. The requirements for each of these components is not static either. Needs vary with time, economic variables, market forces, changes within the field itself, and a myriad of other factors. It is, therefore, no different from any complex industrial system. I must in candor comment that most folks think that the medical problem has to do with whether or not a town has a physician and is little more sophisticated than that. The Kansas Department of Health and Environment has patiently begun the laborious data collection that attempts to "get a handle" on each of these complex variables and their interrelationship. I am not certain that the state of the art will allow us in the forseeable future to answer these complex problems definitively. This is not "weaseling" - it is an honest statement prompted by the fact that the Department will not promise what cannot be delivered. We will try, and we will do the best job that can be done, I will assure you of that fact. Mr. Metzler has already written you (August 4) of the kinds of efforts we are making in this regard.

(c) I can now give you some straightforward answers, but I shall limit them to the area of physician manpower, or this letter will turn into a book. If you wish more information in other areas, please tell me and I can get it for you if it is available. At the present time, based on the most recent federal data I have available, there are 29 states that have more physicians per 100,000 population than Kansas and 20 states that have fewer. Of our neighboring states, Colorado, Oklahoma, Nebraska, Missouri and Iowa, only Colorado and Missouri have more physicians per 100,000 population than has Kansas. We have no data to suggest that any of these states have any lesser urban-rural physician maldistribution problems than we have. Kansas presently has 126 physicians per 100,000 population (not including osteopaths). Approximately 34% of these are primary care physicians, that is, family practitioners, general practitioners, general internists, or general pediatricians. We have critical physician shortage areas which are defined by the federal government as an area having a primary care physician to population ratio of less than one to 4,000 in a county with a general physician to population ratio of less than one to 3,000 within the entire county in which the scarcity area is located. There are more qualifications, but that is the essence of it. On the basis of that definition and based on the most recent figures available from HEW as of December 5, 1975, our most critical shortage areas, both in physician need and in low per capita income, are:

Chautauqua
Cherokee
Coffey
Elk
Gove
Hodgeman
Nemaha
Rawlins
Sheridan
Washington

There are also equal shortage areas in the following counties:

Allen	Edwards	Lane	Phillips
Atchison	Ellsworth	Leavenworth	Haven in Reno County
Barber	Finney	Lincoln	Rice
Brown	Franklin	Linn	Rooks
Butler	Geary	Logan	Rush
Chase	Graham	McPherson	Russell
Cheyenne	Grant	Marion	Scott
Clark	Gray	Marshall	Seward
Clay	Greeley	Meade	Sherman
Comanche	Greenwood	The Community of Lewisburg in Miami County	Smith
Crawford	Hamilton		Stanton
Decatur	Haskell		Stevens
Dickinson	Jackson	Montgomery	Thomas
Doniphan	Jefferson	Morton	Wabaunsee
The Haskell School Health Center in Douglas County	Jewell	Neosho	Wallace
	Kearny	Osage	Wichita
	Kingman	Osborne	Wilson
	Kiowa	Ottawa	Woodson

Of course, this fugure changes day by day with deaths, retirements, in-migration of physicians, etc. On the basis of these data, I conclude that we have no crisis in health delivery with respect to physician services more serious than that of the typical state. We seem to be right about in the middle.

On September 14, I met with the representatives of the University of Kansas Medical Center and the Wichita State University Branch* and found that they are not very far along in planning any daring solution. They have some interesting data on the ingress and egress of physicians in and out of Kansas and just what is happening to Kansas University graduates. Mr. Meredith of KUMC can give you a good report on this. Their approach is generally conservative and traditional.

I have had this letter typed in absentia while I am attending an out-of-state meeting, but I hope to be back for the committee hearings on September 23. In the meantime, if you need any further information, please contact my secretary, Mrs. Judy Stanley, at 296-7789 and we will to get you whatever you need. Best personal regards.

Respectfully yours,

Lowell M. Wiese, M.D. (js)

Lowell M. Wiese, M.D.
Director of Health

LMW:js
cc: Mr. Dwight Metzler
Dr. James Appelberry
Mr. Joe Harkins

* (Dr. Archie Dykes, Dr. Robert Kugel, Dr. Cramer Reed, Dr. James Appelberry and Mr. Glen Meredith)