Kansas Legislative Research Department November 9, 1976

# M I N U T E S

## SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

October 13 and 14, 1976

Members Present

Senator Wesley H. Sowers, Chairman
Representative Richard Walker, Vice Chairman
Representative Theo Cribbs
Representative Arthur Douville
Representative Mike Johnson
Representative Sharon Hess
Representative Marvin Littlejohn
Senator Elwaine Pomeroy

Staff Present

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

Others Present

Stewart Entz, Kansas Association of Homes for the Aging, Topeka, Kansas
Richard P. Brown, Kansas Health Care Association, Topeka, Kansas
Petey Cerf, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Harriet Nehring, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Judy Runnels, Kansas State Nurses Association, Topeka, Kansas
N. Jack Burris, Kansas Department of Health and Environment, Topeka, Kansas
Mel Gray, Kansas Department of Health and Environment, Topeka, Kansas

### October 13, 1976

The meeting was called to order at 10:00 a.m. by the Chairman, Senator Wesley H. Sowers.

Staff called attention to a letter from Dr. Robert Harder prepared in response to a request to comment on proposals of Kansans for the Improvement of Nursing Homes (KINH) sent to the Committee. The KINH letter is attached to the September minutes.

The Chairman noted Mr. Swanson, Department of Health and Environment, was ready to make a comparison between records of Department inspections and the report of KINH presented to the Committee at the last meeting. However, KINH apparently was unwilling to submit this information with the identity of the adult care homes indicated to the Department. Ms. Petey Cerf, KINH, stated the organization is not unwilling to turn the material over to the Department but had not understood there was a time factor involved. Also, she noted that Mrs. Branson is out of town and it is her study.

The following material was distributed to the Committee:

Attachment A - Statement from the Kansas Association of Homes for the Aging.
Attachment B - Financial Information Pertaining to Mid-America Nursing Centers furnished by Charles Wurth in answer to financial information presented by KINH at the September meeting.
Attachment C - Newspaper Articles Concerning Patient Care in Nursing Homes furnished by the Kansas Health Care Association.
Attachment D - Letter from Chancellor Dykes to Senator Sowers relative to the cost of restoring certain benefits to medical residents and to residencies in primary care.

Proposal No. 32 - Adult Care Homes

Contract Between Home and Resident. It was noted that a contract between the resident and the home, similar to that required in Minnesota, would make residents more aware of the differences between the various types of homes, would clarify the general responsibilities of the home, would help smooth relationships between the parties and might diminish the number of complaints which have to be processed.

Stewart Entz, Kansas Association of Homes for the Aging, stated they would not object to this type of contract, but expressed concern about life care contracts now being used and which are being studied at the federal level.

Based on a Committee decision to draw on the Minnesota law, a motion was made and seconded to instruct staff to draft a bill for Committee consideration, requiring a contract between the home and the resident -- the form, but not the content, of such contract to be approved by the Department of Health and Environment. It was further clarified that this requirement is not to be retrospective, contracts are to be on file and available for inspection at the home, and the contract is to include the general responsibilities but not a list of specific services to be included in a daily or monthly charge. Motion carried.

Establishing Advisory Commission on Adult Care Homes to Secretary of Health and Environment. There was Committee discussion of the establishment of a separate advisory commission on adult care homes. There was also discussion of adding adult care homes as a specific responsibility of the present statutory Advisory Committee on Health to get input from a larger group, of utilization of the ombudsman program and of mandating the involvement of the area agencies on aging in the adult care home area.

By consensus, the Committee report is to show that the Committee considered establishing an advisory committee on adult care homes but recommended that because of the number of agencies serving the elderly and the newness of some programs such as the ombudsman program, no action be taken until these programs have had time to operate and be evaluated.

Providing by Statute that Inspection and Certification Reports be Posted in Adult Care Homes. During discussion, the following points were noted: the adult care home license must be displayed now; certification reports are presently available in the SRS office in the county in which the home is located; the certification report which is in the form of a checklist is voluminous but it is not difficult to understand; there seems little point in filing inspection reports in the local department of health if they are not responsible for the homes; SRS is making available a certificate which could be posted.

In answer to a question, Stewart Entz, Kansas Association of Homes for the Aging, and Richard Brown, Kansas Health Care Association, stated that requiring the posting of notice that licensing inspection and certification reports are available in the administrator's office would not cause any problems for the homes. Representatives of Kansans for the Improvement of Nursing Homes stated they approved of this requirement.

A motion was made and seconded that staff be instructed to draft a bill requiring the adult care home to post notice that inspection reports are available in the administrator's office.

In discussion of the motion, it was noted that the deficiencies, the plan of correction and the time table for corrective action are side-by-side and can be easily read. Using the wording "inspection report and related documents" in the bill was suggested so what a person saw would correctly reflect the current status of the home.

Staff noted that the motion implied a statutory obligation for the administrator to make the reports available. This is to be included in the bill draft.

Motion carried.

Fine System. Staff noted there are two basic problems with the 1976 bill which would have established a fine system: (1) determining what is a sufficient violation to justify imposing a fine; and (2) the appeal procedure.

Staff noted that other states have used the term "substantial violation" or have attempted to classify violations by degree of severity with a set of fines for each class.

In discussion, it was the consensus that the intent of a fine system should be to establish fines which would give added impetus to the adult care home to correct a deficiency but which would not put the home out of existence. Fines should apply only to substantial violations affecting the health or safety of the resident. A home should be given time to correct a deficiency before a fine is imposed. Leaving the specific fine, within a specified maximum and minimum, to the discretion of the Secretary of Health and Environment, as is done in environmental statutes, was suggested.

Staff noted they had not heard from Dr. Harder, Department of Social and Rehabilitation Services, who was asked to check with the Regional Office to see if a fine system would affect the certification of a home.

Concern was expressed over the time a home could be in violation because the filing of an appeal would stay the action. Concern was expressed with developing an appeal procedure which will protect the rights of the home and the well being of the residents.

The Committee asked Representative Walker to work with the Revisor of Statutes Office to draft a bill taking into account the Committee discussion and the laws of other states which have statutory provision for fines.

The meeting was recessed and reconvened at 1:30 p.m.

Nurse Aid Training Program. In answer to questions relative to previous testimony, the Chairman stated he had talked to Mr. Metzler and Drs. Weise and Mankin who were in agreement on the following: The State Department of Education is charged with the responsibility of the aide training program but the Department of Health and Environment expects to make every effort to have the training conducted in adult care homes since this would mean minimum cost to the homes and the students; certain requirements regarding place and instructor will have to be met; in cases where it is not feasible to have ten in a class, this requirement will be waived; the instructor may be an employee of the home if he is certified by the Department of Education and is given exclusive time for this responsibility.

It was the consensus of the Committee that the Committee report should reflect that the Committee gave considerable time to testimony and discussion of mandatory adult care home aide training, its implementation and its implications for patient care and the industry. The report should also give a summary of testimony presented and the concerns expressed by the various groups appearing and include a statement urging the Secretary to maintain the highest degree of flexibility possible in implementing the program. The Committee's recommendation is that no action be taken until the program is implemented and there is an opportunity to see how it functions. In this regard, the Department of Health and Environment should get feedback from all parties concerned on the program's effect on turnover rates, cost, care, and other pertinent points.

Staff was asked to get current information on how many beds are available and how many of these are vacant by type of home and county. Mr. Brown stated this information, which is updated monthly, is available by facility and by county from Mr. Swanson's office. Staff is to get this data. The Committee will consider whether it should be included in the Committee report.

The meeting was adjourned until 9:00 a.m., October 14, 1976.

## October 14, 1976

The meeting was called to order at 9:00 a.m. by the Chairman.

Proposal No. 34 - Safe Drinking Water Standards

Mel Gray, Department of Health and Environment, stated that, after weighing the pros and cons, the Department notified the federal agency of their intent to try to qualify for primacy in administering the Safe Drinking Water Act. This would make the state eligible for continuing federal grants which would mean a better and more adequate program at less expense to the state. However, if the state is to qualify, Kansas statutes will have to be amended to comply with the federal law. These amendments, generally, would mean improvement and not just compliance.

In answer to a question, Mr. Gray stated the state was in the last year of the two-year preliminary grant for which they had qualified. To continue to qualify, the Kansas statutes must be amended by March.

Staff presented a letter from the Regional HEW office regarding federal funding of the Kansas program. (Attachment E)

In answer to a question, Mr. Gray stated the budget submitted by the Department shows a decrease of about $60,000 in state funds. Basically, the Department will have to maintain the 1975 level of funding to qualify for federal funding.

Staff presented a draft on proposed amendments based on points noted in a letter received from the Regional HEW office in June.

After discussion, the consensus was that the staff be asked to review the bill further with the Department of Health and Environment and the Regional HEW office, making any necessary revisions. The bill is to be made as liberal as possible consistent with the federal law. Staff was asked to include repeal of those sections which the Department of Health and Environment recommends be repealed since they are not being used and are not required by federal law. Further discussion was deferred until the next meeting at which time the staff is to present a revised draft of the proposed bill.

Proposal No. 33 - Medically Underserved Areas

Model Rural Health Center. Staff presented a draft of the proposed resolution as requested by the Committee. (Attachment F)

It was noted the intent of the resolution is to direct attention to physicians but also is to include other health care personnel. After consideration of several terms, the consensus was to use the term "physician and allied personnel" throughout the resolution. Since the phrase "professionals in the healing arts", page 1, paragraph 1, does not reflect terminology of present laws, it is to be changed to "physician and allied personnel".

In the title paragraph, "steps to be taken toward" are to be changed to be more positive.

"Chairman, Board of Regents, and President, Board of Healing Arts," are to be added to the last paragraph on page 2.

Staff is to prepare a revised resolution for Committee consideration.

Adding Geographic Location of Applicant to Admission Criteria. Staff presented a draft of the proposed resolution as requested by the Committee. (Attachment G) Concern was expressed with the terms "middle and upper class communities" page 1, paragraph 1, line 4. By consensus, "middle and upper class" is to be deleted.

The title paragraph is to be rewritten to focus more on students coming from underserved or non-urban areas. Suggested wording was "to foster admissions from medically underserved areas".

Since it was felt the contents of the second "Whereas" are already understood and might imply a downgrading of academic standards, this section is to be deleted.

For clarity, the third "Whereas" and the fourth "Whereas" are to be reversed in order. In paragraph 3, page 1, the phrase "if the health and welfare of the people in those rural areas shall not be impaired" is to be deleted.

In paragraph 4, page 1, "Whereas" is to be deleted and "Studies show" inserted in lieu thereof. The rest of the sentence is to be changed as necessary.

Since the last part of paragraph 1, page 2, might infer a criticism of the admissions committee, the consensus was to reword the latter part of the paragraph beginning with "it would be better". Suggestions were, "choices should be made based on the needs of society" or "it is desirable to make choices which reflect the needs of society".

In the last paragraph, page 2, "new" is to be changed to "additional" and "Chairman, State Board of Education" and "Chairman, Board of Regents" are to be added.

Wherever possible, personal pronouns are to be deleted.

Staff is to prepare a revised resolution.

Increased Funding of Residencies in Primary Care. Staff noted there has been federal action in this area which stipulates the percentage of residencies "affiliated with medical schools" which must be in primary care if the school is to qualify for capitation grants. In answer to a question about current percentages in the School of Medicine, reference was made to a letter from the Kansas Legislative Research Department to Representative Littlejohn. Copies of the letter were reproduced for the Committee.

Staff presented a draft of a proposed resolution as requested by the Committee. (Attachment H) The following action was taken:

Page 1, paragraph 1, line 3, after "Kansas" insert "in the long term" for clarification.

Page 1, paragraph 2, line 1, delete "Because of this awareness"; line 2, delete "reflects the realization" and insert in lieu thereof "recognizes".

Paragraph 3, page 1, is to be reworded deleting all figures except the ratio of primary care physicians. In line 6, insert "general" before "pediatrics"; delete "and"; insert "general" before "internal"; and after "medicine" insert "and general ob-gyn". In line 5, delete "general practice,". This will comply with the definition agreed on by the Committee.

Page 1, paragraph 4, delete lines 1 and 2 and through "however," in line 3.

Page 2, line 3, delete "earmarked" and insert in lieu thereof "designated". In line 3, delete "interested in" and insert in lieu thereof "committed to".

Page 2, paragraph 1, line 4, delete "we favor". In line 5, change "to" to "for" and change "interested in" to "committed to". In line 7, change "earmarked" to designated"; insert "must be achieved" after "care"; and change "1980" to "1979".

Page 2, last paragraph, line 3, delete "for duplication". "President of the Kansas Hospital Association" is to be added to the list of people who are to receive copies of the resolution.

Six Year BS and MD Program. Staff presented a draft of a proposed resolution as requested by the Committee. (Attachment I)

After discussion of "calendar years" and "academic years", the consensus was to change "calendar" to "academic" in the title paragraph. The title paragraph is to be changed to reflect that the school is to investigate the feasibility of this program.

Staff stated that in drafting the resolution, it had been assumed the accelerated program would be in addition to the present program. It was noted that any students accepted in an accelerated program would probably have to be a part of the total 200 entering students or additional accreditation requirements would have to be met.

Staff reported the University of Missouri School of Medicine at Kansas City is raising two questions about the long-range affect of their accelerated programs -- (1) what it does to the student emotionally, socially, and physically, and (2) what happens to the graduate who, at age 30, decides he does not want to be a physician.

After discussion, the consensus was to make the following changes:

Page 1, paragraph 1, line 1, delete "In the early 1970's a number of" and insert in lieu thereof "Some" and delete "and other". In line 2, delete "health sciences"; change "throughout" to "in" and insert "have" before "implemented". In line 3, delete "health". In line 4, delete "practitioner" and insert in lieu thereof "physician".

Page 1, paragraph 1, line 1, insert "Among" before "The", delete "calendar" and insert in lieu thereof "academic". In line 2, change "is" to "are" and delete "health". In line 3, delete "practitioners" and insert in lieu thereof "physician".

Page 1, paragraph 3, line 2, delete "high school".

Page 1, paragraph 4, line 3, delete "eliminating" and insert in lieu thereof "reducing". Another suggestion was to change the first of this sentence to "method of increasing the number of physicians". Consensus was to use the first approach. Delete all after "program" in line 6, all of line 7 and through "program" in line 8. In line 8, delete "them" and insert in lieu thereof "medical student". In line 10, change"calendar" to "academic".

A copy of the corrected draft is to be sent to Chancellor Archie Dykes for his comments and suggestions.

Recruitment. Staff presented a draft of proposed resolution recommending a division of professional recruitment within the State Department of Economic Development. The Committee noted the intent had been to direct the University of Kansas School of Medicine to assist communities in recruiting physicians. Other agencies are to cooperate. Staff was instructed to re-draft the resolution in line with the directive in the September minutes.

Data Collection. A resolution is to be drafted directing the Department of Health and Environment to collect data on health personnel pertinent to evaluating underserved areas and to developing programs to meet the needs of these areas. The resolution is to direct the Department of Health and Environment to seek data from other agencies and to direct other agencies to cooperate with the Departmentin collecting data.

The Secretary of State is to be instructed to deliver enrolled copies of this resolution to the Secretary of the Department of Health and Environment, Insurance Commissioner, licensing agencies, and to Drs. Kugel and Reed.

All Resolutions. Staff is to check all resolutions for correctness of titles. In designating persons to whom the Secretary of State is to send copies of the resolutions, only titles are to be used.

The house of origin is not to be specified in the resolutions. Revisions of all resolutions are to be presented at the November Committee meeting.

Scholarship-Loan Bill. Staff stated they are still working on the draft of the proposed bill and will present it at the next Committee meeting. By consensus, "primary care" in this bill is to be defined as in the resolutions.

The Chairman noted the Board of Regents has requested the bill be effective on publication in the state paper so the money will be available when students need it. Staff is to check with the Board of Regents about a cut-off-date for the exchanging of MD and DO slots.

It was clarified that the bill is to specify 16 students each year for three years. This is an additional 16 each year.

Minutes

The consensus of the Committee was that "general ob-gyn" should be included in the definition of primary care in the last paragraph on page 6 and "academic" should be inserted between "6" and "years" on page 7 of the September minutes. A motion was made and seconded to approve the minutes of the September meeting as altered. The motion carried.

Proposal No. 35 - Alcoholism Statutes

Staff was instructed to note in the Committee report that the Committee had to set priorities because of time limitations.

Staff was instructed to note the evolving federal law in this area. The Committee recommends the proposal be assigned to a Committee appointed specifically to study this issue.

Proposal No. 36 - Welfare Overview

Staff stated that in the past this has always been assigned to a separate committee. The committees have monitored the fiscal status of SRS programs on a monthly basis and have worked with the Department of Social and Rehabilitation Services on new legislation needed to comply with federal law. By consensus, the Committee recommends that whenever the Department of Social and Rehabilitation Services foresees changes in federal laws or federal rules and regulations, a welfare overview committee be appointed specifically for this purpose. The report is to note that the Committee had looked at welfare overview in terms of nursing homes.

It was noted the Committee had heard brief testimony relative to the homemaker program. Staff presented the background leading to the change in this program. This is to be included in the report with the recommendation that the Legislature give further consideration to this program and the problems noted by staff during the next Session.

After discussion, the November meeting was rescheduled for November 22 and 23.

Prepared by Emalene Correll

Approved by the Committee on:

11/22/76
Date

Attachment A

KANSAS ASSOCIATION OF HOMES FOR THE AGING, INC.

ONE TOWNSITE PLAZA
SUITE 1000 · TOPEKA, KANSAS 66603
phone 913 · 2320564

October 12, 1976

Senator Wesley H. Sowers
527 Union Center
Wichita, Kansas 67202

Dear Senator Sowers:

In anticipation of your Interim Health Committee's work scheduled for October 13, 1976, regarding adult care homes, I would like to respectfully submit the following comments for your consideration.

PROPOSAL 32/THE ISSUE

Your Committee represents the convergent point, the vortex, of a basic issue confronting the State of Kansas--HOW WILL THIS STATE DEAL WITH THE CARE AND NEEDS OF ITS ELDERLY-INFIRM CITIZENS.

Advances in medicine and nutrition have extended longevity. Thus, the number of elderly citizens in the State of Kansas continues to increase. At the same time, changing social attitudes have, for the most part, eliminated the tradition of progenitorial care.

Confronted with these circumstances, the "Government", responsible for the "health" and "welfare" of its citizenry, has, in the past decade, assumed an ever-increasing role in the care of its elderly-infirm populace. This period of transition has not been smooth. Many early efforts at legislation and regulation, well intentioned but lacking realism, spawned confusion and inequities. Sparked by this emerging need and resulting confusion, considerable study and interest have been generated in seeking to correct and adjust the acceptable care which society will provide to its elderly. This Committee represents the latest and best effort by Kansas to deal with this issue.

Regulatory agencies, providers, consumer groups, etc., etc., have all appeared before the Committee, and been given every opportunity to characterize the issues and offer direction. For this opportunity, the providers are most appreciative.

Your Committee has considered many aspects of adult-care facilities and long-term care of the elderly in Kansas. However, it is only when the Committee steps back and adopts the broad perspective of this issue that it can effectively take action with regard to any of its component parts. Problems of constant inspection, provisional licenses, the fine system, cost reimbursement, rules and regulations, etc., etc., etc., are all parts of the puzzle. The challenge to the Committee, it would seem, is how to fit the puzzle together. Should it wrestle with specific parts of the issue at the risk of taking action inconsistent with the overall issue, or should it consider legislative revisions and proposals that consider and "fit together" the entire puzzle.

Although we fully recognize that this is not the only issue facing the legislature of Kansas, when considered in its proper perspective; that is, the number of persons affected (ultimately every one of us), the amount of tax dollars spent, the social and moral judgments that must be made, care of the elderly, we sincerely believe, ranks equally with that of education, highways, etc., and represents a major area of activity for the Health Committee.

In an effort to synthesize the issue and priortize some of its component parts, we would offer the following additional comments.

## LEVEL OF CARE (RULES AND REGULATIONS)

As stated in the July 1976 New England Journal of Medicine:

> "The nursing home industry is, on paper, the most closely regulated sector of the health-care system."

Such a short and concise statement, in and of itself, is almost an understatement, when you consider that virtually every aspect of the operation of a long-term facility is regulated; e.g., permission to build such a facility, location of facility, design of facility, staffing of facility, services to be provided, records to be kept, reports to be made, inspections to be conducted, and the amount of money to be paid for rendering such services on

behalf of the State. Consider for example the proposed regulation for Kansas that, in a residential setting (not skill nursing or intermediate nursing, but purely residential setting):

> "Bed location shall be designed to align parallel to the exterior wall of a minimum of three feet (91.4cm) clearance from both sides and the foot of the bed to the nearest obstacle. No bed shall be located more than two deep from the exterior window wall."

Thus, by regulation, the State of Kansas, in seeking to establish the level of care for its elderly citizens, goes so far as specify limitations in the location of beds in residential living units.

We would ask the Committee to specifically clarify the Regulation as to nurse-aide training by authorizing training in facility and reimbursement on all costs related to such training, including labor costs for fill-in and travel beyond the facility.

The net result of these regulations is that they establish the prescribed level of care. The State, through its publication of regulations and legislative approval thereof, determines in great detail the quality of care to be offered. Thus, it is important that the Committee be apprised of the significance of these Rules and Regulations. Their adoption represents an official prescription of care for the elderly-frail of Kansas.

## COSTS OF CARE (COST REIMBURSEMENT)

As alluded to in my comments before the Committee in September, it is nonsensical to discuss the prescribed level of care which the State desires for its elderly without considering, in the same discussion, the method of implementation and the cost of implementation. Marvelous suggestions for better care, including detailed Rules and Regulations requiring extensive medical training, specially designed facilities, nurse-aide training, are cheap to those who proclaim them. They are not cheap to the elderly.

Consumer advocates that demand outlandish and untried techniques do not speak for nor represent the interest of the elderly-frail. These expressions by consumer advocates have been most beneficial in sparking an interest and awareness outside the provider group, but their preoccupation with condemnation, shortage of hard evidence, and totally inoperative suggestions, have not benefited the elderly of Kansas. It should be clearly understood that there is a direct correlation or relationship between the demands of consumer advocates and the financial impact of their demands upon the elderly-frail.

There is a second factor that is preliminary to a meaningful discussion of cost reimbursement. Specifically, the "arm" of the State (Department of Health and Environment) charged with prescribing and enforcing the level of care cannot operate detached from or without coordination with the "arm" of the State which represents the payment mechanism or source of reimbursement for the care provided to the State under contract (Department of Social and Rehabilitation Services). The problem arises when the prescribed or mandated care exceeds the funds available to provide for that care. This dilemma does not unfavorably reflect upon the agency charged with the enforcement of the care or the agency responsible for paying for such care. The dilemma is, very simply, that the equation does not balance. The cost of services mandated exceeds the funds available to pay for such services. Thus, the shortage of funds is met by flat-rate reimbursement on a varying percentile. The difference between what is paid and what it costs is manifest in failures to comply, shortage of staff, etc., etc.

In the last analysis, all talk about cost reimbursement, all the problems that it entails, all of the proposed solutions, boil down to a relatively simple equation--an equation which this Committee should at this time deal with.

Based upon the foregoing, we believe the following action should be taken by this Committee:

1. <u>Assuming that the Rules and Regulations prescribe the level of care desired, the statute providing for reimbursement of care provided the State of Kansas must be amended to clarify</u>

the equation. The statute must be amended to mandate, in clear and unequivocal terms, the commitment of the State to fully underwrite the costs of the care it has prescribed for those citizens who cannot pay for the care themselves. We stand ready and willing to assist in the drafting of an amendment to the statute, seeking such a clarification. This should be approached along the lines prescribed in the Medicare-Medicaid Administrative Reimbursement Act (S-3205) authored by Sen. Herman Talmadge.

2. Any plan for reimbursement of costs, by necessity, must include definitive and uniform accounting concepts and auditing procedures. Just as the financial equation in cost reimbursement is extremely simple, it is equally simple to understand and appreciate the need for determining, reporting and verifying costs. Once it has been determined by the State that it intends to underwrite the cost of a certain level of care to its elderly citizens, regardless of their ability to underwrite such costs, then any such delivery system or contract for securing said services from providers, should envision an acceptable system of reporting, accounting and auditing such expenditures. This suggestion is also a part of the Talmadge Act.

3. Specific provisions for the pass-through of mandated costs, be they capital improvements, Life Safety Code, Nursing Care, by amendment to SRS Regulation 30-10-12-B-4(A-5)(d), to read:

> "All costs or expenses incurred by the facility in implementation of mandated federal, state or municipal statutes, ordinances, rules or regulations, shall be submitted with proof of compliance and costs of compliance, and thereafter, the Secretary, or his designated agent, shall adjust the rate of reimbursement for said facility to include an amortization of such costs."

4. Finally, once the State has "prescribed" the level of care to be given its elderly citizenry, and once the State has developed the mechanism for underwriting the costs of such care, it remains the responsibility of the State to appropriate the funds for underwriting this commitment. It is only at this point, when the care demanded by the consumer advocate or

prescribed by the regulatory agency is underwritten by an appropriation of the taxpayers' representatives, that it can be said that the State has fully dealt with the issue of its elderly-frail citizens.

MATTERS RELATED TO THE FOREGOING

The State has a dilemma. Different standards prescribed by the State and Federal Governments have bred tremendous confusion. Thus, the State is choosing to adopt the Federal standards, since all but a few homes in the State must meet these criteria anyhow. But consider:

1. When Kansas chooses to adopt extensive Rules and Regulations, and the inevitable costs which they entail, it should be clearly and unequivocably understood that these costs are passed on to private-paying Kansas citizens, as well as those who recieve the benefits of Medicaid. Both the regulatory agencies and this Committee, and in fact, the entire legislature, should clearly understand the impact of these Rules and Regulations on the private citizens of Kansas, who now quietly reside in long-term care facilities, striving to maintain their dignity and believing that public support is the ultimate indignity. These Rules, and the costs which they entail, may well force the much-feared indignities of "welfare" status on these proud but helpless senior citizens.

   The logical extension of this reality is that the costs of this "prescribed" level of care will force many more elderly to accept the benefits of Medicaid, thus the taxpayer picks up the tab.

   These important policy decisions are squarely before this Committee and the 1977 Legislature.

2. <u>The Rules and Regulations adopt, for the most part, an outdated and highly criticized federal "model" of care for the elderly</u>. In a sincere effort to eliminate the confusion in Kansas that has existed because of a substantial difference between State requirements for adult care homes and federal requirements for those receiving federal money, Kansas is proposing to simply adopt the federal regulation. The irony of

this approach is that these same federal regulations are presently being considered by the Subcommittee on Health and Long-term Care of the Select Committee on Aging of the U. S. Congress, which has found that such regulations need substantial revision and that, as they now exist, they have bred poor care, high cost and fraud.

This is not to suggest that all regulations, as proposed, are bad or not needed. Clearly this is not the case. We are simply noting the unavoidable results of a blanket adoption of the federal mandates. As Senator Herman E. Talmage, of Georgia, has observed, in authoring his Medicare-Medicaid Administrative and Reimbursement Reform Act (S-3205):

> "Without necessary reforms, we would simply be building on quicksand."

3. <u>The Rules and Regulations pertain principally to one aspect of the care of the elderly--their medical needs</u>. They should anticipate an infinitely broader viewpoint of long-term care for the elderly.

Again, this concern results from the blanket acceptance of the federal "model" for care. The "medical" model of prescribing care for the elderly is totally outdated, and ignores completely the much broader aspects of such care. As Dr. Stanley Brody, of the University of Pennsylvania, testified before the Subcommittee of the Select Committee on Aging:

> "While the aged have need for acute medical care, the major requirement is in the continuum of services for the clinically disabled that will enable them to function optimally. Any health system which continues to be limited to a disease orientation will not meet the increasing needs of the aging community. Medical services must take their place as a part--and only a part--of the continuum of health care."

And after extensive deliberations on this issue as part of the suggested revisions in the federal Regulations, the report of the Subcommittee, reported in U. S. Government Publication

entitled "NEW PROSPECTIVES IN HEALTH CARE FOR OLDER AMERICANS, RECOMMENDATIONS AND POLICY DIRECTIONS OF THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE OF THE SELECT COMMITTEE ON AGING, 94TH CONGRESS", at Page 43, concludes:

> "The Subcommittee believes the present acute-medical orientation of the nation's health policy, largely based upon the compromises in the 1965 Medicare and Medicaid statute, should be changed. A preventive and medical-social model needs to be developed to avoid later costly curative care and allow the elderly to be productive in the community."

Our Association, in conjunction with our national Association, the American Association of Homes for the Aging, Inc., has, for more than two decades, espoused the "social components of care" concept. If any member of the Committee would be interested, we are prepared to provide a publication dealing specifically with this concept of care for the elderly. The question before the Committee, and more particularly, before the 1977 Kansas Legislature, is whether or not it is expedient to adopt the federal model until such time as someone else drafts a better model. The magnitude of this issue probably is too great to deal with at this point. Admittedly, literally hundreds and hundreds of hours of consideration have been given to the proposed Rules and Regulations, but for the most part, for technical and administrative revision. They have not been fully considered and evaluated for the broader, philosophical and social issues which they encompass. We must wait for Congressman Pepper's committee to deal with this issue.

4. <u>The Rules and Regulations ignore the concept of "Continuum of Care"</u>. Every person is different and has different needs--that is, until he chooses or disability dictates that he enter a long-term care facility. At that point, whether or not any particular resident needs the full gamut of prescribed services or not, he or she is going to get them and is going to pay for them. Building construction, nursing services, entire facilities, are either skill, intermediate or residential, and all costs incurred in services provided are determined by a strict

classification. Obviously at some point, most residents have need of many of the services prescribed at each level of care, but it is obvious that the care prescribed is so structured that in most cases, should it meet the precise needs of the elderly, it is accidental rather than planned. The aging process, both mental and physical, is a continuum, and care should be tailored accordingly. Unneeded services should not be forced upon residents, and whatever services are needed by a particular person should be made available.

## CONCLUSION

We would be remiss if we did not publicly declare our most sincere appreciation for the commitment of time and energy by the Committee, by Secretary Metzler, Dr. Wiese, Dr. Mankin, Mr. Swanson, Dr. Harder, Mr. Richards, Mr. Newman, Mrs. Correll, Mr. Furse, and the many, many other persons, all of whom are fully aware of the issues discussed in this letter. Having served as an officer in the FORUM OF STATE EXECUTIVES and having, in that Forum, listened to the "state of the art" in the other forty-nine states, I feel that the elderly citizens of the State of Kansas are indeed fortunate to have people such as these committed to these issues.

Very truly yours,

Stewart L. Entz

SLE/lm

Midland Mutual Investment Corporation, Inc.

Represented by John Jones

| | 1975 | 1974 | 1973 | 1972 | 1971 | 1970 |
|---|---|---|---|---|---|---|
| Revenues from Nursing Homes | $4,587,218 | $3,949,908 | $3,589,021 | $3,190,127 | $2,552,545 | $1,799,176 |
| Number of Beds | 1134 | 1080 | 1028 | 1025 | 975 | 821 |
| Revenue per Bed | $4045 | $3657 | $3491 | $3112 | $2618 | $2191 |

Girard Rest Homes, Girard

Concordia Rest Homes, Inc. Concordia

Wakarusa Manor, Inc. Lawrence

Eureka Rest Home Eureka

De Soto Rest Home, Inc. De Soto

Spring Hill Manor, Inc. Spring Hill

Olathe Nursing Home, Inc. Olathe

Cottonwood Manor, Inc., Emporia

Emporia Rest Homes, Inc. Emporia

Caney Rest Home, Inc. Caney

Fredonia Rest Home, Inc. Fredonia

Hillcrest Manor, Inc. Fredonia

Neodesha Rest Home, Inc. Neodesha

Edwardsville Manor, Inc. Edwardsville

Edwardsville Convalescent Center, Inc. Edwardsv

Parkway Care Home Edwardsville

Attachment

Because there are presently fewer than 300 Mid-America stockholders, Mid-America intends to cause the registration of its common stock under the Securities Exchange Act of 1934 to be terminated.

For the three month period ended June 30, 1976, net revenues of Mid-America were $1,392,398 compared to $1,225,018 for the same period in 1975, and net income was $39,521 or $.13 per share as compared to $26,755 or $.09 per share for the same period in 1975.

Of the 314,250 shares issued during both years there were 299,654 shares outstanding at 6-30-76 and 308,730 shares outstanding at 6-30-75. The earnings per share are computed on the number of shares outstanding on these dates.

You are urged to review the Offer to Purchase for Cash, dated July 23, 1976, a copy of which has been previously sent to you and the enclosed Letter of Transmittal for further information concerning the Offer and Mid-America.

Assistance in accepting the Offer and additional copies of the Offer to Purchase may be obtained from

MICK, STACK ASSOCIATES, INC.
17 EAST SIDE FINANCIAL CENTER
7701 East Kellogg
Wichita, Kansas 67207

tel. no. (316) 685-4141
Kansas toll free tel. no. (800) 362-2300

or from

MID-AMERICA NURSING CENTERS, INC. ←
4510 West Central
Wichita, Kansas 67212

(Chas. Wirth)

tel. no. (316) 943-2203

four K-32, an east-west high , and a north-south highway (a future extension of I-435), which will provide Kansas City International Airport with an access highway into Kansas. Edwardsville Industrial Park is a planned business-industrial community designed to provide a pleasant and attractive environment for an employer at the crossroads of the midwest. It offers the unusual combination of a small town with its high quality life style adjacent to a large metropolitan market. Edwardsville Industrial Park is part of a complete new community development including a single-family housing area, a neighborhood shopping center with an outstanding restaurant, and a large and growing mobile home village of almost 350 families.

These facilities are adjacent to the industrial park and provide the conveniences working people want — all within walking distance of their place of employment.

● Parkway Single-Family Residential Community in our Edwardsville planned unit development has a common green lawn area behind the homesites for use as playground area for all of the homeowners. The company furnishes the finished sites with underground utilities, streets and green area. The homes are constructed and sold by private builders. The project is unique in that it is the first cluster type housing subdivision in the Kansas City area.

● The Mobile Home Villages at Edwardsville and Kansas City, Kansas, projected to have been completed and occupied by 960 families in mid-1976, have been caught in a national dilemma of repossessions resulting from sales to many uncreditworthy buyers. Until young married couples and retirees, who account for 70 per cent of all mobile home purchasers, buy these repossessions (many of which are already situated in existing parks) thus absorbing the used mobile home supply, the demand for mobile home lots will continue to be slow.

We now have 619 mobile homes in our two parks. 296 in Kansas City, Kansas, at 97 per cent occupancy and 323 in Edwardsville at 79 per cent occupancy, a combined total occupancy of 87 per cent. Our projection was to have completed and have occupied 960 mobile home spaces by 1976, but this projection will have to be extended to, perhaps, 1980. The soaring price of conventional one-family homes is creating a vast new potential market for mobile homes, especially the double-wide homes. The biggest single factor holding back mobile home sales today is the mixed emotions of financial institutions concerning the proper time to move forward to their former levels of mobile home financing.

● The Shopping Center at Edwardsville is the hub of the mobile home village, the Parkway and Edwardsville Industrial Park with a total of 31,600 square feet. In the first two phases completed, we have 76 per cent of the center occupied by a supermarket, a restaurant and four other service shops.

● The Spring Hill Shopping Center on a 24-acre tract in the town of Spring Hill, Johnson County, Kansas, is being developed as another "new community" project. Phase 1 has been completed with a building which is occupied by another Bob's Super Saver unit along with space for the basic shops required by the community. The center is 70 per cent leased. As part of this development, the Spring Hill Nursing Home was completed and opened for patients in February 1975.

## HEALTH CARE

● Midland Business Investment Corporation, Inc., through wholly-owned subsidiaries has a substantial investment in the health care industry. We own and operate 20 nursing homes, 19 in Kansas and one in Missouri, with patient beds totaling 1,134.

Our first home was constructed in 1962 and our most recent home, a 50-bed facility in Spring Hill, Kansas, was opened February 25, 1975. All of our homes were built to our own specifications after we studied the needs of the area to be served and determined the profitability of a health care facility. Despite the fact that we opened a new nursing home this past fiscal year, our overall occupancy rate never fell below 95 per cent, which is a great tribute to the administrators of our 20 homes.

A considerable amount of money and effort was invested this year in bringing our health care facilities up to the new federal standards which, incidentally, change constantly. These new rules not only apply to the physical plant but also to employee staffing and to additional reports and paper work.

The health care industry is undergoing constant changes, changes which concern us since there are too many agencies now involved in our daily operations. Attempting to maintain jurisdiction over various phases of operations is a multiplicity of agencies created by the city, county, state and federal governments. The added paper work to be accomplished and the required attendance at meetings by our supervisors are becoming unnecessary burdens.

We are confident, however, that the dedicated and problem-solving people who head up our nursing home division will handle these distractions with their customary dispatch.

## BOB'S SUPER SAVER, INC.

● Midland Business Investment Corporation, Inc., entered into a joint venture with Bob Kleier in 1973 for the ownership and operation of retail supermarkets to be located in communities considered by the larger chains to be too small to be profitable. The on-going concept is to offer modern supermarket facilities to people in communities which presently do not have such facilities.

Presently there are five operating stores, one of which is being replaced by a larger and newer facility. The supermarkets are located in facilities ranging in size from 9,000 to 14,500 square feet, and they carry a complete line of produce, meats, grocery, and household products.

Net income as a per cent of sales was 1.7 per cent for the fiscal year ended August 31, 1975, which far exceeds the industry average. Accordingly, the company will aggressively pursue additional supermarket outlets in those areas which meet our profitability criteria.

UNION GAS SYSTEM AND CONSOLIDATED SUBSIDIARIES

# TEN YEARS OF FINANCIAL AND STATISTICAL HIGHLIGHTS

| For The Years Ended August 31, | 1975 | 1974 | 1973 |
|---|---|---|---|
| **REVENUES** | | | |
| Natural Gas | | | |
| Residential and Commercial | $ 8,077,062 | $ 6,345,513 | $ 6,404,569 |
| Industrial and Other | 6,027,792 | 4,636,347 | 3,614,997 |
| LP-gas | 8,262,486 | 8,130,382 | 6,355,756 |
| Nursing Homes | 4,587,218 | 3,949,908 | 3,589,021 |
| Mobile Home Sub-Division | 557,212 | 508,889 | 432,580 |
| Real Estate Sales | 303,825 | 609,828 | 581,297 |
| Supermarket Sales | 3,006,917 | 1,756,511 | 564,236 |
| Other Revenues | 505,646 | 361,587 | 264,505 |
| Total Revenues | $31,328,158 | $26,298,965 | $21,806,961 |
| **GAS SALES VOLUMES** | | | |
| Natural Gas Residential & Commercial MCF | 8,553,354 | 7,554,212 | 8,406,902 |
| Natural Gas — Industrial MCF | 11,461,669 | 11,391,170 | 10,778,557 |
| Total — Natural Gas MCF | 20,015,023 | 18,945,382 | 19,185,459 |
| LP-gas — Residential & Commercial Gallons | 30,264,085 | 26,834,026 | 39,075,899 |
| LP-gas — Wholesale Gallons | 2,279,857 | 1,003,113 | 1,887,757 |
| Total — LP-gas Gallons | 32,543,942 | 27,837,139 | 40,963,656 |
| **NUMBER OF CUSTOMERS at Year-End** | | | |
| Natural Gas | 43,030 | 41,908 | 40,734 |
| LP-gas | 30,771 | 30,465 | 31,337 |
| Total | 73,801 | 72,373 | 72,071 |
| **GAS STATISTICS** | | | |
| Maximum Day Sendout — MCF | 108,354 | 91,192 | 93,229 |
| Gas Produced & Purchased Locally MCF % | 4.1 | 5.3 | 4.1 |
| Heating Season as Percent of Normal (Note 5) | 106.5 | 94.2 | 112.8 |
| **MOBILE HOME & NURSING HOME STATISTICS** | | | |
| Nursing Home Beds | 1,134 | 1,080 | 1,028 |
| Mobile Home Village Spaces | 706 | 706 | 692 |
| **CAPITAL STRUCTURE** | | | |
| Common Equity | 11,631,491 | $10,884,644 | $10,249,184 |
| Long-term Debt | 13,440,384 | 14,113,036 | 13,132,178 |
| Other Notes Payable | 802,600 | 1,670,753 | 652,130 |
| Total Capitalization | $25,874,475 | $26,668,433 | $24,033,492 |
| Debt Ratio Percent | 55.1 | 59.2 | 57.4 |
| **CASH EXPENDITURES FOR PLANT (Net of Retirements)** | | | |
| Natural Gas and Non-Regulated Properties of Parent | $ 851,715 | $ 1,118,330 | $ 1,319,827 |
| LP-gas | 298,953 | 280,212 | 700,316 |
| Nursing Homes | 524,608 | 816,883 | 110,993 |
| Mobile Home Sub-Divisions | 71,175 | 136,692 | 376,487 |
| Shopping Center Operations | 706,536 | 632,774 | 209,326 |
| Super Market and Other Operations | 105,815 | 94,626 | 34,293 |
| Consolidated | $ 2,558,802 | $ 3,079,517 | $ 2,751,242 |
| **PER SHARE OF COMMON STOCK** | | | |
| Net Income | $ 1,550,642 | $ 1,466,234 | $ 1,552,123 |
| Earnings (Notes 1 & 3) | 1.11 | 1.05 | 1.11 |
| Dividends Paid (Note 3) | .56 | .56 | .55 |
| Book Value | 8.33 | 7.77 | 7.30 |
| Shares Outstanding at End of Year (Notes 2 & 4) | 1,396,794 | 1,399,594 | 1,404,732 |
| Market Price (Bid) at August 31 (Note 4) | 8 | 8¾ | 9¾ |

NOTES: 1. Includes extraordinary items of .06 per share in 1970, .04 per share in 1969 and .25 per share in 1967.
2. Excludes shares held as Treasury Stock.

= $ 365-1.32

= $4045.17

| 1972 | 1971 | 1970 | 1969 | 1968 | 1967 | 1966 |
|---|---|---|---|---|---|---|
| $ 5,696,424 | $ 5,681,131 | $ 5,437,939 | $ 5,059,789 | $ 4,578,113 | $ 4,210,909 | $ 3,971,209 |
| 3,587,820 | 3,071,304 | 2,744,231 | 2,632,945 | 2,457,942 | 2,368,190 | 2,527,477 |
| 5,015,296 | 5,196,814 | 4,680,639 | 4,059,999 | 3,685,722 | 3,485,765 | 2,780,812 |
| 3,190,127 | 2,552,545 | 1,799,176 | 1,215,569 | 935,873 | 733,767 | 515,414 |
| 311,830 | 215,788 | 150,767 | 133,434 | 131,908 | 113,090 | 79,906 |
| 159,890 | 80,938 | 278,392 | 272,805 | 185,315 | — | — |
| — | — | — | — | — | — | — |
| 213,954 | 185,456 | 225,731 | 442,107 | 387,020 | 300,174 | 204,026 |
| $18,175,341 | $16,983,976 | $15,316,875 | $13,816,648 | $12,361,893 | $11,211,895 | $10,078,844 |
| 7,367,629 | 7,733,520 | 7,626,005 | 7,361,547 | 6,644,241 | 6,048,936 | 5,651,412 |
| 11,042,807 | 10,502,830 | 9,912,504 | 9,715,704 | 9,182,292 | 8,792,910 | 9,528,586 |
| 18,410,436 | 18,236,350 | 17,538,509 | 17,077,251 | 15,826,533 | 14,841,846 | 15,179,998 |
| 32,663,872 | 34,415,103 | 34,550,963 | 29,965,373 | 26,293,896 | 24,067,118 | 22,620,211 |
| 1,790,067 | 1,001,440 | 1,154,061 | 1,364,596 | 1,483,681 | 2,323,024 | 2,765,823 |
| 34,653,939 | 35,416,543 | 35,705,024 | 31,329,969 | 27,777,577 | 26,390,142 | 25,386,034 |
| 39,526 | 38,150 | 36,910 | 35,757 | 34,779 | 33,372 | 32,617 |
| 30,553 | 29,422 | 28,425 | 26,817 | 23,178 | 22,493 | 22,024 |
| 70,079 | 67,572 | 65,335 | 62,574 | 57,957 | 55,865 | 54,641 |
| 98,058 | 89,289 | 93,785 | 87,592 | 85,953 | 78,589 | 86,269 |
| 5.5 | 6.5 | 8.1 | 9.0 | 9.1 | 9.6 | 10.1 |
| 95.8 | 104.8 | 108.7 | 112.5 | 104.3 | 98.2 | 95.4 |
| 1,025 | 975 | 821 | 530 | 430 | 330 | 330 |
| 605 | 504 | 400 | 305 | 304 | 304 | 235 |
| $ 9,466,003 | $ 8,797,457 | $ 8,265,476 | $ 7,682,474 | $ 6,763,200 | $ 6,259,490 | $ 5,843,598 |
| 11,380,001 | 12,280,816 | 11,702,966 | 7,871,402 | 8,380,161 | 7,881,038 | 5,721,847 |
| 1,903,957 | 736,314 | 270,547 | 629,403 | — | 150,000 | 615,000 |
| $22,749,961 | $21,814,587 | $20,238,989 | $16,183,279 | $15,143,361 | $14,290,528 | $12,180,445 |
| 58.4 | 59.7 | 59.2 | 52.5 | 55.3 | 56.2 | 52.0 |
| $ 906,729 | $ 504,382 | $ 765,640 | $ 758,954 | $ 846,256 | $ 1,409,371 | $ 1,556,845 |
| 594,748 | 379,105 | 597,155 | 1,199,370 | 240,030 | 189,858 | 678,123 |
| 539,135 | 264,524 | 2,357,610 | 962,748 | 344,169 | 196,203 | 398,250 |
| 241,826 | 354,063 | 297,677 | 324,786 | — | 54,064 | 89,031 |
| 387,692 | — | — | — | — | — | — |
| — | 16,083 | 133,101 | (857,789) | 2,937 | 918,351 | 608,216 |
| $ 2,670,130 | $ 1,518,157 | $ 4,151,183 | $ 2,388,069 | $ 1,433,392 | $ 2,767,847 | $ 3,330,465 |
| $ 1,378,810 | $ 1,206,604 | $ 1,152,103 | $ 1,303,739 | $ 849,210 | $ 697,626 | $ 565,024 |
| .98 | .86 | .82 | .94 | .62 | .51 | .41 |
| .50 | .43 | .37 | .33 | .27 | .20 | .19 |
| 6.74 | 6.26 | 5.87 | 5.45 | 4.89 | 4.56 | 4.25 |
| 1,405,732 | 1,406,062 | 1,409,508 | 1,410,056 | 1,384,752 | 1,374,810 | 1,374,516 |
| 9¼ | 9¼ | 8½ | 12¾ | 7⅝ | 5¾ | 4¾ |

3. Earnings and dividends per share of common stock have been computed on the basis of the weighted average shares outstanding adjusted to give effect to the 100% stock distribution in 1965, the 5% stock dividend and the 3-for-1 stock split in 1967, and the 2-for-1 stock split in 1974.
4. Book value, shares outstanding at year end and the market price (bid) have been adjusted to reflect stock dividends and stock splits, as disclosed in note 3, where appropriate.
5. Figures represent temperature deficiency factors when the mean daily temperatures were below 65° F. Above 100% is colder than normal, below 100% is warmer than normal.

Attachment C.

22 Oct 75

EAGLE
10/18/76

# Educate families

## Ann Landers

Dear Ann Landers: I work in a nursing home mainly for elderly people who need to be rehabilitated. They have had a variety of illnesses, mostly strokes, arthritis and broken bones. We have helped many people walk again, talk again and return to a life worth living.

My anger is directed against the families of my patients. For example: I have in my care a woman who is grossly obese. We put her on a diet but her daughters are full of guilt because they feel their mother should be living with them. So they attempt to ease the guilt by bringing her candy, cakes, cookies — everything she shouldn't eat. This woman is gaining weight instead of losing and we can't do anything about it.

Another patient who had a stroke could not feed himself. We worked diligently with him and he was doing well. Then his daughter decided we were being mean to her father. She started to come to the hospital daily to spoon-feed him. Now he has become totally dependent and refuses to do anything for himself.

I can't sign my name because nurses are expected to be compassionate toward everyone. I guess I'm a failure because my compassion goes primarily to my patients.

Please print this. Somebody might learn something. — Seattle

**Dear Seattle: As one who is close to the Rehabilitation Institute of Chicago, I am well aware of the dedication of physicians, nurses and therapists.**

**According to Dr. Henry Betts, medical director of the institute, they encounter very little of the recalcitrance you describe at this facility because educating the families is considered part of the treatment. When relatives understand the importance of cooperation, they become part of the team.**

Attachment D

# THE UNIVERSITY OF KANSAS

Office of the Chancellor
223 Strong Hall, Lawrence, Kansas 66045
(913) 864-3131

October 4, 1976

The Honorable W. H. Sowers
State Senator, District 31
234 Brookside Drive
Wichita, Kansas 67218

Dear Wes:

A few weeks ago, you asked us to develop some information in response to questions that have arisen during the work of the Special Committee on Health and Welfare. I am sorry we have been so long in responding, but I learned only recently that your inquiry to the Medical Center had not been answered. I now have the information to respond, and for clarity I shall summarize that information under separate headings below.

Cost of Restoring Health Care Benefits for Medical Residents

In the past, members of the housestaff and their families were given access to the patient care services of the Medical Center without charge. In addition, physician services were provided free of charge by members of the clinical faculty. It is estimated that the Medical Center "wrote off" more than $50,000 a year to provide this benefit for medical residents.

As of July 1, 1976, this benefit was discontinued, and residents have been advised that they will have to provide for their own health care through purchase of health insurance such as that offered by Blue Cross and Blue Shield. The cost for an unmarried resident would be approximately $18 per month, I'm advised. If married, the resident's cost, if the spouse were also covered, would be approximately $50 per month.

Since we have at the Medical Center approximately 332 residents, more than 80 percent of whom are married, the total cost of providing health care benefits would be about $173,000 annually. (This is computed by multiplying 264 married residents times $600 and adding the 68 unmarried residents at $216 each.) The figures are rounded and are as close as we can determine at this time, but the total indicates the size of the cost. If the state were to provide health insurance benefits for just the residents (and not for members of their families), the cost would be approximately $72,000 annually at current rates.

Cost of Providing Medical Malpractice Insurance Coverage

The cost of providing medical malpractice insurance coverage for residents varies widely among fields of specialization, and occasionally within fields as well. The cost per resident by field is as follows:

Anesthesiology--varies from an annual premium of $394 with a stabilization fund surcharge of $177 to an annual premium of $941 with a surcharge of $423.

Otorhinolaryngology--annual premium of $941 with a stabilization fund surcharge of $423.

Family Practice--annual premium of $206 with a stabilization fund surcharge of $93.

Obstetrics and Gynecology--annual premium of $1123 with a stabilization fund surcharge of $505.

Internal Medicine--average annual premium of $206 with a stabilization fund surcharge of $93.

Neurology--annual premium of $349 with a stabilization fund surcharge of $157.

Ophthalmology--annual premium of $579 with a stabilization fund surcharge of $261.

Pathology--annual premium of $206 with a stabilization fund surcharge of $93.

Pediatrics--annual premium of $206 with a stabilization fund surcharge of $93.

Psychiatry--annual premium of $206 with a stabilization fund surcharge of $93.

Radiology--annual premium of $349 with a stabilization fund surcharge of $157.

Rehabilitation Medicine--annual premium of $206 with a stabilization fund surcharge of $93.

Surgery--average annual premium of $941 with a stabilization fund surcharge of $423.

Neurosurgery--annual premium of $1489 with a stabilization fund surcharge of $670.

Orthopedic surgery--annual premium of $1489 with a stabilization fund surcharge of $670.

Plastic surgery--annual premium of $1123 with a stabilization fund surcharge of $505.

Urological surgery--annual premium of $758 with a stabilization fund surcharge of $341.

Cardiothoracic surgery--annual premium of $1,489 with a stabilization fund surcharge of $670.

As you can determine from the foregoing, the cost of providing medical malpractice insurance coverage for medical residents is substantial. Including residents at both the Medical Center and those in Wichita hospitals who are state-supported, the total cost, given the current number of residents by field, would be between $200,000 and $250,000. Moreover, it is anticipated that the cost of medical malpractice insurance will increase by 25 percent next year. These costs are not in our budget for FY 78 since we have had no authorization to request the support.

Data on Residencies in Family Practice, Internal Medicine, Pediatrics, and Obstetrics-Gynecology

You requested a listing by classification of the number of doctors completing residencies in these four fields in 1974, 1975, and 1976, along with the anticipated corollary numbers for 1977, 1978, and 1979. You asked also for the number of University of Kansas School of Medicine graduates in these fields and the number of residencies in Kansas available to them.

To provide that information for you in a useful format, we have constructed three tables which I have attached to this letter. The growth in the number of residents in family practice is worth special mention, as is the increase in the number of residency positions in that field and the decision by growing numbers of our students to go into primary care fields. As you can see, the number of residents completing training in family practice has grown from 3 in 1974 to 12 this year; and the number is expected to rise to 26 by 1979. Indeed, from this next summer on, we will see the results "at the end of the pipeline" of our efforts to produce more family doctors and primary care practitioners.

Wes, I hope this information is what you wanted and that it is helpful to you and the Special Interim Committee on Health and Welfare. If you should want additional information of any kind, be sure to let me know.

Sincerely,

Archie R. Dykes
Chancellor

ARD:ew

Attachments

Table 1. Number of residents who completed training programs in Family Practice, Internal Medicine, Pediatrics, and Obstetrics-Gynecology under the aegis of the University of Kansas School of Medicine in 1974-76, and estimated number of completions, 1977-79.

| Department | 1974 | 1975 | 1976 | Total 1974-76 | 1977 | 1978 | 1979 | Est. Total 1977-79 |
|---|---|---|---|---|---|---|---|---|
| Family Practice | 3 | 14 | 12 | 29 | 23 | 25 | 26 | 74 |
| Internal Medicine | 20 | 33 | 30 | 83 | 30 | 37 | 39 | 106 |
| Pediatrics | 4 | 4 | 4 | 12 | 5 | 8 | 9 | 22 |
| Gynecology/ Obstetrics | 3 | 6 | 7 | 16 | 7 | 7 | 5 | 19 |
| TOTALS | 30 | 57 | 53 | 140 | 65 | 77 | 79 | 221 |

Table 2. Number of available first year residency positions in State of Kansas, July 1974-July 1976, and estimated openings, July 1977-July 1979.

| Program | 1974 | 1975 | 1976 | Total 1974-76 | 1977 | 1978 | 1979 | Est. Total 1977-79 |
|---|---|---|---|---|---|---|---|---|
| Family Practice | 19 | 19 | 23 | 61 | 32 | 34 | 34 | 100 |
| Internal Medicine | 32 | 34 | 36 | 102 | 42 | 39 | 39 | 120 |
| Pediatrics | 8 | 9 | 13 | 30 | 10 | 12 | 12 | 34 |
| Gynecology/ Obstetrics | 7 | 9 | 8 | 24 | 5 | 6 | 6 | 17 |
| TOTALS | 66 | 71 | 80 | 217 | 89 | 91 | 91 | 271 |

Table 3. First year residency positions in State of Kansas and distribution of selections by graduates of the University of Kansas School of Medicine. Data on available positions is based upon figures in Table 2.

| Program | 1974 | | | 1975 | | | 1976 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Positions | Selected* I | O | Positions | Selected* I | O | Positions | Selected* I | O |
| Family Practice | 19 | 12 | 14 | 19 | 13 | 8 | 23 | 15 | 11 |
| Internal Medicine | 32 | 20 | 21 | 34 | 30 | 44 | 36 | 19 | 20 |
| Pediatrics | 8 | 4 | 9 | 9 | 7 | 8 | 13 | 5 | 7 |
| Gyncology/ Obstetrics | 7 | 2 | 2 | 9 | 2 | 3 | 8 | 4 | 5 |

* I=Number of graduates who selected residencies in Kansas.
O=Number of graduates who selected residencies outside of Kansas.

Attachment E

UNITED STATES ENVIRONMENTAL PROTECTION AGENCY

REGION VII
1735 BALTIMORE
KANSAS CITY, MISSOURI – 64108

July 12, 1976

Mr. Norman Furse
Office of the Revisor of Statutes
Topeka, Kansas 66612

Dear Mr. Furse:

In response to your request of last week concerning federal funding for the Kansas water supply program, I offer the following:

1. In the fiscal year 1976, the Kansas water supply program with a total budget of $266,272 received EPA grants of $12,500 in the form of a demonstration grant, and $111,500 for a program grant.

2. The tentative EPA program grant allocation for the Kansas water supply program for fiscal year 1977 is $222,900.

3. Federal funding of the Kansas water supply program after fiscal year 1977 will, as with other federal program grants, be based on future federal budgetary allocations.

I hope this information is adequate. If I can be of further help, or if you require more information, please do not hesitate to call us.

Sincerely yours,

John H. Morse,
Regional Counsel

Attachment F

HOUSE CONCURRENT RESOLUTION NO. ____

By Special Committee on Public Health and Welfare

A CONCURRENT RESOLUTION recommending that steps be taken toward development of rural health care centers in Kansas.

WHEREAS, Increases in the supply of professionals in the healing arts have not resulted in more equitable distribution of health care manpower in the state of Kansas; in fact the maldistribution has worsened in the past decade; and

WHEREAS, In searching for ways to solve this problem of physician distribution, one approach should be the development of model rural health care centers; and

WHEREAS, In addition to making the practice of medicine in Kansas rural areas more attractive to new physicians, the development of model rural health care centers would provide much needed clinics for those ambulatory patients who would normally not have access to adequate medical services in their time of need; and

WHEREAS, Reputable studies have shown that there is a high probability that a doctor will establish a medical practice in the geographic area where he or she serves a medical residency; and

WHEREAS, Development of model rural health care centers, which will also serve as training centers for Primary Care residents, will decisively affect the decisions of medical students because of the exposure of such young doctors to the benefits of medical practice in communities and areas which are not now sufficiently served; and

WHEREAS, When doctors are encouraged to establish medical practices in smaller communities and rural areas of our state, it becomes essential that opportunities be provided for professional stimulation and growth; and

WHEREAS, Increased emphasis is being given to programs of

continuing education for practicing physicians so that they may avoid the harmful effects of isolation from the advances in medical science and in the techniques of practice; and

WHEREAS, If model rural health care centers are developed, in addition to serving as clinics for ambulatory patients and training centers for Primary Care residents, they would also serve as central locations for continuing education programs for area physicians: Now, therefore,

Be it resolved by the House of Representatives of the State of Kansas, the Senate concurring therein: That the University of Kansas School of Medicine shall submit a written report to the Legislature containing specific recommendations as to the construction and staffing of such centers.

Be it further resolved: That the University of Kansas School of Medicine present a comprehensive set of recommendations for the location and utilization of model rural health care centers in the smaller communities and rural areas of our state.

Be it further resolved: That the secretary of state be directed to prepare an enrolled copy of this concurrent resolution for mailing to Dr. Archie R. Dykes, Chancellor of the University of Kansas and to Dr. Robert Kugel, Executive Vice-Chancellor, Kansas University School of Medicine.

Attachment 2

HOUSE CONCURRENT RESOLUTION NO. _____

By Special Committee on Public Health and Welfare

A CONCURRENT resolution recommending the University of Kansas School of Medicine to add to their criteria for admission to medical school the Kansas geographic location of the applicant.

WHEREAS, The need for producing an increased number of physicians in rural areas of the state of Kansas has been well documented. If patterns of the past continue, the large majority of new physicians will choose to practice in middle and upper class communities which are near major population centers. Even though in the past few years the number of physicians has increased, this increase will have little effect on the shortage of physicians practicing in rural areas; and

WHEREAS, One of the most important factors considered by admissions committees in determining who among all the applicants should constitute the group to be admitted annually, has been the scholastic average maintained by such applicants in the University studies prior to the date of their application; and

WHEREAS, In recognition of the need for medical practitioners in rural areas throughout the state of Kansas, we believe that particular attention should be given to the communities in which they live in determining which applicants are to be admitted to the college of medicine if the health and welfare of the people in those rural areas shall not be impaired; and

WHEREAS, We believe that sons and daughters of persons residing in the rural areas are more likely to return to those areas and engage in the practice of medicine since by virtue of their background and experience will especially motivate and suit them for rural practice: Now, therefore,

Be it resolved by the House of Representatives of the State of Kansas, the Senate concurring therein: As a practical induce-

ment to qualified youth interested in a medical career, we support the use of the geographic location of the applicant as an additional criteria for the selection of those students who will be admitted to the University of Kansas School of Medicine. We feel that since the admissions committee is annually faced with an abundant number of qualified candidates for admissions, it would be better to make choices which will reflect the needs of society rather than simply choosing candidates on the basis of minute differences in academic credentials thereby making more certain that residents from all parts of the state will have adequate medical service available in their time of need.

Be it further resolved: That the secretary of state is hereby directed to transmit a copy of this resolution to Chancellor Archie Dykes and to Dr. Dwight J. Mulford, Dean of Admissions of the University of Kansas School of Medicine.

Be if further resolved: That Dr. Mulford communicate this new standard for admissions to all colleges and universities located in the state of Kansas.

Attachment #4

HOUSE CONCURRENT RESOLUTION NO. ____

By Special Committee on Public Health and Welfare

Re: Proposal No. ____

A CONCURRENT RESOLUTION directing the Kansas Board of Regents to give primary consideration in increasing the funding of residencies in medical school in the area of primary care, with an eventual goal of at least 50% of residencies in primary care.

WHEREAS, The Kansas Legislature realizes there is a need to concentrate on increasing the aggregate supply of health manpower in the state of Kansas through increasing enrollments in health professional schools and maintaining the fiscal viability of such schools; and

WHEREAS, Because of this awareness, the Kansas Legislature reflects the realization that health manpower problems currently relate not so much to total numbers but to the distribution of health professionals and the shortage of primary care physicians; and

WHEREAS, According to updated professional organization data, there are 2,879 active MD's in the state of Kansas. Of these, 41 percent are primary care physicians, or a ratio of 53 primary care physicians per 100,000 persons. Primary care physicians defined are Doctors of Medicine in general practice, family practice, pediatrics, and internal medicine. This ratio is below the national average and also is below the recommended primary care ratios. Even though the magnitude of the problem varies with the comparison ratio and the geographic area selected, Kansas does have a physician shortage or, more precisely, a primary care physician shortage; and

WHEREAS, The number of applicants for instruction in the medical sciences at the University of Kansas has increased during the past few years, however, in order for the state of Kansas to

have a medical environment which reflects the needs of the Kansas society, more residency positions need to be earmarked for those graduates interested in primary care medical practice: Now, therefore,

Be it resolved by the House of Representatives of the State of Kansas, the Senate concurring therein: That, in recognition by the legislature of the state of Kansas of the urgent need for primary care physicians, we favor development of additional residency programs to those graduates interested in primary care medical practice, with an eventual goal of at least 50% of residencies positions earmarked for primary care by 1980.

Be it further resolved: That the secretary of state is hereby directed to transmit a copy of this resolution to the chairperson of the state board of regents for duplication and transmitted to every member of the state board of regents and one copy to Archie Dykes Chancellor of the University of Kansas.

Attachment I

SENATE CONCURRENT RESOLUTION NO. _____

By Special Committee on Public Health and Welfare

A CONCURRENT RESOLUTION recommending that a program, which permits qualified students to complete requirements for both a B.S. and M.D. degree within six calendar years, be developed.

WHEREAS, In the early 1970's a number of medical and other health sciences schools throughout the United States implemented curricular changes which would result in graduating a health practitioner after six calendar years of instruction instead of the customary eight years; and

WHEREAS, The stated advantages of a six calendar year curriculum is that it will increase the overall supply of health practitioners, increase by two years the number of years that each graduate would expect to practice, and increase the utilization of educational facilities; and

WHEREAS, These experimental accelerated programs have shown that high school students with high scholastic ability and motivation can be selected and can succeed academically in accelerated programs: Now, therefore,

Be it resolved by the Senate of the State of Kansas, the House of Representatives concurring therein: As a method of eliminating the shortage of physicians in the state of Kansas, we recommend that the University of Kansas School of Medicine be directed to determine the feasibility of implementing into their curriculum an accelerated program in which high school students with high scholastic ability and motivation can be selected to participate in a program which will allow them to complete their requirements for both their undergraduate degree and M.D. degree within six calendar years.

Be it further resolved: That the secretary of state be instructed to deliver an enrolled copy of this resolution to Dr.

Archie R. Dykes, Chancellor of University of Kansas, and Dr. Robert Kugel, Executive Vice Chancellor, University of Kansas School of Medicine.