Approved 3-5-85
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Sen. Roy M. Ehrlich at
Chairperson

10:00 a.m./p~~m~~. on February 28, 1985 in room 313-S of the Capitol.

All members were present except:

Committee staff present:

Conferees appearing before the committee:
Dick Hummell, Executive Director, Kansas Health Care Association
Ellen Chambers, RN, President, KHCA Nursing Council, Medicalodges, Coffeyville
Dr. Lois Scibetta, Executive Administrator, Kansas State Board of Nursing
David Twarog, RN, Director of Nursing, The Heritage Nursing Home, Girard
Pauline Wells, Administrator, Centennial Homestead Nursing Home, Washington
Lynelle King, Kansas State Nursing Association
Paul Florquist, Administrator, Western Prairie Care Home, Ulysses
Paul Wurth, Director of Operations, Mid-America Health Centers, Inc., Wichita

Others Attending: See attached list

Chairman Ehrlich welcomed nurses visiting the Senate Public Health and Welfare Committee.

SB-273 - Authorizing 24 hours a day licensed nursing personnel

Dick Hummel, Executive Director, Kansas Health Care Association, testified and presented written testimony supporting SB-273. Mr. Hummel testified that adult care homes are caring for a much older and sicker clientele than in the past, necessitating more extensive and expensive care. Studies show intermediate care facilities have been voluntarily increasing nursing staff levels based on related needs. The question is whether or not 24 hour coverage will result in the best utilization of limited health care financial and manpower resources. Attachment I

Ellen Chambers, RN, testified and presented written testimony in support of SB-273. Ms. Chambers cited the nursing homes greatest problem has been the lack of nursing personnel; also the need to utilize LPNs and RNs abilities for the residents needs. Attachment II

Dr. Lois Scibetta, Executive Administrator, Kansas State Board of Nursing testified and presented written testimony supporting the concept of SB-273. Dr. Scibetta stated that the Board of Nurses objected to specific sections, namely D, E and F and recommended that those sections be deleted. Attachment III

David Twarog, RN, testified and presented written testimony supporting SB-273. Mr. Twarog testified that the only suitable method in having 24 hour nurse coverage in an intermediate care facility that would cover availability, practicality and cost, would be to follow guidelines set forth in SB-273. Attachment IV

Pauline Wells testified and presented written testimony in support of SB-273. Ms. Wells stated that in their rural area it is nearly impossible to find a registered nurse or a practical nurse and cited other difficulties encountered due to lack of qualified help and costs absorbed to offset the medicaid rate. Attachment V

Lynelle King, Executive Director, Kansas State Board of Nursing, testified and presented written testimony supporting SB-273. Ms. King testified that KSNA believes the elderly in nursing homes deserve care of licensed nurses 24 hours a day and KSNA supports a Waiver for homes unable to obtain LPNs or

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 313-S, Statehouse, at 10:00 a.m./p.m. on February 28, 1985

RNs after good faith is exhibited; KSNA feels that SB-273 is not necessary and recommends the approach to be presented by cabinet secretaries of Department of Health and Environment, Social and Rehabilitation Services and Department on Aging. Attachment VI

Paul Florquist testified and presented written testimony supporting SB-273. Mr. Florquist testified concerning the difficulties of hiring qualified persons to work necessary shifts and the cost impact of 24 hour licensed nurses. Attachment VII

Due to lack of sufficient time for his presentation, Paul Wurth, Director of Operations, Mid-America Health Centers, Inc., Wichita, handed committee members written testimony. Attachment VIII

Meeting adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-28-85

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Joanne Trego. Halstead, Ks.	KSNA Dist IV
Jeanette Lewis, Topeka, KS.	Washburn Univ.
Lorraine MacTaggart, Topeka, KS.	Washburn Univ.
Brenda Shorton, Topeka, KS	Kansas Assn. of Nursing Students
Barbara Sandquist Topeka, Ks	Washburn University
Sandra Tesch Topeka, Ks.	Washburn University
Melissa Graham Topeka, KS.	Washburn University
Marian Pannone, Topeka, KS	Washburn University
Paula Mudd Salina KS	Marymount College
Pam Barnhart Delia, Ks	Stormont-Vail School of Nursing
Pamela Perkins Topeka	Stormont-Vail School
Shirley Wichman Topeka	Stormont-Vail-School
Kimberly Patterson Topeka	Stormont-Vail School
Carla A. Lee Wirta	Pres. Ks Nurses Foundation
Martha Marie Housh RN	KSNA, Dist #1
Joe Haefele Topeka	Washburn University
Laurie Blungardt SALINA	Marymount College
Becky Lorenz Salina	marymount College
Holly Brimon Topeka	Washburn University
Yvette Hamm Topeka	Washburn Univ.
Todd Krass Topeka	Washburn University
Ruth Hoppe Topeka	Washburn University
Linda McWilliams Topeka	Washburn University

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-28-85

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Butch Eaton Topeka	Countryside Health Centre
Shara Leatherman "	KHCA
Paul Wuth Wichita	KHCA
Marna L Parker	KSNA - District 18 Manhattan
Sue Akers. RN.	Cloud Co. Community College.
Mae Moore SN	CCCC
Elvira Sorick SN	CCCC
Elaine Waddell SN	CCCC
Teresa Hamm Manhattan	KSNA District 18
Mary Bommelaere SN	CCCC
Angie Becker	CCCC
Debbie HAAS	Stormont Vail Student Nurse
Monica Texhorn SN	CCCC
Lynette Nelson SN.	C.C.C.C.
Ettanis Solen S.N.	CCCC
BARBARA LEWIS, SN.	MARYMOUNT COLLEGE
Rhonda Schardt SN Salina, KS	Marymount College
Lisa J. Stouffer, S.N. Salina, Ks	Marymount College
Judy Asparight Salina, KS	marymount College
Elizabeth Plummer Lyons, Ks.	Dist #1 Rice Co. Hosp.
Brenda Hamm Newton	Bethel College
Cindy Schwartz Newton	Bethel College
Laura Soash Topeka	

pg 1

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-28-85

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
SHEILA NORTON	WASHBURN UNIV. SCH. OF NSG
Linda Hughes	Washburn Univ.
Laura Bullock	Washburn Univ.
Rose Dressman	Stormont-Vail School of Nursing
Gertrude Jones 1914 Central Dodge City, KS	Ksna Dist 19
Deane Gholson 2206 Woodrow Dodge City, Ks.	Kansas State Nurses Association Dist 19
Teresa Stover - Box 505 D. City, Ks.	DCCC -
Kim Maley - Box 152 Offerle, Ks.	Dodge City Community College
Susan Mathes 1021 Main, Cimarron, Ks	Dodge City Community College
LaDuita Zielke Box 4 Protection, Ks.	Dodge City Community College
Sharon Brewer Box 1014 Meade, KS	Dodge City Community College
Ruth McCoy Box 602 Johnson Ks	Dodge City community Colo
Kay Seaton 131 W Market Dodge City Ks	Dodge City Community College
Lori Heacock 6619 Floyd Overland Park	University of KS School of Nrsg
BETTY DAUGHERTY 631 E WALNUT MEADE	DODGE CITY COMMUNITY COLLEGE
Margaut Cason 2208 Roanoke Rd. Dodge City	Dodge City Comm. College
Marie Cason 2208 Roanoke Dodge City	Dodge City Community College
Sheri D. Adams 200 Middle Rd. Dodge City Ks	Dodge City Community College
Terri Kirby 816 Washburn Apt #3 Topeka Ks	Stormont Vail school of nursing
Joan Sheverbush Rt 4, Pittsburg Ks.	Pittsburg State University
Deana Keele Pittsburg Ks	" " "
Kim Fisher, Pittsburg, KS	" " "
Karen Radcliffe, Topeka, Ks.	KSNA - district 1

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-28-85

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Blaine Wells Washington Ks.	Stormont-Vail School of Nursing (Student)
Sue E Brun	Stormont-Vail School of Nursing
Marjorie McBready, RN	Stormont-Vail School of Nursing
Brenda Searight Concordia, Ks	Cloud County Comm. College
Ann Natsedl Concordia, Ks	Cloud County Community College
Kate Kennedy Concordia, Ks.	Cloud County Community College
Margaret Garst Concordia, Ks.	Cloud County Community College
Doris M Stanley Topeka Kansas	Washburn University
Ruth E Kreider Newton	Bethel College
Patty Speer RN Garden City	St Catherine Hosp.
Joyce Potter Topeka	Stormont Vail School of Nursing
Jeanne Ward Topeka KS	Stormont Vail School of Nursing
Linda Dupenbrock Overland Park	KSNA; Kumed Center
Jim McBride Topeka	United Way
Lois Swartzog Mid. Valley	KSNA - LCC
Ruth Harrell Kansas City	KSNA - Dist. 2
Marilyn Overstreet Ozawkie	KSNA - Dist #1
Martha Conlin Lawrence, Ks.	Stormont-Vail School of Nursing
Kandy Bruce Salina, Ks.	Marymount College - Nrsg Student
Marilyn Chamberlin Lawrence	Dist 17
Alma M Swanson Lawrence KS	KSNA Dist 17
Diana Kloppenstein Lawrence, KS	KSNA #17
Freida Schriner Topeka	KSNA #1

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-28-85

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Sharon Klassen Miltonvale, Ks.	Cloud County Community College
Dianne Michaud Clyde Ks	Cloud County Community College
MAUREEN WEDEL HALSTEAD KS	KSNA
Jim Behan Atlanta KS	AARP SLC of Kansas
Amanda Murdock Concordia, Ks	Cloud County Community College
Valerie Jewson Concordia Ks	Cloud County Community College
Karen Smith Concordia, Ks.	" " " "
Todd Smith Concordia Ks	" " " "
Amy Brummer, Beloit Ks.	CCCC
Debbie Garst Beloit, Ks.	CCCC
Ann DeLap Concordia, Ks	CCCC
Jan Bergthon concordia, Ks	CCCC
Rhonda Cye Concordia Ks.	CCCC
Mirelle Sciara Con Ks	CCCC
Ann Kiel Concordia Ks	CCCC
Norma Hein, Durham, Ks.	KSNA
Carolee Neufeld, Hillsboro, Ks.	KSNA

0 - 2-28-85 - Dick Hummel
SB-273 -

TESTIMONY PRESENTED BEFORE THE
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

By
Dick Hummel, Executive Director
Kansas Health Care Association

February 28, 1985

SB No. 273, AN ACT relating to adult care homes; authorizing 24 hours a day licensed nursing personnel under certain conditions.

Mr. Chairman and Committee Members:

On behalf of the Kansas Health Care Association, a voluntary non-profit organization representing 250 licensed adult care homes, both tax-paying as well as non-profit, large and small ownership interests that on average render 50% of their care to the medically indigent, we appreciate this opportunity to appear in support of SB 273 which was introduced at our request.

The issue of additional licensed nursing personnel in Kansas intermediate care facilities and all of its ramifications -- health care costs and Medicaid funding, availability of personnel, a phase-in for compliance, training of nursing personnel, the utilization of limited federal-state funding, and the practicability of it -- are all honed-into this bill in order for you to make a fair and honest decision whether such service is necessary, affordable, and the best way to meet nursing home residents' nursing care needs.

We will provide a brief background about our resident population and services, Medicaid funding, and then review the bill's contents.

KANSAS NURSING HOME RESIDENTS' CHARACTERISTICS.

26,000 persons, or about 7% of Kansas elderly population, reside in nursing homes. The typical person is 84 years old; predominately female, widowed, with two or more chronic conditions. The largest percentage of our population, perhaps considered the "old-old" and the fastest growing, is the over-age 80 category.

Studies show that dependencies in activities of daily living (ADC) increase with advanced age, requiring more extensive and expensive care.

"We Care"

221 SOUTHWEST 33rd ST. • TOPEKA, KANSAS 66611 • 913/267-6003

2/28/85
Attachment I

Coupled with these characteristics and dependencies are more medically dependent residents because of the Medicare DRG prospective pricing system for hospitals resulting in sooner and earlier discharges to nursing homes and other settings.

To summarize, nursing homes are caring for both an advancingly aged population and for persons with greater, more acute medical needs.

*DEFINITION SKILLED NURSING FACILITY (SNF): Immediate supervision of the nursing services staff shall be provided by a director of nursing services (RN) who is employed, full time, on the day shift. Each facility shall provide for each nursing unit (60 beds) a registered or licensed practical nurse on the day shift, seven days a week. If a licensed practical nurse is the only nurse on duty during the evening or night shift, there must be an RN on call.

ESSENCE: 24 hour a day nursing supervision. There are 46 SNFs in Kansas.

DEFINITION INTERMEDIATE CARE FACILITY: Nursing services under the supervision of a health services supervisor (RN or LPN) with a RN or LPN on the day shift, seven days a week per nursing unit. If no licensed nursing coverage during the evening or night shift, there must be an RN on call and an RN must provide four hours consultation per week.

ESSENCE: Licensed nurse on day shift with RN on call and four hours RN consultation a week. There are 325 ICFs in Kansas (294 regular ICFs, 11 are ICF-MHs and 20 ICF-MRs).

*MEDICAID FUNDING. Approximately one-half of Kansas nursing home residents (12,492 patients a day) have care funded by the Medicaid program, and it is important in our opinion to have a general understanding of how adult care homes' daily rates are determined. The system is prospective, meaning rates today are based upon previous historical costs.

Actual costs are reported annually, are arrayed into four cost centers with screen and limits applied to arrive at allowable costs per day, with a final, fifth cost center limit arbitrarily selected and applied to actual costs to further reduce actual patient-related costs. This process results in a future facility-specific daily rate (flat rate regardless of individual patient's actual nursing care needs and neutral to any additional costs a facility may have to incur during the rate period).

Approximately one-half (44%) of Kansas ICFs in the Medicaid program did not receive back their actual, allowable costs in 1983 under this system.

SB 273 - PROVISIONS

The bill requires ICFs (with the exception of MR and MI) to staff as the minimum one LPN on the second and third tours of duty.

[Currently about one-third of Kansas ICFs are voluntarily providing additional nursing personnel over the minimum requirements as their situation and cir-

cumstances warrant. Post Audit Report, "Cost and Quality of Care," June, 1984.] EXHIBIT NO. I.

The increased staffing is contingent upon the following conditions being met:

A. Medicaid Funding (lines 0068-0079). The total allowable costs incurred for providing such services are to be remitted to adult care home providers within 30 days of compliance; existing providers that have already voluntarily increased their staffing over the minimum are to be reimbursed likewise, with such nursing costs not subject to arbitrary limits or screens. So, if an adult care home must pay $50 an hour to attract the nurses, perhaps not so far-fetched in western Kansas, SRS will pay its full, just portion of the cost rather than an arbitrary percentage with the additional liability imposed upon the private-paying sector.

   Regarding the immediate funding rather than a year or more later, Post Audit also addressed this in their suggestions (page 24).

   Various cost estimates for around-the-clock coverage have been presented, from $1.8 million by SRS to $3 million by Post Audit. Attached as Exhibit No. 2 is our estimate of a range from $4 to $9 million dollars, perhaps still understated because of such unpredictable variables as the impact of a mandate upon not only increasing LPN salaries but also other nursing personnel wages.

B. One-Year Phase-In for Compliance (lines 0080-0091). Homes would be given a year to come into compliance, and if exercising good faith efforts to recruit and hire additional nurses but if in vain, would not be subject to a civil penalty (monetary fine) by the Kansas Department of Health & Environment (KDH&E).

   This is an extremely important provision, in view of the fact that KDH&E now summarily issues correction orders for under or lack of staffing along with a host of other reasons, with it becoming almost routine to expect a correction order after a state survey.

   Again, an important provision, as later you'll be addressed by conferees about their voluntary recruitment-retention efforts and problems.

   Based upon the experiences of our rural members, guaged in a survey of them, we'd propose this section be amended to permit a two-year phase-in time period for compliance for them.

C. Nurse Employment in an Adult Care Home (lines 0092-0095). A nurse who has received any state-federal financial assistance in their nursing education program would be required to be employed in a nursing home for a year.

   Upon closer reading, we suggest this section be amended to cap-

ture the intent of a loan or financial tuition assistance forgiveness for such employment.

PRECEDENCE: 1) Similar provision by the Legislature for physician incentives to work in medically-underserved areas. 2) The Statewide Health Coordinating Council report, "Nursing Resources in Kansas," December, 1981 carried such a recommendation.

D. Nursing Education (lines 0096-0098). All professional and practical nursing education programs contain as a minimum 25% course content in geriatric nursing.

This modest proposal is offered with the understanding that schools have been placing greater emphasis in this area, but rather than to be scoffed at, we submit that don't our elderly in Kansas (two in every ten persons are over age 60; Kansas ranks 9th nationally in proportion of elderly to total population; increasing number of elderly utilizing hospital and nursing home institutional services while expansion of home health care delivery and community-based care also) deserve to know and receive care from nurses who have at least received one-fourth of their education in meeting their special needs?

E. Roster of Nurses Provided to Adult Care Homes (lines 0099-0101). As recruitment assistance, the Health Department would furnish a listing of the names and addresses of nurses to adult care homes.

This section may need to be amended to have the list provided by the Board of Nursing, although the list could be given to KDH&E for nursing home distribution.

An additional amendment to limit the scope of this section might be to strike "in the state" (line 0102) and add "in the geographical area of an adult care home."

F. Summary of Conditions (lines 0103-0108). If the conditions listed in the bill in lines 0068-0102 are not found to exist by the licensing agency, the definition of licensed nursing personnel staffing for intermediate care facilities remains as is.

CONCLUSION

Adult care homes are caring for a much older and sicker clientele than in the past, necessitating more extensive and expensive care. The Medicaid program, which purchases over 50% of intermediate care services, reimburses providers under a prospective system, with rates subject to screens and limits, resulting in a flat, facility-specific daily rate regardless of an individual's patient care needs and costs.

Studies show that intermediate care facilities have been voluntarily increasing their nurse staffing levels, based upon resident care needs and facility-specific factors such as location, nurse availability, and funding. Competition is also a factor.

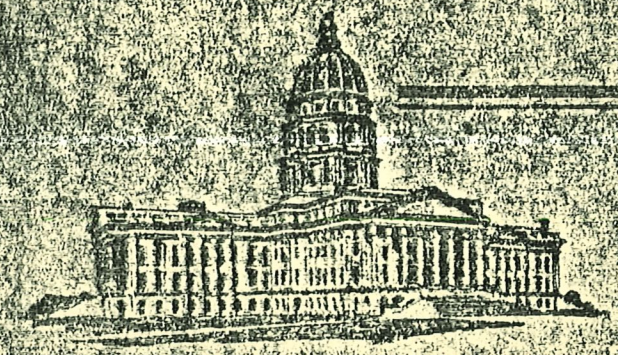
If total LPN coverage is required, can the standard be met by all -- rural and smaller facilities in particular -- and will it result in the best utilization of limited, health care financial and manpower resources?

Should the voluntary effort continue -- gradually building towards a reimbursement-driven system of individual patient assessment and classification which will remove such distinctions as artificial levels of care and a growing bias against accepting heavier care, Medicaid patients, and targeting expenditures to actual patient nursing needs -- or should uniform, mandated nursing coverage for all ICFs be in place?

If so, SB 273 contains all the necessary ingredients -- funding, availability, education, and attitude.

I'd be happy to respond to any questions.

OFFICE



PERFORMANCE AUDIT REPORT

Adult Care Homes in Kansas—
Cost and Quality of Care

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
June 1984

EXHIBIT NO. 1

Staffing levels. As might be expected, a relationship between costs and staffing levels does exist. Higher-cost homes did tend to have higher levels of staffing, though this was not always the case. The auditors had to balance this relationship with their observations that, in the 36 homes, many other important quality factors had little apparent relationship to costs. These factors included community involvement and staff attitude.

Administrator experience. One relationship the auditors did note between costs and a quality indicator was the amount of experience of the home's administrator. They found that lower-cost homes tended to have administrators with more experience. It may be that experienced administrators are better able to hold down costs, but there are other possible interpretations as well, and the auditors did not have time to evaluate them fully. They did note that there was no apparent correlation between an administrator's educational level and the total costs associated with the home.

During their visits to the 36 homes, the auditors compiled information on a variety of subjects. Appendix B contains a detailed listing of their findings. Some of the more significant findings are contained in the box on the next page.

The auditors' findings should not be used to conclude that there are no relationships at all between the amount being spent to care for residents and the quality of care they receive. The findings do suggest, however, that the relationship between cost and quality is quite subtle. Attitudes play a very important role in the quality of care, and attitudes cannot automatically be bought with more money.

Alternatives for Consideration to Improve the Quality of Care in Adult Care Homes

As the previous section of this report pointed out, Kansas' adult care home regulations address quality-related factors as thoroughly as regulations in any state the auditors reviewed. These states included two known to have innovative regulatory programs. Nevertheless, there may be alternatives that can be considered to improve the quality of care.

One such alternative, already under extensive discussion in the State, is to require 24-hour nursing care. At present, intermediate care facilities are required to have a registered or licensed nurse on duty only during the day shift (homes must have a nurse on call and readily available during other shifts). This section analyzes that alternative in considerable detail. It also examines changes that might be made to the reimbursement system itself to bring about greater emphasis on quality of care.

Twenty-four Hour Care by Registered or Licensed Nurses May Be Feasible in Many Areas of the State, but Small Homes and Homes in Rural Areas May Have Difficulty Meeting the Requirement

Providing additional licensed or registered staffing already seems to be a growing trend in the industry. A number of adult care home administrators who

SUMMARY COMMENTS FROM AUDITOR VISITS TO ADULT CARE HOMES

—Eighty-eight percent of the administrators interviewed said that they made no effort to set a limit on the number of Medicaid recipients in the home. Only six percent of the sample said their home had a formal policy governing the number of Medicaid recipients.

—Registered nurses were paid an average beginning wage of $7.53 per hour; LPN's got $5.85. Certified Medication Aides received an average of $3.97, Certified Nurse Aides $3.67, and aide trainees were paid $3.59.

—Sixty-seven percent of the homes visited do not provide 24-hour licensed staffing. Forty-seven percent of the administrators said that the availability of staff was a factor in their decision. Forty-four percent said that the cost of licensed staff was a factor.

—Administrators estimated the turnover of staff in their facilities at an average of just over 34 percent annually, for all employees. A sizeable number of the staff turning over appeared to be nurse aides.

—Statewide, turnover appears to be much higher in the urban areas. Many of the rural homes' administrators reported that the main cause of turnover was the employee moving out of the area. In the urban areas, nursing homes compete with hospitals, other nursing homes, and even restaurants for the same unskilled or semi-skilled labor.

--Only 22 percent of the administrators blamed turnover on low pay. Thirty-one percent thought that competition with other facilities was at least partly to blame.

--Although state regulations allow homes to hire aide trainees, 25 percent of the homes surveyed do not hire aides who are not already certified. Several of the other administrators, whose homes do hire non-certified aides, said they would prefer not to, or try not to.

—Of those administrators who do hire untrained aides, 69 percent said their homes absorb the cost of the training.

—Eighty-one percent of the administrators reported that their homes had an active and organized volunteer program.

--One hundred percent of the homes surveyed have contracts with local providers for audiology, physical therapy, and other health services. Regarding emergency hospital transfer agreements and ambulance service, 86 percent have formal contracts for these services, 11 percent have informal arrangements, and only one home reported having no arrangements of any kind.

—Almost half (49 percent) of the administrators reported having had difficulty finding providers for at least some health services.

—Forty-three percent of the administrators thought the present regulatory system was excellent or adequate, 13 percent thought it was very deficient, and the rest believed the system was deficient in some areas.

—The auditors asked if the State surveyors ever gave the homes any useful information, such as drawing the administrator's attention to cleanliness problems. Fifty-nine said that feedback from the survey process was "often" helpful. Thirteen percent said it "never" was.

—Seventy-one percent of the administrators said that the Medicaid system, as currently administered, does not provide adequately for good quality care.

were interviewed indicated they were increasing their licensed or registered staff coverage as it became possible to do so. Reasons which were cited for this change included admissions of new residents with more severe medical needs (at least in part due to the recent institution of diagnostic-related group-based reimbursement in hospitals). While some administrators indicated they did not feel 24-hour licensed staffing was necessary, those who had moved in that direction indicated they "slept better at night," or thought the needs of residents were better met.

Establishing 24-hour care would cost an estimated $3 million for salaries and benefits. To estimate the cost of requiring each facility to have 24-hour licensed staffing, several assumptions were made. First, it was assumed that at least as many facilities are currently providing more than 8-hour licensed staffing as during the week examined in depth by the auditors (February 13-19, 1983). Second, it was assumed that most facilities would make the transition by replacing medication aide hours on evening and night shifts with licensed practical nurse hours. Third, it was assumed based on the State's salary survey and the auditors' recent visits to homes, that the wage difference between medication aides and licensed practical nurses is $2.00 per hour.

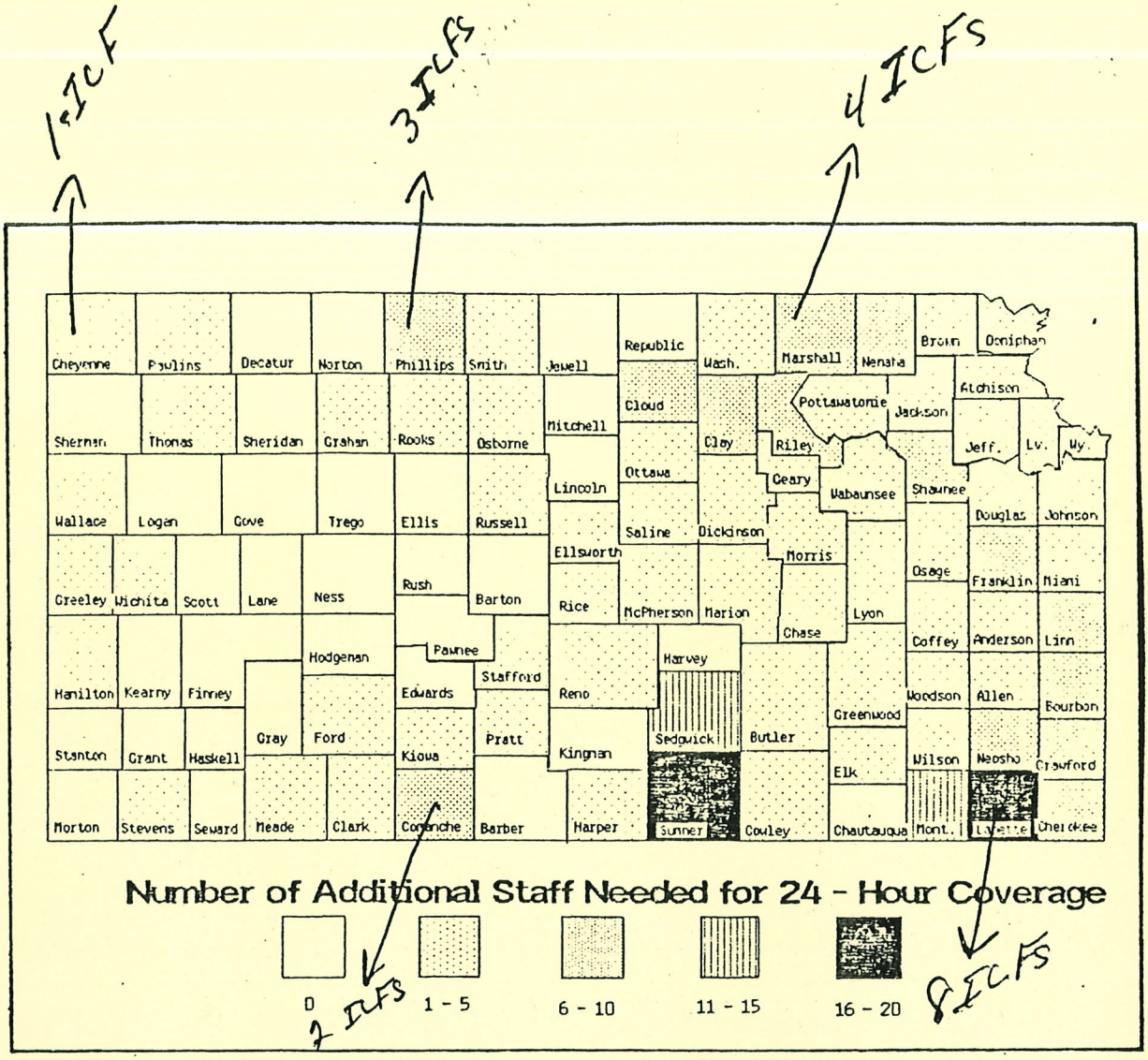
The analysis showed that in order to fulfill a 24-hour licensed staffing requirement, the 256 intermediate care facilities would need to provide an additional 20,505 hours of licensed staff time per week. This represents a 60 percent increase over the 34,660 hours which were provided during the sample week. Of the 20,505 additional hours, 9,198 were on the evening shift and 11,227 were on the night shift. Based on the assumptions noted above, the total cost of the increased requirement for all intermediate care facilities in the State would be about $3 million. Approximately half of this amount can be expected to be passed through to the Medicaid reimbursement system.

Additional staff requirements could pose problems in some areas of the State. To determine how many additional licensed or registered personnel would be needed to provide the required coverage, the auditors used quarterly report information on the number of full time and part time personnel which were employed by each of the 256 facilities during the sample week. The number of full-time equivalent licensed and registered staff was determined for each facility. The assumption was made that a facility would want to have five full-time employees to provide the necessary 168 hours of licensed staffing. This would provide a margin for vacations, illness, and turnover. Two projections were made. First, an estimate of the maximum number of new hires was made, based on the assumption that none of the part-time employees would increase their hours. Using that assumption, 484 new full-time equivalent staff would be required Statewide. Second, a low-end projection was made, assuming that all part-time employees would go to full time. Using that assumption, 329 new employees would be required Statewide.

These two projections provide a range of the likely number of nursing staff that would be needed to put a 24-hour staffing requirement into effect. Because the auditors were not able to include staffing information from approximately 40 intermediate care facilities, the top end of the range may need to be extended somewhat. Nonetheless, the range as developed provides a reasonable estimate of the staff that would be needed.

The map on the next page shows the relative impact on each county of the State. For the most part, the counties that would need the greatest increase in staff are in the more heavily populated eastern half of the State. As the map shows, however, additional staff would be needed in a number of rural counties in the State. Filling those positions might prove difficult even though the number of positions to be filled is relatively small.

A 24-hour staffing requirement would have a greater effect on small facilities than on large ones. During the week sampled, 11 facilities were providing 24-hour licensed coverage seven days a week. All but two of them



had 100 beds or more. On the other hand, three-fourths of the 91 facilities providing no evening or night staffing by licensed or registered nurses had fewer than 60 beds. Thirty-eight of these facilities had 50 beds or less. Even if all the part-time nursing staff in the 91 homes went to full-time status, these homes would need to hire 189 additional nurses.

One of the possible reasons that smaller facilities are less likely to provide 24-hour licensed coverage is the effect that doing so would have on their overall staffing composition. On average, the percentage of licensed or registered staff time provided per resident is 15.5 percent of total nursing time, or .317 hours per patient day. The table on the next page provides an estimate of how the average would vary if a 24-hour requirement were instituted. As the table indicates, if smaller facilities were to meet a 24-hour staffing requirement, they would be providing a much higher percentage of licensed staff time than the current average for all facilities. In addition, they would be providing for more licensed time per resident than the current average. As the table shows, for facilities with 70 beds or more, it is possible to provide 24-hour licensed coverage without significantly increasing either the percentage of licensed staff time or the licensed time for resident, assuming an average of 2.0 hours of care is being provided to each resident.

Number of Beds in Home	Percentage of Total Staff Time That Would Be Provided By Registered or Licensed Staff	Hours Per Resident Spent by Registered or Licensed Staff
30	40%	.80
40	30	.60
50	24	.48
60	21	.42
70	18	.36
80	16	.31

The auditors' findings with regard to 24-hour care indicate that, for many areas of the State and for many of the larger homes, instituting such a requirement would probably not prove too expensive or too difficult to comply with. Homes in rural areas, however, might have some difficulty obtaining additional staff, and small homes would be placed at a definite disadvantage in keeping their costs down.

A Reimbursement System Based More Heavily on Actual Services Provided Might Help the State Relate Costs to the Quality of Care

Concerns related to the reimbursement system include whether the amount of reimbursement provided by the Medicaid program is sufficient to cover the reasonable cost of good quality care, and whether the system provides incentives or disincentives for providers to meet the full needs of their residents.

In regard to the overall quality of health care being provided, the auditors' review of regulatory inspections and reviews showed that most facilities can improve in one or more areas, and some have severe problems. On average, however, during fiscal year 1983 only 23 out of approximately 370 adult care facilities of all types were on a provisional license in any given month. This is about six percent of all facilities. Since the percentage of homes on provisional licenses is fairly low, and low cost facilities were not disproportionately represented among those receiving provisional licenses, it would appear that the amount of reimbursement being provided is sufficient to permit a reasonable level of compliance with regulatory requirements.

Regulatory requirements are generally accepted to set minimum standards of acceptable care, and they do not provide a good measure of performance above the minimums. Nor were the auditors able to develop good measures of quality beyond regulatory compliance. As a result, the actual level of overall quality in Kansas adult care homes remains unclear. What does seem clear, however, is that the issue of quality is sufficiently complex that one cannot assume it will improve automatically if additional money is spent or reimbursed.

The current reimbursement system does not take some important factors into account. According to a health policy study on adult care home reimbursement issued by the Governors' Association's Center for Policy Research in

March 1983, reimbursement policies are among the most powerful policy tools available to the States. Payment mechanisms therefore should be consistent with state policy and goals, and should explicitly recognize the various factors which are of concern in the state. Throughout the course of the audit, concerns have been expressed to the auditors by the regulatory agencies, the industry, and others about the fact that the current Kansas reimbursement system does not take some important factors into account.

One of these factors is the varying care needs of residents. The reimbursement rate is a single, facility-specific amount, but intermediate care residents include individuals with a wide range of needs--from very independent to totally dependent. As a result, the system contains an incentive to accept more independent residents over those who need more care. This is expected to cause increased difficulty in placing more seriously ill Medicaid residents as the elderly population of prospective nursing home residents becomes older, more dependent, and more numerous. In addition, administrators of facilities which the auditors visited indicated they are already experiencing an impact from the new Medicare and Blue Cross-Blue Shield hospital reimbursement systems. These systems, which pay a flat rate for the medical treatment of patients based on their diagnosis, provide an incentive for hospitals to cut costs by shortening the length of stay. As a result, hospitals and physicians are transferring patients who have more critical medical needs to nursing homes. For private pay residents, additional charges can be made for services over and above those provided to most residents. However, for Medicaid residents, the combination of Medicare reimbursement limits and Medicaid daily rates creates a possibility that residents can be caught in the middle--with the hospital ready to dismiss them and the nursing homes unwilling to accept them. While it is yet uncertain how great a problem this may prove to be, it is a current cause of fear and speculation.

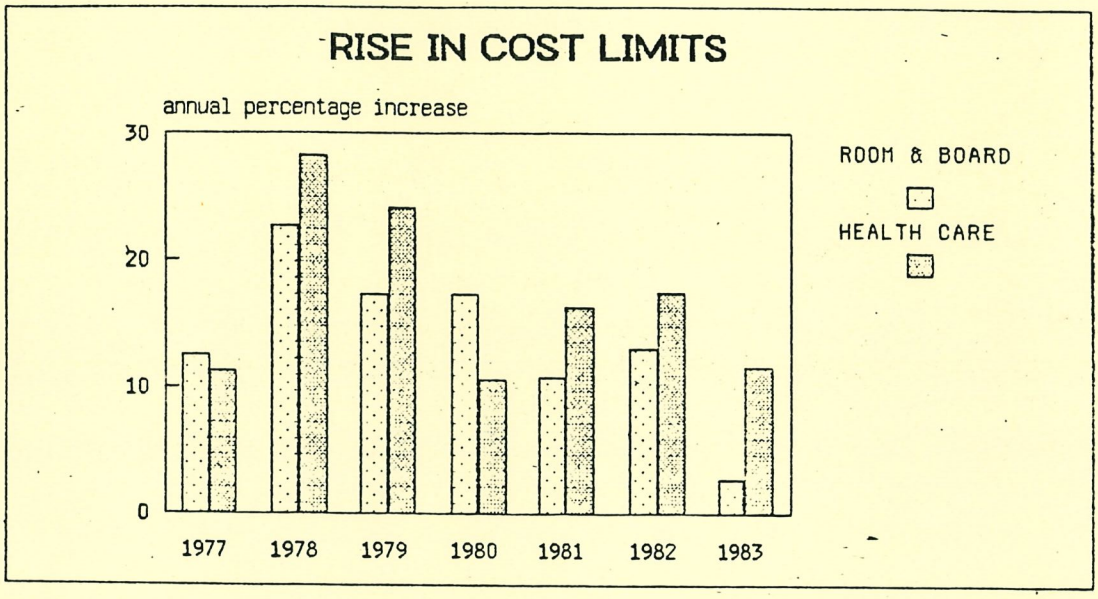
A second concern related to reimbursement is that the current system provides reimbursement rates which are based on the previous year's costs. This means that increased costs of any changes, including those mandated by regulation, such as training or staffing requirements, are borne by the industry for the first full year plus an adjustment period before they are reflected in the facility's rate. This facet of the system provides a disincentive to make voluntary improvements or to take on residents in need of heavy levels of care.

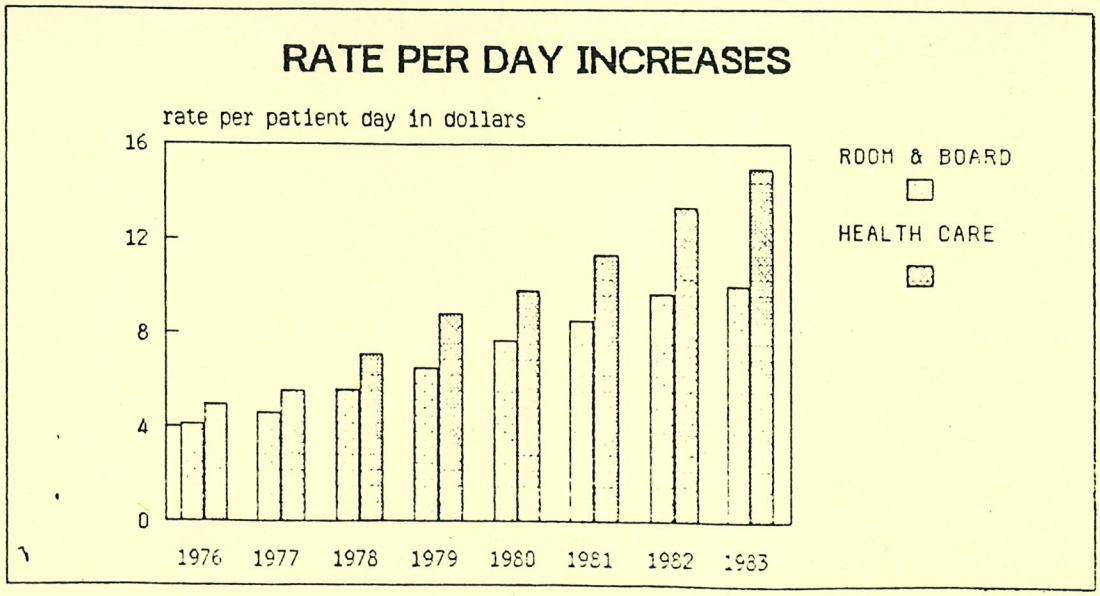
A third concern relates to the State's ability to determine what services are rendered at a given level of reimbursement. The services rendered above the minimum level required can vary considerably. Physical therapy services are a particularly good example of such variations. In the facilities which were visited, the auditors found that most routine physical therapy services were provided by aides with specialized training in restorative therapy, under the direction of a physical therapy consultant. In some facilities, one aide was responsible for all restorative therapy. At the other extreme, one facility had provided all aides with specialized training, and residents received therapy service as frequently as three times a day, seven days a week. Such variations are not reflected in either costs or staffing ratios, both of which were lower than average in the facility providing services three times a day.

A final concern relates to the State's ability to control increases in Medicaid costs. Since resident care costs are 70 percent of intermediate care

facilities' average total costs, the effectiveness of efforts to restrain overall increases in Medicaid expenditure over time could be limited if expenditures in these areas are allowed to increase at their current rate. Since 1976, the daily reimbursement limit for intermediate care facilities has increased an average of 10.5 percent per year. As the graph below illustrates, the cost limit increases have been even higher in health care (17.1 percent) and room and board (12 percent).

The State's policy thus far has been to exercise less restraint on costs directly related to patient care, as reflected by the 90th percentile limit for these cost centers. While this reflects concern for residents' needs, extreme variations in expenditures have resulted. For the 258 intermediate care facilities whose costs were examined, per patient day costs ranged from $6.69 to $23.02 for health care services, and from $4.52 to $13.45 for room and board.





Since expenditure levels do not appear to be clearly related to residents' needs or services provided, it seems probable that in some cases residents' needs are not fully met, and that in other cases unnecessary costs are being incurred.

Because room and board costs show less variation than health care costs, and fewer concerns have been raised about that cost center, no major recommendations are being made in regard to the way that cost center is handled. Since much of the variation in costs in that cost center is in staff costs rather than food and supplies, it is possible that some fiscal restraints could be applied in that area without jeopardizing the services provided to residents. One way of doing that might be to lower the cost center limit. This might, however, reduce the occurrence of amenities and innovations.

Changes made by other states may merit consideration in Kansas. To address the types of concerns discussed above, some states have made substantial changes in their reimbursement systems. According to the Governors' Association Study cited earlier, eight states have adopted reimbursement systems which explicitly address needs of residents. Those states are Illinois, West Virginia, Ohio, Washington, Maryland, New York, Massachusetts, and Utah. Although these systems generally assign a dollar value to the cost of providing care to patients with specific needs, the techniques employed vary considerably.

To assess the applicability and potential effects of a needs-based reimbursement system on Kansas, the auditors reviewed several of the systems which states are using and examined the Maryland system in some detail. This system, which became effective in January 1983, is more refined than most. Its basic characteristics are explained in the box on the next page. Using features of these programs, the auditors determined the likely effects in Kansas if such an approach were to be instituted here. Their review showed the following:

--On average, existing staffing ratios would be high enough to meet residents' assessed needs. The auditors assessed the care needs of 1,442 residents in the 36 facilities they visited. Of these patients, 579 (40 percent) were classified as needing light care, 492 (34 percent) as needing moderate care, and 371 (26 percent) as needing heavy care. Based on these assessments, residents required an average of 2.12 hours of nursing care (exclusive of activity director and social service time) per day. According to staffing reports provided to the Kansas Department of Health and Environment for the most recent quarter available, these 36 facilities provided an average of 2.12 hours of nursing staff time per patient day. On average, then, sufficient staff time is being provided to meet the assessed needs of Medicaid residents in these homes.

--Some nursing homes are overstaffed and some are understaffed in relation to residents' assessed needs. Although on average, assessed needs matched the staffing ratios being provided, facility-by-facility comparisons showed few close matches between assessed needs and actual staffing ratios. According to the Maryland time figures, some homes provided more nursing staff time than necessary and some provided less. In relation to the assessed level of need, some homes were understaffed by as much as .83 hours per patient day and some were overstaffed by more than one hour per patient day. Two assumptions were made which

COST IMPACT: 24 HOUR NURSING CARE IN ICF

A. Legislative Division of Post Audit.

1. 256 ICFs in data base.....$3.0 million
(ASSUMPTIONS)

   a. Same percentage of facilities are currently providing more than 8-hour licensed coverage as in sample.

   b. Medication aides replaced by LPNs.

   c. $2.00 wage difference between medication aide ($3.97 hour) and LPN ($5.85 hour).

2. Add to data base 40 ICFs not included in Post Audit report (excluding 31 MR and MH facilities). 15.6% increase.....$ 468,000.00

TOTAL $3,468,000.00

B. KHCA Projection (SB 273) For ICFs Currently Staffing Over 8-Hours.

1. One-third ICFs (100) already exceed minimum on either 2nd-3rd shift.....$1,530,000.00

2. SRS limits (Medicaid 56% of ICF days; 45% ICFs receive less than actual daily costs (-11%).

   a. SRS portion of Total .....$856,800.00.

TOTAL A & B =$4,324,000.00

C. KHCA Projection SB 273.

1. NO LPN currently on 2nd-3rd shift
(600 LPNs X $15,300 annual) .....$9.18 million

   a. Medicaid Portion (56%).....$5.14 million

2. One-third have LPN on one shift .....$7.65 million

   a. Medicaid Portion (56%).....$4.28 million

3. One-third have LPN on two shifts .....$6.12 million

   a. Medicaid Portion (56%).....$3.42 million

4. One-half have LPN on one shift .....$6.88 million

   a. Medicaid Portion (56%).....$3.85 million

EXHIBIT NO. 2.

5. One-half have LPN on two shifts .....$4.59 million

   a. SRS Portion (56%).....$2.57 million

UNPROJECTABLE VARIABLES NOT INCLUDED:

1. Mandate will increase all salary levels by "x" percent?

2. If "x" percent of medication aides are terminated and laid-off, additional unemployment compensation costs?

3. Salary levels in certain areas (rural in particular) to increase five-tenfold to attract nurses?

D. SRS FY 86 BUDGET FOR 24-HOUR CARE .....$1.8 million

(2) SB-273 - 2-28-85 - Chambers

February 28, 1985

TO: The Committee on Public Health and Welfare

FROM: Ellen Chambers, R. N., President of The Nurse Counsel of KHCA.

SUBJECT: Senate Bill 273

Mr. Chairman and Members of the Committee.

My name is Ellen Chambers, I live in Gardner, Kansas.

I have been a Registered professional nurse in Kansas for 30years. I graduated from Mt. Carmel School of Nursing, Pittsburg, Kansas and have spent my working life in Kansas hospitals in Neodesha, Independance, Caney, Gardner, Shawnee Mission Medical Center, and Olathe.

For the past 7 $\frac{1}{2}$ years I have been a Consultant Nurse for Medicalodge Inc. of Coffeyville.

On behalf of the Nurse Counsel of the Kansas Health Care Association, a voluntary non-profit organization, representing 250 licensed Adult Care homes with Registered Nurses and L.P.Ns ad D.O.Ns and H.Ss as well as staff members. The nurse counsel is in total agreement with Senate Bill 273 and will support its passage, but we do have concerns.

Long term care facilities are largely dependent on Licensed Nurses--Practical and Professional--to carry on their medical nursing health programs. It is shamefully paradoxical that the facilities that carry the name of a profession in its title--The Nursing Home--has as its greatest problem the LACK of Nursing PERSONNEL. There are many reasons for this and long term care must address this issue.

There is the problem of inappropriate use of health care personnel. Cast in the Medical Model, the most skilled staff (RNs and LPNs) are forced to nurse the chart and give credibility to the bookkeeping of care. Thus the least clinically skilled provide the bulk of hands on care.

There exists and will remain serious problems in shortage of personnel. This shortage is not only related to societal changes (e.g. womens liberation and civil rights) but also to the significant issue of the negative image of the Nursing Home and the publics lack of confidence in the long term facility.

The bill that is before you--SB 273, is very important to Nursing Home Nurses. I have spent time talking to several members of the Executive Committee of the Nurse Counsel from Moran to Marysville--from Olathe to Great Bend and we all agree that Licensed Nurses around the clock is the goal we all want to reach and maintain.

2/28/85
Attachment II

However, we seem to be having the same problems:

1. Where and how do we find these Nurses.
2. If we have the Licensed Nurses, How can we best utilize them for resident care.

Take item 1--where or how do we find Licensed Nurses. The usual methods put forth for recruitment are Newspaper Ads and visits to local schools of Nursing/AVTS.

Moran Manor - states they have been trying to find an 11 to 7 Nurse since February 1984 without success. They have ads in 5 area Newspapers and have had for the past year with no results.

Mary Marshall Manor, Marysville, has licensed Nurses only on the day tour of duty. They feel that their location and the general Nursing home image are making it very difficult for them to find more Nurses.

Regency Health Care Center, Halstead, continues to be short of a night relief Nurse. This has gone on for some time. They are in competition with 3 area hospitals and 4 other Nursing Homes. They, too, state "Ads Don't help".

Liberal Good Samaritan Center, Liberal told me they have sufficient Nurses as they have an AVTS in town and several of their Aides have gone on to be LPNs. This is also true in Atchison Medicalodge.

Sherman County Good Samaritan Center, Goodland has no Licensed Nurses on their 3 to 11 or their 11 to 7 shifts. They have been unable to fill these shifts with Licensed Nurses and are using CMAs.

As for Medicalodge, we, too, use Newspaper ads in an attempt to hire. We attend schools of Nursing Job Days. This is a time when we are available to the Junior and Senior Nursing students to explain what we have to offer for benefits--salaries--locations--and types of jobs. I have attended these functions at Washburn, Kansas City Kansas Community College, Wichita University and Johnson County Community College. The usual comments are "What are you giving away"--"Nursing Homes, Ugh"--"I don't want to take care of old people"--"Why do all Nursing Homes smell bad?"--"If I can't find anything elae, I'll get back with you." We have obtained no Nurses from this program.

Three years ago we obtained a complete registry of Licensed Nurses in the state of Kansas. (This list included people known to me who were dead and/or out of state.) We sent letters to those in our area. In my division the postage bill was $300. plus the letters and time. We obtained no nurses from any of this effort.

We also have a Scholarship program for aides or LPNs interested in furthering their Nursing education. We are growing our own Nurses, but this takes time and money.

The Nurse Counsel of KHCH also has a nurse scholarship for people wishing to be LPNs or RNs. It is a matching program with the Nursing Homes of the organization.

Item 2:--If we had the Licensed Nurses, how could we best utilize them for resident care.

GOOD question--let's look at a fairly typical shift--3 to 11--Shift change report at 2:45 p.m. to 3:15 p.m.--to find out about medication changes, dondition reports, new admits, Doctors visits.

3:15 p.m.--Do quick check on any new admits or ill residents.

4:30 p.m.--have meds set and ready to pass (takes about 30 to 45 minutes depending on system--number of residents vs number of meds.

4:30--5:30--Pass meds--talking to residents if there is time.

5:30--6:30--Pass trays in dinning room, supervise and feed residents

6:30--7:00--Eat own supper

7:00--7:30--Give PRNs do part of treatments

7:30--Set meds for next pass. Chart if time

8:00--Pass Meds (Not as many, but lots of requests--PRNs--Laxative--etc.

8:30--9:30--Finish Treatments--Chart

9:30--10:30--Help aides do bed checks and check on all Aide documentation--flow sheets--restraint sheets, etc.

10:45--Report to 11 to 7 a.m. shift.

The 11 to 7 shift

10:45 to 11:15--hear report

11:15 to 11:45--Do bed checks of INC Residents on her hall (Yes, they have total care)

11:45--12:00--Set up and pass meds (a lot fewer this shift)

12:30--Review work assignments with aides. Start Laundry (It's do it yourself in a lot of homes) so you can do later bed checks.

12:45--Give PRN meds and repeat sleepers

1:00--2:00--Bed checks and changes as needed--turn all residents unable to turn themselves. Chart.

2:00--2:30--Supper for self

2:30--3:00--Chart and stuff charts--check charts for new orders, etc.

3:00--4:00Check on Laundry and do bed checks and changes again.

4:00--5:00--Wash wheel chairs, Geri chairs, or clean other areas as assigned.

5:00--6:30--Start getting residents up for breakfast--check ans strip wt beds--make sure all residents are clean, dry and appropriately dressed.
Chart--Chart--Chart

6:45--7:15--Give report.

And, of course, during both of these shifts lights are to be answered on a timely basis and needs met.

Three to 11 and 11 to 7 shifts in ICF Nursing Homes are usually running with CMAs who can pass pills and deal with minor problems, but residents with special needs are those who are angry, hostile, and combative--those who have paranoid beliefs; the constant complainer--the stripper--the wanderer, and the severely confused and disorientated. These people would benefit from skilled licensed nurses around the clock--people to deal with some of their problems.

Nursing Home nurses care for, and about their residents.

We all want LPNs or RNs around the clock. BUT, we need to know how and where to find them and we need to be able to utilize their abilities for our residents' needs.

(3) 2-28-85 - SB 273 - Dr. Lois Scibetta

KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601
Telephone 913/296-4929

TO: The Honorable Roy Ehrlich, Chairman, and Members of the Senate Public Health and Welfare Committee

FROM: Dr. Lois Rich Scibetta, Executive Administrator
Kansas State Board of Nursing

DATE: February 28, 1985

RE: Senate Bill 273

Thank you Mr. Chairman, for this opportunity to comment on SB 273, on behalf of the Board of Nursing.

The Board of Nursing is supportive of the concept of 24 hour licensed nursing personnel coverage in adult care homes. However, the Board does have some objections to specific sections of this Bill, and the attending conditions for the 24 hour coverage.

Our objections are in Section D - "a licensed nurse who receives federal or state financial assistance in their education program....shall be required to be employed in an adult care home...for...one year." This section is not practical, and restricts and limits aid in the form of grants. Approximately 1700-1800 nurses are licensed annually in Kansas, and many are on some type of scholarship/aid. There would not be enough positions to accomodate all the nurses, and this section is discriminative in that acute care facilities and other settings are excluded as places of employment.

Section (E). This section required that educational programs in the state of Kansas include 25% course content in geriatric nursing care. This requirement is unsuitable because it is the faculty of the program, not the State Board of Nursing who determine the curriculum for their educational program. This would infringe upon the academic freedom of the faculty. It should be noted that many schools now utilize nursing homes for student experience.

Section (F). Deals with the provision of a roster of licensed nurses to adult care homes. If this refers to the Board of Nursing, this would be an expensive proposition. The University of Kansas at Wichita runs the computer tapes and updates every six months for the Board. The current price to the user is $200. Each adult care home would have to bear this cost. In addition, Kansas University at Wichita might be unwilling to comply with the volume of this request. The exact purpose of this section is obscure.

The Board further objects to the "conditional" nature of the Bill. The requirements almost guarantee non-compliance.

2/28/85
Attachment III

As noted earlier, the Board agrees in principle, with the concept of 24 hour licensed nursing coverage, however, it disagrees with the specific conditions outlined in Section D, E and F.

The Board recommends that these sections be deleted.

I will be happy to answer any questions which the Committee may have. Thank you.

LRS/amm

(4) SB-273 - 2-28-85 - David Twarog

DATE: February 28, 1985

TO: SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

RE: Senate Bill No. 273 (Authorizes 24 hours a day licensed nursing personnel under certain conditions)

WITNESS: David Twarog, Registered Nurse; Director of Nursing for the last eight years at the Heritage Nursing Home, Girard, Kansas.

PLACE OF EMPLOYMENT: The Heritage is a 100 bed intermediate care facility located in Girard, KS, which is a community of 2,600 residents located in southeast Kansas.

At the present time the Heritage supplies 30 hours of licensed nurses per day which covers the time period from 6 a.m. to 11:30 p.m.

I would like to take this opportunity to comment on the aspects of 24 hour nursing coverage in intermediate care facilities and if such a need is definitely warranted to follow the criteria in Senate Bill No. 273.

Over six months ago when we heard that 24 hour nursing coverage may be mandated we decided to try to implement this in advance of any law or regulation.

We soon found that there were three problems with the adding of a licensed nurse on our third shift, which is from 11:00 p.m. to 6 a.m. These dealt with availability, practicality and cost.

1. In regards to availability we ran a classified ad in our local newspaper, which has circulation throughout the county. This

2/28/85
Attachment IV

ad was for registered nurses as well as licensed practical nurses to apply for full or part time positions. We have continued this ad for the last six months in every publication of the paper.

We have had only four people apply during this time. Two of the applicants were registered nurses seeking a second job, that is, working in the hospital and wanting to come to the Heritage on their days off. The administration at the Heritage felt that these applicants were unsuitable because of the fatigue factor of holding two jobs without sufficient days off.

The third applicant was a registered nurse who had graduated from nursing three years ago. Since that time she had switched jobs three times, not holding any one single job for longer than six months. The administration found her unsuitable because of lack of experience and possible dependability problems.

The fourth applicant was a licensed practical nurse who over the last five years had only worked as a private duty nurse for an elderly gentleman who lived at home. She also was rejected for lack of experience in nursing and management.

2. In regards to practicality of a licensed nurse on our night shift, we attempted to form a job description which would be implemented when we found suitable applicants.

Through much deliberation we found that we could take two courses of action, that is, have the licensed person do ward clerk duties or nurse's aides duties. Neither of these were preferable but due to the lack of residents needing acute care these were the only viable duties we could formulate. This was not practical in that these duties were currently being performed by nurses and medication aides who were doing a competent job.

3. In regard to cost, we surmised from the lack of qualified applicants that in order to attract qualified staff on this shift we would have to give a financial incentive.

We surveyed the area and found our local hospitals are paying registered nurses $8 per hour as a starting salary. Included with this are fringe benefits of insurance, retirement plan, sick leave, etc. In order to hire these additional personnel, our present pay scale for licensed personnel would have to be increased in order to attract the desired professionals.

We believe that the starting salary for a registered nurse would be $7.50 per hour, with plans to raise to $8.50 per hour with in a year. This is higher than our current pay scale. This would necessitate an equitable increase in wage for the present licensed personnel, excluding the director of nursing.

ESTIMATED COST TO OUR FACILITY FOR THIRD SHIFT STAFFING

Present day shift staffing (excluding the director)	112 hrs/weekly
Present second shift staffing	56
TOTAL	168
Additional third shift staffing 7 hrs. 7 days per week	49
Weekly wage at $8/hr.	$392

Additional cost of staffing on third shift

Equitable pay increase to present staff $1 per hour/week	$168	
Third shift wages per week	392	
	$560	
	52	weeks
	$29,120	
S.S. tax (7%), State unemploy (1.6%) Fed. tax (0.8%)	2,737	
	$31,857	

This would result in about a $1.00 per day cost increase to our residents, or $30 more a month.

In conclusion I feel that when weighing these three factors of availability, practicality and cost, the only suitable method to have 24 hour nursing coverage in an intermediate care facility is to follow the guidelines as set forth in Senate Bill 273.

(5) SB-273 - 2-28-85 - Pauline Wells -

DATE: February 28, 1985

TO: Senate Public Health and Welfare Committee

FROM: Pauline Wells, Administrator, The Centennial Homestead, Washington

RE: Senate Bill 273

Our facility finds it impossible to hire a registered nurse or a licensed practical nurse in our rural area. The professional wishes to stay with hospital work. Most nurses think a nursing home is without challenge. They prefer acute care settings and being able to work with a doctor who makes daily rounds. We have a director of nursing who works the day shift five days a week. A LPN who works partime on the first and second shifts. No more than twelve days a month. Our other LPN works every other weekend,because of a farm problem. She is able to help between the hours of 9:00AM and 5:00PM for professional coverage. Our facility must hire a med-aide the weekends she work to pass 6:00 AM meds. This is an additional expense. Most nurses do not receive enough training in geriatric nursing. This will be the nurse of the future. The cost to our facility to hire two more LPN's would be $25,000, which in turn increases all payroll taxes. This would affect private pay $75 more per month.($875-950). Our monthly rate for nursing home residents in this area has gone as high as the public can absorb. it is unfair for the private pay resident to offset the medicaid rate. Federal funds should help defray this additional burden. After all SRS demands the same care for their residents as private pay. Nursing homes would need a year to comply with bill #273. If you have tried in good faith to comply with the bill, the fine would be unfair. A LPN on the night shift would not be necessary. You could not justify

2/28/85
Attachment V

the cost. Meds are kept at a minimum. Med-aides could handle this shift since the director of nursing is on call for emergencies.

(6-SB-273-2-28-85-Lynelle King

KSNA

the voice of Nursing in Kansas

Statement of Kansas State Nurses' Association
By Lynelle King, RN, MS, Executive Director
Before the Senate Public Health and Welfare Committee
February 28, 1985

In Favor of 24-Hour Licensed Nurse Coverage in Nursing Homes; Questioning conditions in SB 273

Mr. Chairman and members of the Committee, my name is Lynelle King and I am the Executive Director of Kansas State Nurses' Association, the professional organization for Registered Nurses in Kansas.

First, Mr. Chairman, I wish to thank you for your consideration in scheduling this hearing on Nurses' Day at the Legislature, so that nurses from all over the state have an opportunity to attend. That was very gracious of you.

Because there is a long list of persons who wish to testify, I will keep my verbal remarks very brief. Also I will be happy to elaborate further if you wish, tomorrow or some other time, and will be available for questions.

Summary of KSNA's Position

- KSNA believes that our frail, vulnerable elderly in nursing homes in Kansas (including ICFs) deserve care under the auspices of licensed nurses 24 hours a day. "Licensed nurse" includes LPNs and RNs.

- KSNA Supports a Waiver for homes that could not obtain LPNs or RNs, after good faith effort.

- We are very pleased that Kansas Health Care Association also is supportive of 24-hour coverage. However, KSNA believes SB 273 is unnecessary and its conditions will obstruct implementation of 24-hour coverage. We support the approach recommended by the 3 cabinet secretaries (DHE, SRS, and Aging).

Attached are the following materials which go into more detail about KSNA's position and concerns:

1. KSNA's position statement on 24-hour coverage and a two page listing of concerns and questions about some of the specifics of SB 273.
2. KSNA's response to the Legislative Post Audit Study regarding "Cost of and Quality Care in Adult Care Homes in Kansas".
3. Results of KSNA's survey of nurse availability in Kansas.

(cont.)

Kansas State Nurses Association • 820 Quincy • Topeka, Kansas 66612 • (913) 233-8638
Michael H. Goodwin, R.N., M.Ed., M.N. — *President* • Lynelle King, R.N., M.S. — *Executive Director*

2/28/85
Attachment VI

With me are two members of our association who have special expertise to speak about some of the special conditions set forth in SB 273.

1. Mrs. Jan Bergman, RN, C, CNA of Seneca who is co-owner and Director of Nursing of an Intermediate Care Facility in Seneca. She is a nationally known expert and writer on gerontological nursing.

2. Dr. Alice Adam Young, Ph.D, RN, Dean of the Washburn University School of Nursing will speak to some of the education issues in SB 273.

They both will be brief.

Thank you for the opportunity to comment. I will be happy to answer questions or provide more information later.

KSNA
the voice of Nursing in Kansas

Position on 24-hour Licensed Nurse Coverage in Intermediate Care Homes

KSNA believes that our frail, vulnerable elderly in nursing homes in Kansas (including ICFs) deserve care under the auspices of licensed nurses 24 hours a day. "Licensed nurse" includes LPNs and RNs.

KSNA supports a waiver for those nursing homes that are unable to obtain LPNs or RNs, after a good faith effort.

This has been KSNA's top priority for two years, as a means of improving care of the institutionalized elderly.

1. 24-Hr Coverage is Needed

Changes in health care recently which have increased the need for licensed nurses around the clock include:

- Increased age and frailty of nursing home residents, with a high percent over 85 years of age.
- Early discharge from hospitals due to "DRGs" and other cost-containment pressures. Thus nursing home patients are more acutely ill than in the past.
- Home care is more readily available so that only the sicker persons choose institutionalization in an ICF.

2. 24-Hr Coverage Is Cost-Effective

Licensed nurses are more capable of early detection and prevention of complications, which saves money. Complications, if not detected or prevented, lead to much more expensive and intensive medical and nursing care, and even may necessitate hospitalization with its much more costly care.

Jan Bergman, RN, C, CNA, of Seneca, co-owner of Crestview Manor, says her home is a case in point. For 7 years Crestview Manor (an ICF) has staffed with licensed nursing personnel around the clock, yet she states that the home has one of the lowest reimbursements in the State, as reported by Legislative Post Audit.

3. There are LPNs available in most, and RNs in many, areas of the state to accomplish the 24-hr requirement.

- KSNA supports a waiver for those homes that could not find licensed nurses to work, after a good faith effort.
- There are many indications of nurses available in many areas including many rural areas. (There are a number of counties where all the positions in all agencies are full - there are no openings; many LPNs have been laid off across the state as a result of factors surrounding the "DRGs" system of reimbursement; many RNs have been forced to cut back to part-time work who desire full-time; 1984 nursing graduates had increased difficulty in finding jobs - some are still not employed.

4. KSNA and RNs stand to gain little by the 24-hr requirement.

We make this point to emphasize that KSNA's interest in this matter truly is related to our concern for the safety and quality of care of residents in intermediate care homes. Realistically we expect that LPNs would be the level of employee more likely to be hired by ICFs to fulfill the requirement of 24-hour licensed nursing coverage. There appear to be more LPNs available and their pay is less.

Having LPNs around the clock would truly be an improvement for those homes that now have only aides on duty most shifts.

Kansas State Nurses Association • 820 Quincy • Topeka, Kansas 66612 • (913) 233-8638
Michael H. Goodwin, R.N., M.Ed., M.N. — *President* • Lynelle King, R.N., M.S. — *Executive Director*

KSNA's Concerns Re: SB 273

Because KSNA supports 24-hr-licensed nurse coverage, we have concerns about many aspects of SB 273. Under SB 273, 24-hour coverage could be required only if all the long list of difficult, costly conditions are met. It appears that SB 273 would make 24-hr coverage impossible.

SB 273 is unnecessary. The Secretary of Dept. of Health and Environment already has the authority to require 24-hr coverage via regulations, and the Governor's SRS budget contains $900,000 to implement the requirement. KSNA supports that approach - through regs and the budgetary process.

Some of the conditions of SB 273 and KSNA's comments and concerns:

A. That 24-hour care would be construed as no more than 1 additional LPN per facility (regardless of size of facility or patient acuity) for the 2nd and 3rd shift.

As a practical matter, that's where we will undoubtedly have to start, but we would not like to foreclose the possibility of staffing according to resident need (number, type and acuity of patients) at some later time. Also, why not keep terminology of "licensed nurse" which is broader, instead of narrowing it to "LPN" only.

B. Total allowable Medicaid costs to be reimbursed (including those currently providing 24 hour care) with such costs not subject to the usual cost center limitations.

We understand that it would be a precedent to remove the cost center limitations and thus would greatly increase the fiscal note of this bill - we do not see how one could justify removing the cost center limitations.

C. One year phase-in for compliance. Waiver if good faith effort has been made to obtain licensed personnel; the burden of proof would be on the Dept. of Health and Environment that a good faith effort was not made.

A phase-in of course would be necessary and KSNA supports a waiver for homes which cannot find licensed personnel. This could be handled better through DHE's regulatory process than by statute. However, the burden of proof should be on the nursing home and their efforts subject to regular review.

D. Any LPN or RN receiving federal or state assistance in education would be required to work in an Adult Care Home for 1 year.

KSNA has supported nursing scholarship programs targeted to underserved areas. However, the above requirement is quite sweeping. How is "federal or state assistance" defined? Most schools of nursing in Kansas receive some state aid, which of course assists the LPN or RN students enrolled. Each year the amount varies of federal loans or other support to nursing students. In the past, more than 60% of students received some federal aid. Can the nursing homes of Kansas absorb the hundreds of nursing graduates each year who have received state or federal assistance? How would the homes be forced to accept the graduates?

We also understand there was a court decision which ruled out such a requirement; we understand that one cannot legally make such a requirement of an individual.

(cont.)

We are happy to hear reports that the proportion of nursing graduates working in nursing homes is increasing. At least one nursing school, Pratt County Community College, reported recently that the largest percent of their 1984 graduates are employed in nursing homes!

E. All LPN and RN nursing education programs would be required to include a minimum of 25% counse content in "geriatric nursing care".

KSNA has supported a strong gerontological component (including clinical) in all schools of nursing. Kansas State Board of Nursing has required this for some years. How does one measure 25% content? Most schools of nursing have an integrated curriculum (gerontological concepts are integrated throughout the curriculum) - how can the percent be quantified? Also - is 25% a little high? There are many facets of learning in schools of nursing - psychosocial, physiological, pathology, biological sciences, community health aspects, patient-education aspects, care of patients with cardiovascular symptomatology, respiratory dysfunctions, degenerative diseases, infectious diseases, on and on to give just a few examples.

What must be cut back to allocate 25% to gerontological nursing? How will this affect "reciprocity" to other states? Will nursing school programs have to be lengthened by a semester - or a year? How would that effect cost and enrollment?

F. Dept. of Health and Environment would be required to provide annually a roster of names and address of all LPNs and RNs in the state.

The list comes from State Board of Nursing and with LPNs and RNs total there would be more than 30,000 on the list! Do the nursing homes need such a list? Would it be cost-effective to provide such a large list to every nursing home in the state?

Unless all of the above conditions are met the state could not require 24-hr licensed nurse coverage in ICFs - if SB 273 were passed.

KSNA believes these conditions are impossible.

SB 273 is unnecessary - it could be taken care of by regulations by DHE. Actually SB 273 would prevent the implementation of 24 hour coverage.

What we support:

- Regulations under DHE to provide 24-hr coverage - with a waiver for homes that could not obtain LPNs or RNs.
- Retain in the Governor's fy 1986 SRS budget funds to implement the 24-hr requirement

For more information: KSNA, 800 Quincy, Topeka, Kansas 66612
(913) 233-8638

KSNA Statement - in response to Legislative Post-Audit Report

RE: Report on Adult Care Homes in Kansas — Cost and Quality of Care

The Kansas State Nurses' Association, the professional association for registered nurses in Kansas, would like to take this opportunity to comment on several aspects of the most recent post audit report for nursing homes. We are extremely interested in this particular report. Our association has as one of its goals for 1984 the improvement of nursing participation in adult care homes. In addition, our membership adopted a resolution, Standards of Care for the Older Adult, last October. Improving the quality of care for older Kansans is a high priority of ours, and we believe that nurses have an important role to play in assessing the needs of the elderly in nursing homes and planning and implementing their care.

Our comments will focus on three major areas addressed in the report.

1. The suggestion that small homes and homes in rural areas may have difficulty meeting a requirement for 24 hour care by registered or licensed practical nurses.
2. The proposal which would tie reimbursement to actual services provided.
3. The fact that overall staffing levels exceed the requirements established in the regulations.

Impact of 24 Hour Nursing on Small and Rural Homes

The availability of licensed nurses in rural areas is not the critical problem it was just a few years ago. There are several reasons for this. The major one relates to the impact of DRGs on hospital staffing patterns for nurses. Fewer people are being admitted to hospitals, stays are shorter, and patients generally are sicker and require more acute care. Fewer nurses are needed because with shorter stays the overall census is down. However, the nurses that are needed are those which can provide a high level of care. This has resulted in some hospitals shifting to an all registered nurse staff and a narrowing of the job market for licensed practical nurses. A case in point is in southeast Kansas where an educational program for LPNs is closing because of the non-existence of jobs for its graduates. A number of the hospitals in that area are moving to an all R.N. staff.

There are reports of both RNs and LPNs in various parts of the state who upon graduation can not find jobs or are only able to get part-time employment. A number of hospitals which were traditionally able to offer jobs to any new graduate of programs which affiliated with them now have only a handful of slots available for new graduates. A new graduate in southwest Kansas tells how her local county hospital paid her nursing school tuition with the requirement that she come to work for them after graduation. However, when she graduated they had no job for her. She had to go to the next county to find a job. Some new graduates have even left the state because they found other states had a more open job market.

Hospitals are not the only places which can not absorb the available supply of nurses. A home health agency in southwest Kansas advertised for an RN in newspapers in ten counties in that area. The result was forty-five nurses applying for that one job.

The types of patients being admitted to nursing homes is changing, in part due to DRGs. With changing care needs the need to open up additional jobs for licensed nurses in adult care homes is imperative. This issue will be discussed in more detail later in this letter. We would be agreeable to seeing 24 hour nursing phased in across the state, allowing smaller homes and those in the rural areas to have more time to come into compliance with the requirement.

Tying Reimbursement to Actual Services Provided

We can not dispute the report's suggestion that more money spent does not necessarily equate with an improved quality of care being provided. There needs to be a system which will more accurately represent the care requirements of individual residents. We would agree the current system of classifying according to light, moderate, or heavy care is too broad. With reimbursement being determined by an averaging of care requirements, there appears to be no incentives for accepting residents who require heavier care. By basing reimbursement on a system which would take individual care needs into account, the payment would more accurately reflect the nursing skill and time commitment needed to provide the care.

We would be in agreement with building into the system a mechanism which would encourage restorative care, i.e., paying more for spoon feeding than for tube feeding. At the same time, if a resident's care requirements decrease, the reimbursement should be allowed to stay at the higher level for a period of time as suggested in the report.

As mentioned previously, the types of patients being admitted to nursing homes is changing. With shorter hospital stays being one end result of DRGs, patients admitted to nursing homes are sicker. Another factor is that the elderly are living longer. With increased age generally come more chronic illnesses and the complications which accompany multiple health problems.

With the nursing home population becoming sicker and older, the level of care needed can be expected to be more complex, requiring the skills of greater numbers of licensed or registered nurses. If reimbursement is more closely tied to the actual needs of the individual resident, then it will be possible to pay for an appropriate mix of licensed and registered nursing personnel who are prepared to meet the high level needs.

Nursing is currently looking at ways to cost out nursing care per DRGs. One method being evaluated in New Jersey is "relative intensity measures" which measures the amount and cost of nursing time required by patients in different DRGs. Other states are looking at systems to identify the total amount of nursing time with individual patients. While realizing that nursing homes do not come under DRGs, the methods being developed to measure costs of nursing care appear to have the potential to be utilized in non-hospital settings. If a reimbursement system is to be developed based on actual services provided, we strongly recommend that nursing input be an integral part in the development of this system.

Over-all Staffing Levels Exceed the Requirements Established in the Regulations

The primary question raised by this finding is whether compliance with regulations can be equated with quality of care. Regulations generally set minimal standards and are not intended to guarantee excellence. As the report pointed out, services rendered above the minimum level required vary considerably.

On the average, staffing ratios reported were said to be high enough to meet assessed needs. However, the data was collected in 1983 before the DRG system went into effect. The DRGs have brought about a change in care requirements. The market, not the regulations, should dictate the type of staffing mix needed. These changing care requirements call for a larger component of staff to be licensed or registered nurses.

In conclusion, we would like to say that this report proves to be informative. It makes recommendations for improvement which warrant further consideration. KSNA would ask that you call upon us for input as these recommendations are further analyzed.

(7) - SB-273 - 2-28-85 - Paul Hoyer

Western Prairie Care Home

300 E. MAIZE
ULYSSES, KANSAS 67880

Member of ahca

TELEPHONE 356-3331

February 28, 1985

Senate Public Health & Welfare Committee
Kansas State Capital
Topeka, Kansas

Re: Kansas Health Care Association
Proposed Licensed Personnel Legislation
SB-273-24

Dear Gentlemen:

I appreciate this opportunity to speak before you concerning the proposed 24 hour licensed nurse coverage in adult care homes in Kansas.

I am the Administrator of Western Prairie Care Home in Ulysses, Kansas. We are a 75 bed, licensed facility.

I was asked to answer three questions in regard to the proposed legislation. The first being:

If I were to have to replace or hire staff based on the proposed new requirement, what procedure would I follow?

Before I could answer that, there are, I feel, several assumptions that would have to be made and understood.

In the replacement of any personnel, we always go to our application file to see if we have an application that is current and that we may have interest in pursuing.

Next, we would place a help wanted ad in two communities besides our own in hopes that we could attract a licensed LPN or RN to make an application with us. Those ads would be placed in the Ulysses News, The Garden City Telegram and The Liberal Southwest Daily Times. The cost to our facility for the ads alone would be $141.67 per month.

The next factor that we would have to consider would be; how close am I to the proposed requirement and will I need one full time licensed person or three or four licensed persons to meet the requirements.

I would like to make three assumptions based on the above statement:

First: If I were now just operating my facility based on the state requirements for an Intermediate Care Facility, I feel we would have an extremely difficult time satisfying the requirement even in a years time.

2/28/85
Attachment VII

Second: Assuming we already meet the requirements in part, then we would have to pursue the application file, ads and nursing school and nursing journals.

The next questions is; What can we offer the Licensed person? Can we offer a full time position or can we only offer a part-time position and hope that it would develop into a full-time position? We must also consider the need for relief help, who is going to cover the shift when the staff person is on vacation, sick, etc. When you go from a partly covered situation to a full covered licensed schedule, we must deal with that problem.

The legislature must understand that living in rural Western Kansas is not like living in Topeka or Wichita where an abundance of help is available and where more people are willing to work a part-time job than that of a smaller community where when a nurse needs a job it is normally for a full-time schedule and because of the need to meet family and financial obligations.

Finally; If we know educational opportunities were available for our staff to acquire these LPN licenses and that the state would reimburse us or our staff for training and travel time, we would be in a better position to encourage them to get their training and resume work for us when their training is complete.

Question 2: How many nurses are currently available in your community?

We know of one nurse in the community who is willing to work the 3-11 shift once a week, which because of our current staffing condition, we would be a little closer to meeting the requirement, but her husband may have to move so she may not be available.

Other than this one nurse, I am not aware of any other nurses who would be available within our community. We would have to revert to the approaches outlines in number one.

If I may state our specific efforts made to test the market last October and November 1984: We placed ads in the Garden City Telegram and The Ulysses and Liberal papers. The only response from the local paper was by one girl who we mentioned earlier. She was an RN, so we would be faced with paying her at least $1.00 per hour more for her professional judgement and experience.

We had one other hospital employee answer the ad. They were interested in working for us, however, when they heard the salary being paid they felt they could not afford to take that much drop in pay to come and work for us.

So in summary, I would say on a short term limited basis, trial run, we would not have met the requirement.

In visiting with our local hospital, the Director of Nursing indicated that she had been able to recruit nurses from Oklahoma as well as Northeastern Kansas. If we were to pursue these marketing areas we would have relocation costs, plus they may not be willing to relocate to work at our current wage scale.

Question 3: If we were to satisfy the requirement, what would be the cost impact to our facility?

I need to outline this as to what it would cost us to maintain the state requirement based on our current salary schedule and benefit package, then compare that to compliance to an LPN on each of the two specific shifts. Then finally, compare that to what it is currently costing us to maintain the type of program we have based

on the availability of staff and financial limitations.

Explanation of estimated cost of paying;

3 med aides daily
2 med aides on the 3-11 shift
1 med aide on the 11-7 shift

Average salary - $5.00 per hour
1.00 per hour, cost of taxes and benefits
6.00

$6.00 X 24 hours a day 7 days a week = $1,008.00 X 52 weeks = $52,416.00 or $4,368.00 per month.

Estimated cost of two LPN's, one on each of the 3-11 and 11-7 shifts.

Estimated hourly wage - $6.40
Taxes and benefits 1.24
7.64 X 16 hours X 7 days = $855.68 X 52 weeks = $44,495.36 ÷ 12 = $3,707.95.

To take our first comparison, we see $4,368.00 for three employees to be replaced by two employees at $3,709.75, a difference of $659.00. However, on both the 3-11 and 11-7 shifts, a facility will still have to maintain one, if not the two, medication aides to assist in passing medicines while the LPN has the opportunity to supervise and evaluate patient care to assure proper treatments, etc. are being administered. So you are, in essence, adding $3,709.00 to the payroll and only in a small number of situations would you be increasing less that that amount each month, plus you also have to consider the need to have replacement staff available because no one can work seven days a week. With that additional staff, you have added vacation and sick leave expense to this monthly payroll.

Finally; Let us look at Western Prairie Care Home, USA, a reality, as most of the administrators experience the cost impact today. Because we desire to give as much quality care and service as is affordable, we have gradually increased our license coverage in the facility over the past two years.

We cannot, by virtue or reality again, find LPN's that are 100% available to work the 3-11 and 11-7 shift. To meet our goal, we accept what positions our current staff want and desire to work to meet their family and financial needs. We have an LPN on the 3-11 shift 18 days per month, four of those days, which are on weekends, she works 12 hour shifts to help with the day (7-3) coverage. One RN covers one of the other 3-11 shifts four days per month. The remaining 3-11 shifts are covered by our medication aides with an LPN or RN on call for emergencies and consultation.

On the 11-7 shift, we have an RN who works four nights a week or seventeen days a month. The remaining nights are covered by our med aides with RN emergency coverage available. We estimate this coverage cost us $3,294.72 a month.

One very important factor that must be made here is this; We are a County run home, thus, we have additional tax money available to assist us so we can have a quality program. However, if it were not for the tax supported dollar, the facility would not meet the needs of our elderly adequately. All aspects of the program would have to be cut to maintain a break-even-point in our operating budget.

In conclusion; Yes we believe in 24 hour licensed nurse coverage, however, the state must examine the facts, the cost impact and their willingness to be committed to provide adequate reimbursement per day to deliver a product that will meet the demands of caring for the large number of older Kansans who will be placed in adult care homes in the future.

(8) - SB-273 - 2-28-85 - Paul Wurth

Mid-America Health Centers, Inc.

120 S. MARKET / 120 BUILDING / SUITE 400 / WICHITA, KANSAS 67202 / (316) 262-4206

TESTIMONY PRESENTED BEFORE THE

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

BY

PAUL W. WURTH, VICE PRESIDENT OF MID-AMERICA HEALTH CENTERS

MEMBER KANSAS HEALTH CARE ASSOCIATION

FEBRUARY 28, 1985

SENATE BILL NO. 273

"An ACT to require intermediate nursing care homes to be staffed to provide twenty-four (24) hours licensed nursing personnel under certain conditions."

MR. CHAIRMAN AND COMMITTEE MEMBERS:

As a member of the Kansas Health Care Association and the operator of two intermediate care facilities in rural areas, I appreciate the opportunity to appear in support of Senate Bill No. 273.

The need for Senate Bill No. 273 is firmly rooted in the increasing numbers of the chronically ill elderly being admitted to our state's nursing homes. As a conscientious provider speaking on behalf of other KHCA rural facilities, I would like to address several key provisions which directly effect our compliance with the proposed law.

The first critical consideration is the availability of professional nurses to staff our facilities on a twenty-four hour basis. Sources have claimed that there is an ample number of LPN's in the labor market. Educators claim that if 24 hour care is mandated, that enrollment will increase because of new employment opportunities.

The current market problem in the rural areas relating to availability may not be number of graduate nurses, but rather desirability to work in a geriatric setting. A recent graduate informed me that out of her class of 38, only seven desired to work in a nursing home.

2/28/85
Attachment VIII

A second related problem to availability regards recruitment. Community homes in towns of less than 1,000 people find it very difficult to recruit a single nurse to live there, or even more difficult to have married professionals who's spouse may not find employment.

Nurses, single or married, will compete for the best wage and benefit packages to compensate for remaining in the rural areas. Smaller homes do not have the financial flexibility to drastically increase costs for professional nurses.

. In my own facility, we have been unable to find a replacement for a 3-11 nurse because the nurses are asking for benefit plans that include pensions, health and life insurance, and paid holidays off.

If costs increase because market prices change, the importance of immediate cost pass through is critical. It would be grossly unfair to force the full costs of the program on our private pay reesidents. In fact, a full cost recognition by SRS that is not limited by the fifth cost center would encourage providers to structure benefit packages that would keep or attract quality professional nurses to these rural facilities.

The propsed bill states that homes in rural areas will have a one year grace period to comply with the new law. The rural operator will need this time as a minimum to recruit more professional assistance. Secondly, good faith efforts must be an allowable exemption if the facility is unable to replace a nurse who has moved or has been unsuccessful in luring a recent graduate.

Certainly 24 hour care will create a demand, but currently in the rural area, most nurses in town are presently employed or do not want to work. Rural health care has diminished along with the population causing nurses to keep their present jobs. Therefore, new openings will have to be filled by new graduates. At this time it is our <u>hope</u> and <u>expectation</u> that professional nurses will be taking advantage of the opportunity, but today it is still just a hope.

Again, as a provider I feel it is important that the committee understand the need for mandated geriatric training for professional nurses. Geriatric residents are not acutely ill but chronically ill. The difference in care-giving, medically and most importantly, socially and psychologically, is significant. The elderly require an understanding of their advanced illnesses and need for the nurse to provide a long-term professional security blanket of good care.

During the past seven years, I have seen too many good nurses leave a facility because they hadn't realized the difference. The problem was they weren't exposed prior to hiring. We want nurses who are enthusiastic about working in a nursing home because they are the key to our program.

Another recent graduate commented that in her class less than 30% had ever visited a nursing home. Fortunately, this program required 36 days of clinical work in a nursing home prior to graduation. If this had not been the case, the nursing homes would be recruiting professionals, who if worked on the 11-7 shift, would be unfamiliar with the environment in case of an emergency. I understand the curriculum crunch already facing nursing educators, but the elderly need nurses who are knowledgeable about them.

In conclusion, I firmly believe the resident will be well served by this law. I want to participate if the law makers allow me time to recruit, pay for the new professional without penalty and flexibility if the market becomes scarce in the rural areas. I also want nurses who have a good understanding of my residents prior to work and have made a decision that working in a nursing home is an exciting career opportunity.

Mr. Chairman and committee members, thank you for your consideration of Senate Bill 273.