Approved 1-19-84
Date

MINUTES OF THE HOUSE & SENATE JOINT/ COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR JAN MEYERS
Chairperson
at

1:30 ~~a.m.~~/p.m. on January 10, 1984 in room 519-S of the Capitol.

All members were present except:

Kenneth King, excused

Committee staff present:

Committee Secretary, Sue Hill

Conferees appearing before the committee:

Dr. George Varghese,M.D. Assoc.Prof, Rehabilitation Medicine/Univ.K.M.C.
Dr. Dennis Swiercinsky,Ph.D.Neuropsychologist, Mission Ks.
Ms.Patricia Mitchell, Case Mgr. Occupational Center, Salina, Ks.
Dr. Jack Mohler, M.D., Physiatrist, Abilene, Ks.
Ms. Mary Pat Beals, Pres. of Ks. Head Injury Assoc., Roeland Park, Ks.

Senate Chairman Meyers called this informational meeting for joint House and Senate Public Health and Welfare committees to order. Introducing above conferees, and welcoming guests.

Dr. Varghese gave a slide presentation, using printed text. (See Attachment No. 1.for details). Commented the reduced speed limit, seat belts, safety restraints for children and educating the public has help reduce some numbers of head injuries. Urged committee for study on desperate need for continued out-patient care and follow up care facilities for head injury patients.

Dr. Dennis Swiercinsky gave an in depth report on brain trauma. Noted resources in Kansas for specialized care for head injury patients is limited, and there is no facility available presently for care beyond acute care. (See Attachment No. 2.)

Ms. Patricia Mitchell's remarks stressed Quality Care for the head injured and referred to "serious gaps" in treatment in Kansas. She stressed an urgent need in our state for head injured care facilities. (See Attachment No. 3.)

Jack M. Mohler, M.D. gave his views from the private practice side, using several patients as references. Dr. Mohler followed a printed outline, (See Attachment No. 4.)

Many questions and answers followed. Discussion on geographic locations of care facilities, unnecessary injuries because of non-helmet cycle riders. alcohol related accidents, etc.

Meeting was adjourned by House Chairman, Marvin Littlejohn after the Senate Chairman and her committee members had to leave prior to adjournment. Meeting was adjourned at 3:00 p.m.

REHABILITATION PROGRAM FOR THE HEAD INJURED

George Varghese, M.D.
Associate Professor
Department of Rehabilitation Medicine
University of Kansas Medical Center
Kansas City, Kansas

INCIDENCE - 30,000 - 50,000 serious head injuries per year in U.S.A.

50% die in first few days.

3% remain in persistent vegetative state.

Rest have physical and mental deficits.

80% are less than 30 years of age.

IMMEDIATE HOSPITALIZATION

1. Acute phase - Resuscitation
   - Life supportive measures
   - Surgery
2. Rehabilitation phase

   Goal - Channelize neurological recovery.
   - Prevent complications.
   - Improve function.
   - Cognitive retraining.

   Methods - Stimulation (visual, auditory, tactile).
   - Functional training.
   - Perceptual-motor training.
   - Neuromuscular re-education.

   Length of Hospitalization - 2 - 6 months.

STATUS AT THE TIME OF DISCHARGE

GROUP A - Persistent vegetative state - usually requires a long term care facility.

GROUP B - Mild to moderate physical and/or mental deficits. (Most of the patients belong to this group)

GROUP C - Minimal or no physical deficit, but has cognitive deficits.

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COMMON PROBLEMS

FUNCTIONAL DEFICITS - Difficulty with locomotion - 96%

- Difficulty with self-care - 87%

- Difficulty with bowel and bladder control - 66%

COGNITIVE/EMOTIONAL PROBLEMS - 98%

Short term memory loss.

Short attention span.

Inability to perform tasks in a proper sequence.

Decreased ability to comprehend - written and spoken.

Poor judgement.

Lowered tolerance to stress.

PROBLEMS WITH SOCIAL RE-ENTRY - 90%

Withdrawn in public.

Childish behavior.

Bitter or complaining attitude.

Low self-esteem.

Difficulty with making new friends.

RETURN TO THE SAME JOB - only 13%.

FAMILY REACTION TO DEALING WITH THE PATIENT

Depression.

Decreased social contacts.

Frustration.

Financial insecurity.

Disruption of relationship to other family members.

Guilt feeling.

PROGNOSIS

Janet & Teasdale (1981) - 90% of severe head injured patients reached near plateau at 6 months.

Texas Medical School study (1983) only 52% reached near plateau at 6 months and only 78% at 24 months.

K. U. Medical Center study (1983)

Post discharge follow-up - 68% of severely disabled patients showed improvement in functional skills.

45% made significant gains.

PRESENT NEEDS

1. GROUP A - Long term care facilities specifically for the head trauma victims - "Coma Center"
2. GROUP B - 1. Outpatient medical and psychological follow-up.
   2. Cognitive remedial program.
   3. Transitional living facilities.
   4. Vocational programs.
   5. Educate professionals, public and government officials regarding the special needs of head injured.
3. GROUP C - 1. Cognitive retraining.
   2. Vocational rehabilitation.

Community-Based Outpatient Rehabilitation-Remediation Program for the Head Injured Person

Dennis P. Swiercinsky, Ph.D.

Tuesday, January 10, 1984, 1:00 p.m.
10-minute presentation, Kansas Legislative Committee
OUTLINE

A. Characteristics of head injury problems (post-acute care)

1. Social inappropriateness
   a. perceptual distortion
   b. impulsivity
   c. impaired self-monitoring (frontal-limbic lesions)

2. Mental and general cognitive retardation
   a. memory consolidation problems (brain stem)
   b. associative memory problems (cortical association areas)

3. Vocational impairment
   a. reduced learning potential
   b. self-doubts, dependency
   c. inability to handle stress, simultaneous tasks

B. Remediation/Rehabilitation program

1. Definitions
   a. remediation - recovery (cognitive)
   b. rehabilitation - adjust, cope with loss (psychological)

2. Outpatient program milieu (stress uniqueness of H.I. person)
   a. more "normal" social-vocational setting
   b. intense cognitive stimulation (different from nursing care or traditional adult day care), passive versus active
   c. vocational/productivity oriented
   d. psychological re-adjustment
   e. self-identify strengths and weaknesses
   f. advocacy for family, friends, employers, teachers

3. Typical modules
   a. personal-social awareness (group and individual)
   b. neuropsychological evaluation (continuing)
   c. cognitive remediation training (define)
   d. self-sufficiency training
   e. vocational training on re-training

4. Interagency cooperation
   a. social security
   b. workman's compensation
   c. vocational rehabilitation
   d. rehabilitation agencies, programs

Attm. #2
1-10-1984

PAT MITCHELL
OCCK, INC.

AFTER ACUTE CARE:

I. INTRODUCTION:

KANSAS HAS A NETWORK OF PROGRAMS IN PLACE TO SERVE CHILDREN, THE DEVELOPMENTALLY DISABLED, THE ADDICTED, THE ELDERLY, AND THE DISABLED-EMPLOYABLE ADULT. UNFORTUNATELY, WE HAVE NOT CLEARLY FOCUSED ON THE MULTIPLE NEEDS OF THE SEVERLY IMPAIRED DUE TO ILLNESS OR INJURY.

WE SEE AN ATTEMPT TO "BANDAID" NEEDS BY SERVING HEAD TRAUMA VICTIMS IN THE EXISTING PROGRAMS AND WITH EXISTING CONSTRAINTS. WE MUST RECOGNIZE FIRST THAT THESE PROGRAMS ARE NOT DESIGNED TO SERVE HEAD TRAUMA AND SECONDLY - THAT MOST ARE OPERATING ON INADEQUATE BUDGETS, SPACE, STAFF, AND MOST SIGNIFICANTLY WITH LITTLE OR NO EXPERTISE REGARDING HEAD TRAUMA. THE STATE OF KANSAS MUST BEGIN DEVELOPING A PLAN TO SERVE THIS RAPIDLY GROWING POPULATION. BUT - WE MUST ACT TODAY TO SERVE YESTERDAYS INJURED. WE CAN IMPROVE, ADAPT, AND IMPROVISE EXISTING SERVICES WITH COMMITMENT FROM STATE AND PRIVATE PROVIDERS. WE MUST VIEW MODIFICATIONS AS TEMPORARY. A STATE PLAN IS ESSENTIAL.

II. SERVICE NEEDS:

1. A CENTRALIZED INFORMATION AND REFERRAL SYSTEM WITH FOLLOW-ALONG:

AS STATED, THE EXISTING NETWORK OF SERVICES IS NOT IDEALLY SUITED TO THE NEEDS OF MOST BRAIN INJURED PEOPLE. A DIFFICULT AND PROLONGED INVOLVEMENT WITH THE VICTIM AND FAMILY IS REQUIRED, NOT DESIRED, REQUIRED. I AM UNCERTAIN REGARDING THE ROLES OF STATE CIVIL SERVICE ADULT SERVICE PROVIDERS SUCH AS SRS SOCIAL WORKERS, VR COUNSELORS, HEALTH DEPARTMENT, ETC. - BUT I CAN ASSURE YOU (BASED ON THE NUMBERS OF STATE WIDE SERVICE REQUESTS I RECEIVE) THEY ARE NOT INVOLVED OR COMMITED TO PROVIDE CASE COORDINATION SERVICES FOR THIS POPULATION. A FUNCTIONAL SYSTEM IS ESSENTIAL TO INITIATE AVAILABILITY OF SERVICES. IF NOT CIVIL SERVICE - THEN WE MUST CONSIDER FINANCING FOR PRIVATE PROVIDERS.

2. LACK OF EXPERTISE/KNOWLEDGE OF PROVIDERS:

CENTRALIZED TRAINING SEMINARS, MANDATED FOR ANY PROVIDER OF SERVICES FOR THE HEAD INJURED AND WITHOUT EXCEPTION FOR ANYONE RECEIVING STATE OR FEDERAL FUNDING IS ESSENTIAL. VARING DEGREES OF MEMORY LOSS, IMPAIRED LEARNING ABILITY, PERSONALITY CHANGES,

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LACK OF EMOTIONAL CONTROL, ETC. ARE TYPICAL CHARACTERISTICS THAT NEED TO BE UNDERSTOOD. IT WAS TOTALLY INAPPROPRIATE TO EXPEL A 17 YEAR OLD VICTIM FROM SCHOOL BECUASE OF TEMPER OUTBURSTS, IT WAS INAPPROPRIATE TO CLOSE A 26 YEAR OLD VICTIM'S VR CASE BECAUSE HE DID NOT KEEP APPOINTMENTS MADE OVER THE PHONE, ETC. THE STATE CAN FUND TRAINING. YOU PAY FOR SERVICES - YOU NEED TO PAY FOR QUALITY SERVICES.

3. LONG-TERM CARE:

SEVERLY INJURED YOUNG ADULTS USUALLY MOVE FROM A SPECIALIZED HOSPITAL UNIT SUCH AS WESLEY MEDICAL CENTER, TO A LOCAL HOSPITAL, AND THEN FREQUENTLY TO AN ICF IN OR NEAR THEIR HOME COMMUNITY. AN ICF I WORK WITH IS REIMBURSED $30.10 PER DAY FOR ANY STATE FUNDED RESIDENT; 26 YEAR OLD VICTIM OR 86 YEAR OLD AMBULATORY MALE. THE PRICE IS THE SAME. THE NEEDS ARE NOT. FOR EXAMPLE, IF A JOINT IS NOT MOVED THROUGH ITS FULL RANGE OF MOTION SEVERAL TIMES A DAY, THE SURROUNDING MUSCLES, TENDONS, LIGAMENTS, AND JOINT CAPSULE TIGHTEN AND SHORTEN, CAUSING JOINT MOTION TO BECOME LIMITED. WHEN A CONTRACTURE BECOMES SEVERE ENOUGH TO CAUSE PAIN, THE PAIN CAUSES INCREASED SPASTICITY, AND THIS IN TURN ENHANCES DEVELOPMENT OF MORE CONTRACTURES. BOWEL AND BLADDER DYSFUNCTION, SEIZURES, SPEECH IMPAIRMENT, LOSS OF INDEPENDENCE IN EVEN THE MOST BASIC PERSONAL CARE, ARE COMPLICATIONS THE ICF MUST ADDRESS. THREE THINGS YOU CAN DO:

A. HEAVY CARE POLICY - THE DAILY REIMBURSEMENT RATE FOR AN ICF IS BASICALLY DETERMINED BY AN ANNUAL AUDIT, DIVIDED BY NUMBER OF DAYS OF CARE, RESIDENTS, ETC. THE ICF RECEIVING $30.10 PER DAY WILL NOT PROVIDE DAILY PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH, BEHAVIOR MODIFICATION, COGNITIVE SKILL RETRAINING, ETC. DOES KANSAS HAVE A "HEAVY CARE POLICY" WHICH ALLOWS FOR MONTHLY REIMBURSEMENT OF SUPPORT SERVICE COSTS AS OPPOSED TO SPREADING THIS COST IN DAILY FEE INCREASES? IF SO, IT IS NOT READILY AVAILABLE. THREE MAJOR AREA SRS OFFICES I SPOKE WITH DID NOT KNOW IF THE POLICY EXISTED, ETC. A MEDICAL REVIEW TEAM HAS REGULARLY SCHEDULED VISITS TO EVERY KANSAS ICF PROVIDING SERVICES TO MEDICADE PATIENTS. GETTING NEEDED THERAPIES TO HEAD TRAUMA VICTIMS IN ICF'S SIMPLY NEEDS TO BE MANDATED AND CONSIDERED AN ALLOWABLE COST. THE QUESTIONABLE USE OF DRUG THERAPIES TO CONTROL BEHAVIOR AND MOOD SWINGS IS NOT UNCOMMON. DRUG THERAPY WHICH IS CLOSELY MONITORED MAY BE APPROPRIATE IN SOME CASES BUT SHOULD

NEVER BE A SUBSTITUE FOR MORE EFFECTIVE, MORE APPROPRIATE, AND IN THE LONG-RUN - LESS EXPENSIVE THERAPIES. MOVEMENT FROM THE ICF SHOULD BE THE OBJECTIVE FOR THE MAJORITY. MEDICAL REVIEW TEAMS CAN BE ENCOURAGED TO REPORT THERAPIES FOR PHYSICIAN REVIEW.

B. A MEDICADE PATIENT MUST BE CERTIFIED AS IN NEED OF 24 HOUR CARE TO RESIDE IN AN ICF. ONCE THE PHYSICIAN CERTIFIES THIS NEED, A BRIEF BUT RESTRICTIVE POLICY, THE RESIDENT MAY NOT LEAVE THE ICF FOR SERVICES ON A REGULAR BASIS WITHOUT THE STATE REDUCING OR WITHHOLDING THE DAILY REIMBURSEMENT RATE TO THE ICF. WE ARE NOT DISCUSSING USE OF STATE OR FEDERAL FUNDS FOR TWO AGENCIES. IT IS SIMPLY STATED, IF IN NEED OF ICF PLACEMENT, THE RESIDENT MUST RECEIVE ALL NONMEDICAL [redacted] SERVICES IN THAT FACILITY. OCCK AND SIMILAR FACILITIES MAY BE WILLING TO USE <u>OTHER THAN STATE OR FEDERAL FUNDS</u> TO PROVIDE AGE APPROPRIATE VOCATIONAL ACTIVITIES, COGNITIVE SKILL RETRAINING, BEHAVIOR MODIFICATION, ETC. FOR BRAIN INJURED ICF RESIDENTS IN OUR CATCHMENT AREAS. WE CAN NOT BECAUSE SUCH A DAILY PROGRAM WOULD CONTRADICT THE PHYSICIANS CERTIFICATION FOR 24 HOUR CARE AND THUS JUSTIFICATION FOR STATE PAYMENT FOR THE MORE RESTRICTIVE AND COSTLY ENVIRONMENT. JACK GUMM'S OFFICE CAN GIVE YOU A COMPLETE UNDERSTANDING OF THIS CONSTRAINT.

C. MEDICADE OUTPATIENT PAYMENT:

O.T., P.T., AND SPEECH SERVICES ARE AVAILABLE IN COMMUNITY HOSPITALS. RESTORATIVE THERAPIES ARE COST EFFECTIVE IN THE LONG-RUN AND ANY RESTRICTION OF PAYMENT FOR A PHYSICIANS PRESCRIBED PROGRAM JUST DOES NOT MAKE SENSE.

4. SERVICES FOR FAMILIES:

FAMILY REACTIONS ARE CRITICAL TO SUCCESSFUL REHABILITATION. PSYCHOLOGICAL DISTRESS OF PATIENTS AND FAMILIES HAS BEEN FOUND TO BE MORE LIMITING THAN THE PHYSICAL IMPAIRMENT, YET PSYCHOLOGICAL SERVICES ARE OFTEN UNAVAILABLE. WHY ARE THEY NOT AVAILABLE? LACK OF REFERRAL, A LACK OF SENSITIVITY REGARDING NEED, LACK OF TRAINED PROFESSIONALS, PAYMENT, ETC. ARE ALL BARRIERS WHICH WE CAN ELIMINATE IF WE HAVE A COORDINATED EFFORT.

MEDICAL SERVICES ADMINISTRATIVE CONSTRAINTS AND INEQUITIES PRESENT THE MOST OBVIOUS LIMITATIONS PREVENTING THE LOW-INCOME HEAD INJURED VICTIMS FROM RECEIVING QUALITY PROFESSIONAL SERVICES.

FOR EXAMPLE, THE CUSTOMARY FEE FOR NEUROPSYCHOLOGICAL SERVICES IN OUR AREA IS $70 PER HOUR. MEDICAL SERVICES REIMBURSES THE

COMMUNITY MENTAL HEALTH CENTER $55 PER HOUR AND THE PRIVATE PRACTITIONER ONLY $35 PER HOUR. AND YET, THERE IS A LIMIT ON THE TOTAL NUMBER OF HOURS THE PRIVATE PRACTITIONER MAY BILL AND ALTHOUGH THE MENTAL HEALTH CENTER MAY ALLOW TECHICIANS TO PROVIDE SERVICES - THE PRIVATE PRACTITIONER MAY NOT. WHAT I HAVE JUST TOLD YOU IS THAT A COMMUNITY MENTAL HEALTH CENTER RECEIVING MIL LEVY SUPPORT, STATE AND FEDERAL GRANTS, AS WELL AS PRIVATE FEES AND THIRD PARTY PAYMENTS IS REIMBURSED 78% OF THE CUSTOMARY FEE FOR SERVICES PROVIDED BY A MASTERS DEGREED EMPLOYEE WHILE A PRIVATE PRACTITIONER HOLDING A DOCTORATE IN NEUROPSYCHOLOGY RECEIVES ONLY 50% OF THE CUSTOMARY FEE - IF HE RECEIVES ANY FEE AT ALL.

BILLING AND RECEIVING PAYMENT FROM MEDICAL SERVICES IS A MOST COMPLICATED PROCEDURE. FOR EXAMPLE, THE FAMILY MAY HAVE HAD BLUE CROSS/BLUE SHIELD PRIOR TO AN ACCIDENT THAT NOW PREVENTS THE PRINCIPLE WAGE EARNER (THE PATIENT) FROM WORKING. MEDICAL SERVICES REQUIRES BC/BS BE BILLED FIRST - EVEN THOUGH A PHONE CALL VERIFYS COVERAGE IS NO LONGER AVAILABLE DUE TO THE FACT PREMIUMS HAVE NOT BEEN PAID IN THREE MONTHS. DELAYS OF REIMBURSEMENTS OF 90 DAYS OR MORE ARE NOT UNCOMMON.

PRIVATE PRACTITIONERS I HAVE PERSONALLY WORKED WITH FOR OVER FIVE YEARS ARE MEN AND WOMEN WHO WISH TO SERVE REFERRALS BASED ON NEED - NOT INCOME. WITHOUT PROFIT OR AT LEAST BREAKEVEN REIMBURSEMENT THEY WILL NOT BE IN BUSINESS TO SERVE ANY INCOME LEVEL, NOR WILL THE GROCER, YOUR AUTO MECHANIC, OR YOUR BARBER.

THE SALINA VOCATIONAL REHABILITATION OFFICE USES ONE PHYSICIAN FOR OVER 90% OF THEIR INITIAL MEDICAL EVALUATIONS. HE SPENDS FROM 10 TO 15 MINUTES WITH THE PATIENT AND FILLS OUT A ONE PAGE FORM AND IS PAID $35. A PHYSIATRIST AGREED TO AN INITIAL EVALUATION AT MY REQUEST. HE WAS WITH THE FAMILY AND BRAIN INJURED VR APPLICANT FOR OVER ONE HOUR AND PROVIDED A COMPREHENSIVE TWO PAGE REPORT WHICH GREATLY ENHANCED REHABILITATION PLANNING. HE WAS PAYED $35.

WE DO NOT YET KNOW THE FULL IMPACT OF D.R.G's, P.C.N., AND OR OTHER RESTRICTIONS ON MEDICAL SERVICES BUT WE DO KNOW FROM EXPERIENCE THE AVAILABILITY AND QUALITY WILL BE AFFECTED. ANY REDUCTION IN MEDICAL SERVICES WILL INCREASE THE DEMAND FOR SOCIAL SERVICES. HAS ANY PROVISION BEEN MADE TOMEET THESE MULTIPLE NEEDS?

III. SUMMARY:

TEN MINUTES DOES NOT ALLOW FOR ME TO THROUGHLY ADDRESS ALL OF THE SERVICE NEEDS AND RESOURCES WHICH CAN BE IMPROVISED IN LIEU OF A COMPREHENSIVE SERVICE PLAN. TODAY IS AT LEAST A BEGINNING, THE STATE OF KANSAS ALLOCATES LARGE SUMS OF MONEYS FOR STATE AND PRIVATE PROVIDERS BUT NONE THAT I AM AWARE OF TO EFFECTIVELY REFER, COORDINATE, AND ADVOCATE FOR <u>QUALITY SERVICES</u> FOR THE HEAD INJURED AND OTHER PHYSICALLY IMPAIRED PERSONS IN THIS STATE.

YOUR SUPPORT OF THE VOLUNTEER WORK OF THE K.H.I.A., PRIVATE PHYSICIANS, SERVICE PROVIDERS, AND COMMUNITIES IS SINCERELY APPRECIATED. YOUR WILLINGNESS TO INVESTIGATE OUR CLAIMS THAT THERE ARE SERIOUS "SERVICE GAPS" IS ESSENTIAL.

NEWTON PSYCHOLOGICAL SERVICE CENTER
Marvin J. Parrish, Ph.D.
Diplomate in Clinical Psychology
American Board of Professional Psychology

Off: (316) 284-2100
Res: (316) 283-4266

P. O. Box 582
122 West 5th Street
Newton, Kansas 67114

March 31, 1983

Mr. Mike Ahlers
Case Manager and Evaluation Coordinator
Occupational Center of Central Kansas, Inc.
370 Schilling Road
Salina, Kansas 67401

Re: [redacted]

Dear Mr. Ahlers:

Enclosed please find my belated Neuropsychological Evaluation Report on Mr. [redacted] I believe my Report is self-explanatory, but if you should have questions about it or related matters, please feel free to contact me again.

I have some "good news" and some "bad news" about future evaluation efforts. While I am in the process of adding to my staff--one new person is already on board--and am able to anticipate being capable of handling more expeditiously future requests for evaluations, the "bad news" is that changes in our policies here (resulting from changes in the Medicaid system primarily) are forcing us to be more restrictive and less generous in accepting cases. Funding sources associated with the state of Kansas have in many instances set in motion regulations and administrative procedures which render it nearly impossible to serve adequately certain kinds of clients in an outpatient context. We are taking such cases on a "case by case basis" after careful consideration of many factors.

I would like to continue to be able to serve OCCK and its clients, but changes in the "ground rules" emanating elsewhere have necessitated changes in our way of doing things.

Thank you for referring [redacted] to me. I hope something positive will come out of this process.

Respectfully yours,

Marvin J. Parrish

Marvin J. Parrish, Ph.D., ABPP
Diplomate in Clinical Psychology

MJP/kjp
Enclosure

Saline, Ottawa counties focus of health aid test

By MARY JO PROCHAZKA
Staff Writer

A trial government program that could change the way about 2,000 poor people receive medical services is scheduled to take effect Feb. 1 in Saline and Ottawa counties.

If it's successful, the Kansas Department of Social and Rehabilitation Services plans to implement the program statewide within a year, Marlys Mattingly of the Salina SRS office said Friday.

The biggest change in the primary-care network program (PCN) is that clients of the Medicaid and MediKan government medical assistance programs will have to go to one approved physician for all their medical needs.

Any referrals to specialists must be made by that primary-care physician. Exceptions, for which clients still may choose any practitioner, include dentists, podiatrists, chiropracters and optometrists. Medical emergencies also are excepted.

Foster children, and recipients of Medicare, a government medical assistance program for Social Security recipients, are exempted from the PCN program.

The current program has allowed clients to receive service from any physician who would accept Medicaid or MediKan payments.

"This is a pilot project for the state of Kansas," said Mattingly, chief of income maintenance over an eight-county area for the SRS.

PCN initially will be tried in three counties of various sizes: Sedgwick, Saline and Ottawa. It was based on similar programs in other states, Mattingly said.

SRS officials hope it will improve medical care while cutting costs and eliminating duplication of services.

"SRS believes that this program will help to establish a closer doctor-patient relationship between you and your designated primary-care physician," said Robert C. Harder, secretary of the SRS, in a letter sent to clients this week.

"We believe that this program will guarantee you access to health care and strengthen your relationship with a designated physician who is responsible for your overall medical care needs," Harder said.

Some clients were skeptical when first notified of the program and the fact they may have to change doctors after Feb. 1.

Harder's letter was sent to clients after many — including some in Salina — voiced concerns to their SRS caseworkers, Mattingly said.

The original letter included an assignment of each client to a doctor who would become their primary-care physician. Assignments were based on an analysis of which doctor had provided the most medical care for the patient during the past year, Mattingly said.

Doctors eligible to serve as primary care physicians include those engaged in general practice, family practice, internal medicine, pediatrics and obstetrics and gynecology. To participate, doctors had to contract with the

(See Aid, Page 3)

Saline County Population: 48,905

Physicians in Saline County: 100 est.

Physicians in general, family, pediatrics practice: 23 est.

Current doctor/population ratio: 2126 patients per doctor

Medical cards in Saline County: 2300 est.

PCN physicians: 13

Current doctor/PCN patient ratio: 177 patients per doctor

$3 monthly allowance X 2300 = $6900 monthly X 12 month = $82,800 yr.
up front cost

Unknown statistics: 1. percent of 2300 misusing Medicaid/Medikan

2. dollars lost in duplication of services

Question: Will a closer doctor/patient relationship result or will we simply manage recipient use of medical service?

Aid

(Continued from Page 1)

program.

Although doctors initially voiced opposition to changing the program, four physicians in Ottawa County and 13 physicians in Saline County agreed to participate, Mattingly said.

Clients were instructed in their notification that they could be reassigned to another doctor on the list if they didn't approve of their assignment.

But patients who previously went to a physician not contracting with the program must change doctors to rely on Medicaid or MediKan for coverage. And service from most specialists will only be covered if the primary care physician refers the patient for treatment.

"What's happening with this new program is that the client is locked in to one primary care physician," Mattingly said. "They can still go back to another doctor, but they will have to be referred by their primary care doctor.

"The reason for this is so that we can better manage recipient use of medical services," she said.

Primary care physicians will be paid $3 monthly for each PCN patient assigned to them. That doesn't cover medical fees, which will be paid separately by Medicaid or MediKan. Physicians are expected to manage their patients' health care, and questions about unusually high expenses for a particular patient will be referred to the primary care physician instead of to a local SRS caseworker, Mattingly said.

The program also is designed to provide access to better primary health care, to increase physician involvement in Medicaid and MediKan and to contain costs, Mattingly said.

Clients who received [illegible] services from four doctors and had prescriptions filled at four druggists won't be able to duplicate those services anymore, Mattingly said.

A new chapter

The rules governing the hospital industry have frequently been rewritten in an effort to contain health care costs. Now a new chapter is about to begin which is based strictly on financial considerations. In it, the buyers of hospital care will set the price.

Two of Kansas' largest payers of hospital bills, Medicare and Blue Cross and Blue Shield of Kansas, will reimburse acute care hospitals a fixed rate per inpatient according to the patient's illness or injury.

How the system works

Hospital reimbursement will be based on Diagnosis Related Groups (DRGs), an illness classification system developed by researchers at Yale University. Nearly 10,000 diseases were grouped into 23 major diagnostic categories by organ system, similar to the way medical specialities are arranged. The categories were then divided into 467 DRGs. Most patients will fall into one, and only one, DRG.

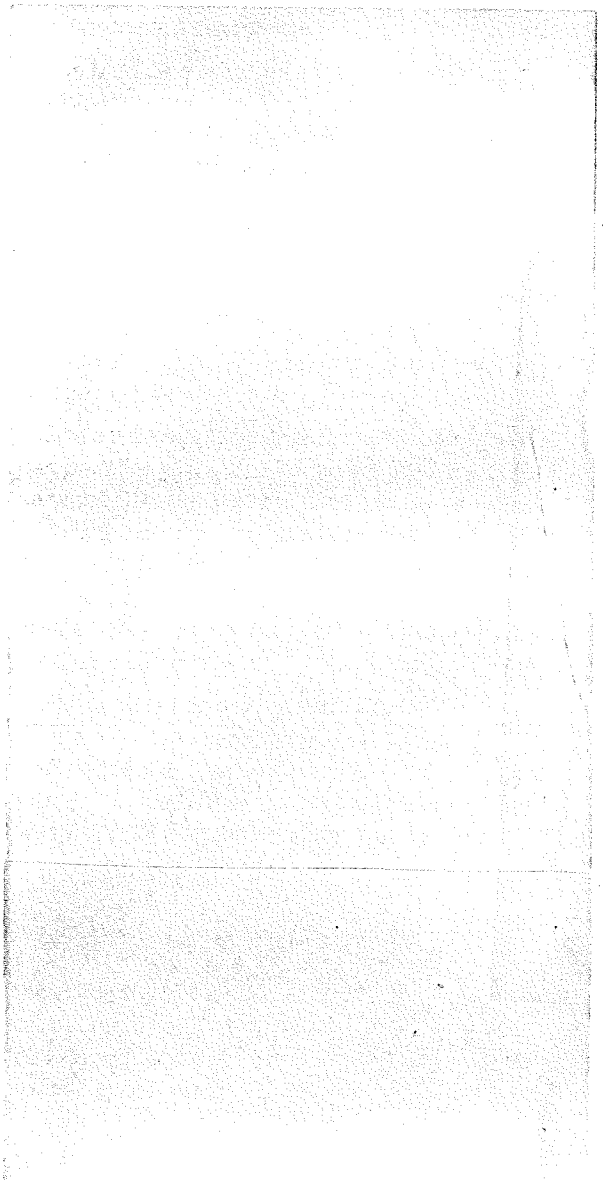
The DRG system focuses on the use of hospital resources. Which illnesses and injuries require the most treatment? How much is "average?" Which require expensive high technology procedures? Which need more intensive nursing care? How many lab tests, therapies, medications and services does each illness require?

By statistically analyzing data from 332 hospitals across the country, the Yale researchers developed an "average patient" profile for each DRG. Included in the profile is an average length of stay range, and weighted factors affecting the cost of care:

- principal diagnosis – why the patient was admitted to the hospital
- secondary diagnosis – a second illness or injury that the patient may be suffering from at the same time
- principal procedure (a major surgery, for example)
- age of patient at time of admission
- discharge status – if the patient was discharged home, to a less acute care facility, etc.

Blue Cross and Medicare have each set a price for each DRG, and will consider it full payment to the hospital. If a hospital can provide care for less than the pre-set price, it will be permitted to keep part of the savings. If care costs more, the hospital must absorb the loss. Patients may not be billed for the difference between a DRG figure and the actual cost of care.

Each year the pre-set prices will change to reflect inflation, hospitals' increased efficiency and other factors. Some critics point out that a hospital may save money in the first year, but lose money the next year when its reduced cost of care is computed into the base amount.



Community Living Services is a unique residential alternative for people who have a developmental disability or similar handicapping condition. 73% of the individuals we serve are mentally retarded. They fall between the mild to severe range of mental retardation by AAMD standards. 27% of the population are moderately to severly physically impaired, or have mild to severe mental illness.

The philosophy of our program is that adults should reside independent of supervision with the normal level of community support. Our program should strive to maintain people in the ideal setting by manipulating community resources rather than manipulating the setting. Manipulation of community resources should be individualized and should vary from the norm only as needed and in as minimum a variation as is possible.

The Community Living Services Program is comprised of 3 services. In Life Skills services we provide training to people who live with families, guardians or in other supervised settings, to assist them in moving to a less restrictive alternative. This usually involves 6 months or less training time, and has resulted in people moving to their own apartment.

Apartment Support Program offers training in Independent Living Skills to people who want to or currently live in their own apartment. The majority of the people we have served in this program previously lived with parents or lived in nursing homes. We believe our program is unique because we have successfully served adults who are severly retarded and/or physically impaired in apartments with no overnight supervision. People who have Cerebral Palsey who previously lived in nursing homes are functioning in apartments. They receive attendant care from SRS and training through our program at a cost well below that of the nursing home rates. Our daily cost per day based on 1982 budget figures was $4.85 per day.

The third service we provide is low cost housing for those individuals who cannot afford standard community housing, these were funded by a loan from H.U.D.. We have 6 - six plexes located in 4 cities in Central Kansas. These are all one bedroom apartments. These are managed exactly as all Housing and Urban Development projects are in there are no overnight supervisors.

Start up funding for Community Living Services was offered by grants from the Kansas Developmental Disabilities Council. We currently receive funding from the State of Kansas Social & Rehabilitave Services Block Grant funding. There is no cost to the clients for services at this time.

The program has been in operation since 1980 and we have served a total of 71 persons in 4 counties in Central Kansas.

We believe this program is a viable alternative to more costly supervised settings. It offers only those services the tenant needs to succeed. By training in the setting where the behaviors are expected to occur, there are no boundries to the success that can be realized. We believe this program is what normalization is about. We feel it is least restrictive with regard to funding, staffing and most important, for the tenants.

occk

Attachment #4

JACK M. MOHLER, M.D.
PHYSICAL MEDICINE AND REHABILITATION
515 N.E. 10TH
ABILENE, KANSAS 67410

PHONE (913) 263-1419

TO: Senate and House Public Health and Welfare Committees.

SUBJECT: Kansas Head Injury Association Presentation, Observations in Private Practice.

DATE: January 10, 1984

FROM: Jack M. Mohler, M. D., Abilene, Kansas

Problems encountered in the head injured patient in my private practice.

1. Patient example.
   Principle: Every long term vegetative coma patient can regain consciousness.

2. Patient example.
   Principle: Head injury patient can be frustrating to work with because they regain the memory of how they were and have trouble accepting the reality of what they have lost.

3. Patient example.
   Principle: In the work force, head injured patients often have innumerable jobs with failure before they can find their place.
   Principle: Head injured do not mix well with mentally retarded patients but seem to get along well with other brain damaged, i.e. post strokes.

4. Patient example.
   Principle: The rate of broken marriages after a head injury is understandably high.

5. Patient example.
   Principle: For the families that do survive, the earning capacity of the spouse may be hindered and financial support hard to find.

Philosophical-Semantic Note:

Rehabilitation - carries with it the hope of return to pre-injury.
Adaption - accepts the presence of permanent disability but tries to minimize its influence and makes sure the remaining potential is used to its maximum.

My hope is that this committee will accept the challenge of the head injured patient as a valid study and help us define the problem in Kansas and see how our existing services can help with their needs.

Thank you.

Attm #4
1-10-1984