Approved 1-28-86
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

10:00 a.m./p.m. on January 21, 1986 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Bill Wolff, Norman Furse, Clarene Wilms

Conferees appearing before the committee:
Barbara Sabol, Secretary, Department of Health and Environment
Joyce Romero, Secretary, Department on Aging

Others present: See attached list

Senator Ehrlich announced a change in the agenda. The Committee will accept requests for bills on Thursday, January 23, 1986.

Secretary Sabol presented the committee with material covering the problems, programs and issues concerning the status of health in Kansas; also a copy of the Annual Summary of Vital Statistics, Kansas, 1984. The Secretary's report stressed the importance of comprehensive prenatal care. Her written report also lists 24 hour care in intermediate adult care homes, mandatory seat belt usage and continuation of funding to local health departments as major concerns. Attachment I Members of the Secretary's staff were introduced.

Joyce V. Romero, Secretary, Department on Aging introduced members of her staff that were present. Secretary Romero presented the committee with material covering the Kansas Department on Aging priorities for 1986. Attachment II Committee members questioned the Secretary concerning all budget cuts made and which will be made affecting meals for the elderly, such as those delivered to homes, etc. It was requested that this information be furnished in writing to committee members.

Meeting adjourned.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 1-21-86

(PLEASE PRINT)

NAME AND ADDRESS	ORGANIZATION
Gary Robbins	Ks Opt. Assn
[illegible] Allen	KHCA.
Sr Diane Hill, OSB	Services to Aging / Catholic Church Office
Dick Hummel	Ks Health Care Assn
Keith R Landis	Christian Science Committee on Publication for Kansas
Barb Reinert	Planned Parenthood of KS
Dr Audrey Sunderraj	Interested Citizen
John Peterson	Ks Assn Prof Psychologists
Marilyn Bradt	Kans. for Improvement of Nursing Homes
Harold Pitts	KCOA
Kevin D. McFarland	KS. ASSOC. OF HOMES FOR THE AGING
Loretta Class	United Way - League of W Voters
PAT SCHAFER	Division of the Budget
Richard Wagner	Ks Dept on aging
Ottar N Wolf	KDHE
Lorne A. Phillips	KDHE
Richard Morrissey	KDHE
Steve Paige	KDHE
Ozzie Young	KDHE
Ken Peterson	KS Petroleum Council

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

January 21, 1986

HEALTH STATUS

Problems, Programs and Issues

Barbara J. Sabol

Secretary

Kansas Department of Health and Environment

As we end the centennial year of public health in Kansas and start our second century of progress, I wish to review some health trends and point out some significant issues. I will discuss problems that will become greater over the next decade. I will point to problems for which the cause is known, but solutions difficult, and to problems which are decreasing although not as rapidly as other similar problems. In addition, I shall describe some of the Department's health programs which relate to these issues.

Legislative authority for the various programs of the Department of Health and Environment appears in many sections of the Kansas statutes. This large set of public health laws forms the basis for the mission of the Department:

> "To protect and promote the health of Kansans by assuring adequate community health services, personal health services, and a safe environment."

In order to carry out this basic mission, the Department has established three major goals. Program areas have been developed in relation to these major goals, with program responsibility assigned to one or more administrative units within the Department.

GOAL I: To provide access to a broad range of information with respect to health, illness, disability and ways in which individuals can protect or improve their own health; and to provide needed services to detect and control, primarily through prevention, illness and disability.

Health Education Programs are one major approach to attaining this goal. Health Education programs are designed to: (1) transfer health information and knowledge, and (2) motivate people toward positive health behaviors. Health education spans

the continuum of human life, with programs for family planning, prenatal risk-reduction, infant and child care, school health, adult health promotion and elderly health promotion. Health education is an essential factor in assuring the continuing trend toward self-motivation and self-responsibility for good health.

Individual Health Protection Programs are the second major approach to goal attainment. These programs consist of such activities as: (1) immunizations; (2) well-person maintenance; (3) dental plaque control.

Detection Programs are the third approach to achieving the first goal. These programs include such activities as (1) condition-specific screening, (2) contact follow-up, and (3) multi-phasic screening.

GOAL II: To promote access, as needed, to essential personal health services with adequate personnel and facilities, quality protection and reasonable costs.

Diagnostic and Treatment Services are provided to a limited number of high risk mothers and children (obstetrical care, diagnostic radiology, dental care and general medical care).

Rehabilitation Services consisting of both medical rehabilitation and provision of prosthetic services is provided annually to over 2,000 children through our Chronically Ill and Crippled Children program.

Health Planning including analysis, policy planning, goal setting, and implementation strategy development is a major program of the Department.

Regulation is another major program necessary to achieve our second goal. This includes facility and manpower licensure and certification.

GOAL III: To protect and promote natural and occupational environments conducive to: (a) optimum human and animal health and, (b) preservation of natural resources.

Environmental Quality Management consists of a broad approach including major sub-program emphasis in water supply; wastewater disposal; solid waste disposal; air pollution; housing hazards control; vector control; toxic substances; radiation hazards.

The Food Protection Program deals with safety concerns related to the processing and sale of food products and the preparation and vending of foods.

Occupational Health and Safety Program responsibility is shared with another state agency. The role of the Department is primarily in the area of health hazards.

The Biomedical and Consumer Product Safety Program is concerned with hazardous drugs and medical devices and other hazardous substances and products.

The preceding summary of goals, programs and operating responsibility demonstrates the complexity of the Department's activities and the resultant necessity for a complex set of interrelated functional responsibilities within the Department. The Department of Health and Environment is, in fact an association of many technical, professional and administrative experts organized around the basic mission and goals of the agency.

Since the beginnings of public health in Kansas the state department's programs have been implemented largely through the efforts of local health departments. The partnership between the state and county departments of health has fabricated an effective public health structure in Kansas. State funding to local health departments will continue. In 1982, legislation was enacted which established a new funding allocation process to health departments that encourages fiscal responsibility at the local level.

The health of Kansans generally is good when using almost any indicator and steadily getting better. Our death rate continues to decrease (see Figure 1) and when adjusted for age, the Kansas rate is significantly lower than the national rate (see Figure 2). This indicates that Kansans are living longer and dying at an older age. The department's efforts over the past 100 years in the areas of infection control, sanitation, infant and maternal mortality, health education, and attention to the quality of food have played a part in the increasing longevity of Kansans. The large decrease in infant and maternal mortality over the last several decades has been a major influence in the decreasing death rates (see Figures 3 and 4).

The health objectives of our department are directed toward (1) reducing or eliminating premature deaths, (2) eliminating or postponing unnecessary disability and chronic disease, and (3) increasing the quality of life for those individuals whose years now regularly extend into the 80's. None of these objectives can be achieved unless we maintain our commitment and efforts toward clean air, clean and abundant water and productive land.

A review of trends helps to determine where we are now and helps to identify the remaining and emerging problems which have resulted, paradoxically in some cases, from the improved health status of Kansans.

It is important to begin with some of the data that we know about Kansas health. The Annual Summary of Vital Statistics for Kansas - 1984 contains most of this information.

1. Problems Related to our Decreasing Death Rates:

   In 1900 only 4% of the population of the United States were age 65 or older. By 1980 the national proportion had increased to 11.3% and in Kansas the elderly category equals 13% of the population. As the baby boom children of the 1940's and 1950's grow older the proportion of population 65 and older will reach 18-22%. In Kansas substantial changes have taken place. In the two decades between 1960 and 1980 our total Kansas population increased by 8.5%. The population over age 65 has increased by 27.5% and the population over age 75 has increased by 46.7%. Our population over the age of 85 is growing faster than any other age group. It should be obvious that the population structure per se has implications for the health of the state and special consideration is warranted for people in the age group, 75 and older. During the last decade the provision of long term care services emerged as one of the most important health and social issues. As you can see the basis for this concern will not diminish. Our department has many interests and responsibilities in this area. We are concerned with the standards of care for individuals living in adult care facilities, and for community services for individuals living in their own homes. We are concerned that these conditions are safe, and healthy; that individuals enjoy their basic rights and will live their remaining years in dignity. Our Department also adopted regulations that will require 24 hour staffing in Intermediate Care Homes with licensed nurses. This will be accomplished in July, 1986. We believe that this is extremely important to better assure quality care for the elderly and disabled in those homes. We are taking additional steps to assure that complaint procedures are adequate and effective in dealing with problems in adult care facilities. Additional legislation allows the department to assess fines more rapidly upon the discovery of infractions which jeopardize the health or safety of individuals in adult care facilities.

In 1984, 96% of Kansans killed in traffic accidents were not wearing seat belts at the time of the accident and only 4% were. A risk factor survey conducted in 1982, revealed that nearly half of adult Kansans never fasten their seat belts and another 20% seldom do. Only 18% reported they always use their seat belt.

According to the Kansas Highway Safety Plan for FY 86, in 1984, 322 fatalities occurred in Kansas. Seat belt effectiveness in fatality prevention would have been 76% if all drivers had used belts when available. Utilizing this measure 245 deaths could have been prevented.

Seventeen (17) states including Nebraska, Oklahoma and Missouri have enacted legislation mandating seat belt use in motor vehicles.

The Kansas Department of Health and Environment recommends that all vehicle occupants be properly restrained, whether by a seat belt or an infant/child restraint system and that the law apply to relevant vehicles on all public roadways.

Most cost effective, however, would be the prevention of accidents. My own view is that calling them accidents is misleading. The causes are clear in over half of the cases: 1) The driving behaviors of young males, and 2) the use of alcohol while driving. The state needs clear strategies for changing these behaviors. Our department nor any other department alone can effect these changes. There needs to be statewide strategies. Some of these are beginning, and our department is participating fully in them. We need clear disincentives to driving under the influence of alcohol. The public needs to be educated on what are probably not "accidents" per se. Strategies to change the driving behaviors of young individuals should be developed. These issues represent instances where the cause is clear and the objectives for our efforts are clear, but the methods of achieving the objectives are extremely complex and difficult.

The second similar example is that of the relationship between lung cancer and smoking. Smoking is considered the number one public health hazard at this time. There is a clear causal relationship between smoking and lung cancer, chronic obstructive pulmonary disease, heart disease and other problems. Not only are the death and morbidity rates high from smoking (it is estimated that 300,000 unnecessary deaths occur annually in the U.S. - about 3,000 of these are in Kansas), but the cost of health care associated

While the department has a deep and abiding concern for the quality of care of the elderly and disabled in adult care homes, we have an equal concern for the elderly living in their own homes in the community. At any one time only about 5% of our elderly reside in adult care homes, while the other 95% are attempting to live independently. Efforts directed toward keeping the elderly active and independent is cost effective as well as humane. The LIVELY program (Life, Interest and Vigor Entering Later Years), which includes screening, wellness programming and case management is now operating in 14 counties of the state through the efforts of local health departments. The Department of Health and Environment, Department of Aging, and Department of Social and Rehabilitation Services are jointly developing a new initiative on health promotion services for the aging. The intent of these efforts is to build local coalitions among agencies serving the elderly and the elderly, themselves, which will bring health promotion and support services to our senior citizens in all areas of the state.

2. Populations Which Are Not Fully Represented by the Decreasing Mortality Rate:

I will address two, namely, the overall black mortality rate and the black infant mortality rate. Blacks die when they are about 10 years younger than whites. In part, this is related to the black infant mortality rate which I will discuss later. However, earlier death in blacks is also due to high blood pressure, other specific diseases such as sickle cell disease and certain kinds of cancer. The department has a program specifically directed at sickle cell disease in Kansas. Laboratory screening is available for anyone through local health departments. There is a program to address the health care needs associated with the morbidity of sickle cell disease as well. The prevalence rate of high blood pressure is greater among blacks than whites. However, both will benefit from the hypertension programs which exist in counties and which have been specifically targeted to populations which include both blacks and the aged. In Wichita a program of high blood pressure detection and control is run in the black community by the churches there.

The black infant mortality rate is not falling at the same degree as the overall infant mortality rate or the white infant mortality rate in Kansas. Figure 5 shows the changes in infant mortality rate since 1954. Whereas the white infant mortality rate has decreased from 23.5 to 8.9,

the black infant mortality rate has decreased from 42.1 to 20.2 A comparison of rates shows the ratio of the black to white rate in 1954 to be 1.8 to 1, in 1984 the ratio is 2.3 to 1. Clearly the black rate is improving more slowly than the white rate. In the past year we have targeted monies and programs to address this concern with a specific focus on education, nutrition, and health services during the prenatal period. Approximately 85% of the births to black individuals and approximately that portion of the deaths occur in 4 counties, namely, Wyandotte, Sedgwick, Shawnee and Geary. We have begun to integrate all health services and whatever other services we can identify in these counties so that the high risk pregnancies are identified early. Follow-up home visits are initiated if necessary, and a resource person by way of a home visitor is identified for each family at risk. Attention is given to the nutrition needs of this group and to the follow-up of the infants after birth. The socio-economic factors in this group, traditional health and health provider practices in these communities are complex and not easily changed. Poverty is a major factor. In Kansas City we are working directly with the Kansas Children's Service League Black Adoption Program in an attempt to influence the teenage pregnancy rate in that community. We believe that these efforts, if properly targeted and supported, will have benefit in the long term.

3. Programs Which Have Identifiable Causes But Difficult Cures:

You will note from Figure 6 that the causes of premature death have changed. Infections and infant and maternal mortality have decreased; chronic disease and cancer are decreasing also, but violent deaths ("accidents") and suicide are increasing.

In the first example, Figure 7, auto vehicle deaths are equal to all other "accidental" deaths and victims are generally young males. Deaths are in great part alcohol related (Figure 8) and victims seldom use seat belts (Figure 9). There are probably 1,500 occurrences of combined severe and moderate head injuries annually. These represent an enormous cost to the state, not only through lost productivity of its citizens but actual costs (private and public) for medical and other health services. Several state programs relate to "accidents" and "accident" outcome. Educational programs and legislation can increase the use of seat restraints which will reduce the risk of injury.

with this morbidity and subsequent mortality is also extremely high. The nonsmoker is often not protected from the ambient pollution caused by those who do smoke. The annoyance and the risk to nonsmokers in terms of cancer, allergies, chronic lung disease, eye, nose and throat irritation is significant. Our department strongly supports a policy of no smoking in the workplace and is working with other state agencies to provide workers with options for achieving no smoking in the workplace as well as other health promotion options.

The department chairs the Interdepartmental Task Force on the Hazards of Tobacco Consumption, which is composed of the Cancer, Lung and Heart Associations in addition to state agencies. The hazards of smokeless tobacco has also been highlighted as an important health awareness issue. The department is supportive of city ordinances which restrict smoking. Presently, Wichita and Overland Park have passed a smoking restriction ordinance and Topeka has one in process.

A new challenge facing the country as well as our state is the infectious disease AIDS. The cause of AIDS is known but a cure or vaccine has not been developed. Our Department is involved with public education and have established alternate test sites at local health departments. Counseling and testing for the presence of HTLV-III antibody are conducted at these sites.

4. Health Care Costs:

The issue of health care costs is very complex and interrelated. The escalation of these costs have been the result of an increase in technological developments in health which have increased the types and costs of patient treatment. The medicare and medicaid programs along with their original payment mechanism, as well as general inflation within the economy has been another significant factor.

Developing and implementing solutions to the problem of increasing health care costs requires the joint efforts of government and the private sector. The federal government initiated the effort through a prospective payment system for medicare providers. Kansas Blue Cross and Blue Shield has taken the lead, among its counterparts in the country, in implementing a prospective payment system for all its members. The direction of health care cost control clearly lies in changes in the health care market place and in the ways health care is delivered.

It appears that much of the responsibility for health care in the next few years will gradually shift from the state and federal governments to local agencies and to families, themselves. The trend toward earlier release of sick patients from the hospital, restrictions on in-hospital admissions and more use of out-patient surgery and facilities mean that more and more frequently, family members must be provided with the support and skills necessary in order for them to care for the patient at home. As our population balance swings more to the elderly, as medical technology continues to prolong life and as the health care dollar dwindles, families and local agencies, such as local health departments and home health agencies, will be called upon to do more and more.

5. Rural Hospitals:

Rural hospitals today are faced with a number of problems and issues that affect not only their financial viability but their very existence. The issues that are presently being addressed are the need to maintain high occupancy levels, the higher proportion of elderly and poor being served in rural hospitals, the difficulty of attracting and retaining medical personnel, the limited ability to purchase expensive high-tech equipment necessary to expand services necessary to attract physicians, and changes in reimbursement for hospital services under Medicare (DRGs).

Regardless of these problems, rural hospitals do have options that would increase their chances for survival. Such options include in-house long-range planning, marketing, diversification of services, corporate restructuring, innovative recruitment and staffing techniques and informal and formal multi-hospital arrangements.

6. General Programs:

For the general health of Kansans, lifestyle factors are emerging, as major determinants for health outcomes. Some of these have already been mentioned, e.g., smoking, alcohol usage, and the country's driving habits, eating habits, physical fitness, attention to stress and safety for others. In FY 1985, the Governor established a Cabinet Sub-Committee on State Employees Health Promotion and Wellness Program called "Health Promotion PLUS." Our department, is chairing that committee. The adoption of healthful lifestyles in the workplace will improve

employee job satisfaction and performance and will reduce health care costs. This program is being promoted through Health Promotion PLUS worksite wellness training programs that our department is offering to both county health departments and state agencies.

Prenatal care is a high priority of KDHE. Many women do not receive adequate care (see Figure 10). The Healthy Start Home Visitor Program of the Department has expanded to provide information on prenatal risk reduction, infant care and prenatal adjustment to families in 30 Kansas Counties. Prenatal risk reduction efforts have also included a Fetal Alcohol Awareness Project. With the voluntary cooperation of liquor store owners, we have distributed 150 signs informing the public about the dangers of drinking during pregnancy. Efforts are continuing to assure professional education and awareness of fetal alcohol and other prenatal risk factors such as general nutrition, smoking and the need for early prenatal care.

Recent research findings on Fetal Alcohol Syndrome and Alcohol Related Birth Defects have indicated a surprisingly high rate of susceptibility of black women to alcohol related birth defects, seven times that of white women. These findings indicate a need for alcohol abuse prevention programs specifically targeted toward black women of childbearing age.

The Department of Health and Environment is taking an active role in the Cabinet Subcommittee on Preschool Handicapped Children as it plans for early identification, follow-along, and development of services for infants and preschool children with high risk for handicapping conditions. To assist with this program the Crippled and Chronically Ill Children's Program has expanded services to include seizures, severe visual impairments and cranio facial anomalies.

The Supplemental Food Program for eligible pregnant breast feeding women, infants and children has been expanded to all 105 Kansas counties. The purpose of this program is to prevent or correct health problems related to poor nutrition.

Family planning services have been provided in 65 communities to 45,000 men and women in 1985. Early pregnancy tests and referrals for comprehensive prenatal care are included in this service.

The ongoing training of school health personnel is an essential factor in the early detection of health problems and early education of children regarding the importance of healthy lifestyles.

For years, there has been an active program for the identification, control and treatment of tuberculosis (TB). The number of active cases have been reduced from 194 in 1975 to 82 in 1985. The Governor has recommended, for FY 1987, that funding to the TB clinics be eliminated.

Because of the widespread use of asbestos and its potential hazard to public health, the Department of Health and Environment is taking the lead, working closely with the Departments of Human Resources and Education, to deal with the problems and respond to school districts for inspections necessary to meet EPA requirements.

In Summary:

Health problems today are vastly different from those one hundred years ago or even 25 years ago. The improvements in life expectancy have uncovered pockets resisting improvement, have created new problems - those associated with old age. The changing times have given us greater understanding of some diseases, but have placed new challenges on our ability to understand other diseases and our ability to prevent them. We are attempting to focus and rechannel our limited resources to address these changing problems.

A significant change has occurred in the population's health status since the turn of the century. Due to public health efforts, there has been a steady decline in morbidity and mortality rates related to a number of acute and infectious diseases. As a result, life expectancy has significantly increased.

However, countering these improvements, there has been a steady increase in morbidity and mortality associated with chronic disorders. The elderly population, especially the 75 years of age and older are at high risk of chronic disease, disability and institutionalization. This aging of the population will continue in the future. However, the challenge lies not only in providing needed services to the elderly, but also to ensure a healthy start for the very young.

The health status of our population depends on the adoption of healthy lifestyles, the availability of accessible and affordable health care services for all age groups and implementing appropriate health care legislation. With these concepts in mind, I wish to reiterate the importance of comprehensive prenatal care, 24 hour care in intermediate adult care homes, mandatory seatbelt usage and continuation of funding to local health departments.

M/1

1986 Legislative Priorities
Kansas Department on Aging
January 1, 1986

1. Sunset Review - The Kansas Department on Aging will be abolished on July 1, 1986 unless the legislature reauthorizes the department.

2. Alzheimer's Task Force - Eight priority recommendations for victims of Alzheimer's disease and their families including a division of assets law, long term care insurance, respite services, a protocol for evaluation and diagnosis, a helpline, education and service centers, education and research, and community support for caregivers.

3. Long Term Care Commission - A one year blue ribbon study of long term care services to develop a comprehensive and coordinated long term care policy for the state. The study will include research on long term care insurance and an adult care home consumer information system.

4. Conservation Rates - The establishment of conservation rates for electric and natural gas customers to provide an incentive to conserve and to benefit smaller users.

5. 24-hour care - Licensed nurse coverage in all intermediate care homes.

Support Issues

1. Adult Family Homes - The services of the Long Term Care Ombudsman should be extended to adult family home residents.

2. Age-rating - The age-rating of Medicare supplement insurance policies should be abolished.

3. Pharmaceutical prices - The State Board of Pharmacy should require the posting of prices for the 25 prescription drugs most frequently sold in the state.

LD:rd

I. Issue: Long Term Care Commission

II. Statement of Issue:

As the state's population ages there is an intensified need for a variety of long term care services which will be accessible to the elderly. Currently there are many non-institutional long term care services provided by State agencies and local community organizations, but there is little cohesiveness among them. A comprehensive plan could serve to increase the coordination between service providers and give direction for future policy development. A Long Term Care Commission could work to integrate the policy efforts now underway and thereby ensure that Kansans in need of long term care services are able to receive them.

III. Background Data:

For many years long term care services were solely perceived as institutional services. The availability of a variety of community-based long term care services can reduce the need for some institutional services. Many elderly can be adequately cared for in the community with appropriate services. The problem is that many more people need to receive long term care services, and a wider variety of services than is currently available, in order to remain in their own homes or community.

An established commission designed to develop a comprehensive and coordinated long term care policy for the elderly could integrate all the individual efforts being made at serving persons with long term care needs, identify gaps in programs and services and other problems, and make appropriate recommendations for change. Having one central entity to address these issues will facilitate the development of a comprehensive and coordinated long term care policy for the State.

I. Issue: Adult Care Home Consumer Information System

II. Statement of Problem or Issue:

How can the state ensure that the public has easy access to quality information that will help in the selection of an adult care home?

III. Background Data and Current Policy:

Two recent trends in institutional long term care, the corporatization of adult care home (ACH) ownership and the increasing disability level of ACH residents, have coalesced to increase the public's need for ready access to quality information that will help in selecting an ACH. Corporatization has the potential to both lower the quality and increase the cost of ACH care. The increasing disability level of residents places greater demands on ACH staff and this can also affect quality and cost of care. Thus the need for information about ACH's is greater than ever. An ACH consumer information system could substantially meet this need. Such an information system could take several forms. A rating system could be developed based upon inspection reports and other relevant data. A standardized checklist of services and other features could be developed and published for all ACH's in the state. Another alternative would be to summarize inspection report data in plain language and publish the information.

K.S.A. 39-932 provides the Kansas Department of Health and Environment (H&E) with the authority to implement an ACH rating system by administrative regulation. Twice, in 1979 and in 1981, Legislative Post Audit (LPA) has recommended that the Department exercise such authority. To date, it has chosen not to do so.

At present at least three states (Florida, Kentucky, and West Virginia) have ACH rating systems in place. New York has implemented a Consumer Information System for residential health care facilities which includes a summary of surveys, complaint investigation, and other inspections. The summary and an explanation factor are required to be posted conspicuously in each facility.

Presently the average consumer in Kansas has a relative paucity of information upon which to make this a very significant decision. At present H&E publishes, at a cost of $4.00, a directory of adult care homes. This directory provides basic information such as address, name of administrator, number and skill level of beds, Medicare/Medicaid certification status, etc. The only quality of care information is a relatively inconspicuous notice of whether a facility's license is provisional or not.

A provisional license is issued when a facility is temporarily unable to conform to all the standards, requirements, rules and regulations established by the ACH licensure act. The fact that an ACH has a provisional license, while clearly useful information, is not helpful in discriminating among homes with such licenses and does not aid in choosing from among the great majority of homes with regular licenses.

K.S.A. 39-935 does require that an ACH post a notice that the most recent inspection report and related documents are available for examination in the administrator's office and, upon request, provide copies of such materials upon agreement of the requestor to pay reasonable copying costs.

Even if consumers become aware of the availability of this information, its usefulness is limited. As Legislative Post Audit indicated, "...the average person would have difficulty interpreting the findings of these reports."

Another flaw in the current "system" of providing information about ACH's, is that certain ACH's (e.g. LTC beds in hospitals or ACH's operated by and in conjunction with hospitals) are exempt from the ACH licensure act. Thus, to the extent that consumer information exists on these LTC beds, another information source must be consulted.

Agency Name: Kansas Department on Aging

I. Issue: Long Term Care Insurance

II. Statement of Problem or Issues:

How can public nursing home expenditures be reduced through the development of long term care insurance.

III. Background Data and Current Policy:

The cost of nursing home care is the largest catastrophic expense for individuals age 65 and over. In 1984, the national average per capita expenditure for nursing home care was $880. Of that total $441, or 50.1%, was paid directly by the elderly and their families. Medicaid covered 41.5% of the total, Medicare 2.2%, and other funding sources contributed 5.1%. Only 1.1% (or $10) of the elderly's expenses for nursing home care was paid by private insurance.

The public has an exaggerated perception of the scope of Medicare and Medicaid coverage for long term care. Medicare actually assists about one percent of the people admitted to nursing homes and seldom covers more than a few days stay. Medicaid is available to low-income persons. In 1984 approximately half of the Medicaid beneficiaries in nursing homes were not initially poor but they "spent down" to the poverty level before qualifying for benefits. Many of these people who "spent down" could have afforded private insurance if it were available.

Not only would the availability of long term care insurance help Kansans plan for their older years, but the state would also benefit from the public's purchase of the insurance. Long term care insurance is one way of relieving pressure on the Medicaid program. In Fiscal Year 1984 the state's Medicaid program provided a total of $92.5 million for nursing home care; 50% of this total was state funds.

I. Issue: 24 Hour Nursing Care

II. Statement of Problem or Issue:

How can the state ensure that adult care home (ACH) staffing standards are adequate to provide quality resident care?

III. Background Data & Current Policy:

Currently skilled nursing facilities are required to have a registered nurse on the day shift seven days a week and a licensed nurse on all other shifts. Intermediate care facilities are only required to have a licensed nurse on the day shift seven days a week. The adequacy of these staffing standards is increasingly being called into question as the disability level of ACH residents increases. The implementation of pre-admission screening for Medicaid ACH residents, Medicare's Prospective Payment System using Diagnostic Related Groups, and home and community-based long-term care services have all combined to result in an increasingly disabled ACH population which requires more complex nursing care.

Many ICF's in Kansas have recognized this fact and voluntarily exceed minimum staffing standards. Recent statistics show that 23% of Kansas ICF's had 24 hour licensed nurse coverage and 34% had 16 hour licensed nurse coverage.

I. Issue: Extending Services of the Long Term Care Ombudsman to the Adult Family Home Residents

II. Statement of the Problem or Issue:

Action by the 1983 legislature removed Kansas Long Term Care Ombudsman services from a growing group of long-term institutional residents, people in adult family homes.

III. Background Data & Current Policy:

The jurisdiction of the Long Term Care Ombudsman (LTCO)was not extended to residents of adult family homes when this new category of residential long-term care was created in H.B. 2026 and 2027. However, the jurisdiction of adult protective services was extended to them through the passage of S.B. 33. Prior to passage of H.B. 2026 and 2027 (now...), any one and two bed long term care residential facilities were considered adult care homes and were covered by the LTCO.

Coverage by the LTCO becomes more important, since the population of adult family homes will grow in the near future as a result of their reimbursement status under the State's Alternatives Program and its Medicaid Home and Community based waiver program. These programs have been operative for approximately two years and are organized to divert people from nursing homes.

Whenever older people are vulnerable and dependent in non-family households, they should be able to use the services of the LTCO. The services of the LTCO should be extended to adult family home residents to re-establish necessary coverage that was inadvertently deleted as a result of passage of H.B. 2026 and 2027.

I. ISSUE/PROBLEM DEFINITION

Required posting of pharmaceutical prices.

Since 1983 prescription drug prices in the United States have increased about 10 percent, almost twice the rate of inflation. Prescription drugs can no longer be considered one of the least expensive components of medical care.

Kansans spent $206 million in 1982 for drugs and drug sundries, or $86 per capita; the comparable United States figures were $22.4 billion or $95 per capita. In 1980 the aged spent more than twice as much per capita than the nonaged for drugs and drug sundries. It is also known that the elderly use significantly more prescriptions per capita than the rest of the population and pay a higher average price, due to larger dosages, per prescription.

K.S.A. 65-1650 states that the Board of Pharmacy can neither require nor prohibit pharmacies from posting their current charges for prescription-only drugs and services. It is known that some pharmacies do display some of their prices and that others maintain a book of prices which may or may not be on public display. However, the number of pharmacies which do either is not known; a pharmacy-by-pharmacy survey would need to be conducted in order to determine the exact number. Furthermore, it is most likely that there are more pharmacies which do not have any method for posting prices than there are those which do.

II. BACKGROUND

There are several states which have laws mandating that prescription drug prices be posted; among these states are California, Pennsylvania, Minnesota, and Ohio.

California passed legislation in 1973 requiring that pharmacies post the prices of the 100 prescription drugs most frequently sold in the state and the professional services and nonprofessional convenience services associated with the dispensing of drugs. The three most commonly prescribed quantities of each of the 100 drugs are listed along with the services which were included in the retail price of each. In addition, pharmacists are required to give the current retail price of any drug sold at the pharmacy. It is noted that the California legislature's intended purpose in mandating this law was to assist the public in making informed decisions based on total value received and not just price alone.

Pennsylvania's legislation, passed in 1976, requires pharmacies to have a price listing of all brand name and generic drug products available for selection. In Minnesota, pharmacies must post a list containing the names and current prices of the 60 prescription drugs most frequently dispensed by the pharmacy based on dollar volume of sales. The 1973 Minnesota legislation also requires pharmacists to provide current price information for any drug requested.

Ohio's 1981 legislation is somewhat different in that it specifies that pharmacists are to fill all prescriptions with generically equivalent drugs unless one of two exceptions is met: 1) the prescriber informs the pharmacist to specifically use the brand name drug; or 2) the generic drug is more expensive than the prescribed drug. The pharmacist must inform the purchaser of the price difference between the brand name and the generic drug, and notify the purchaser that they have the right to refuse the drug selected.

K.S.A. 65-1637 states that pharmacists "*may* exercise brand exchange with a vie toward achieving a lesser cost to the purchaser," unless the prescriber has specified in written form or orally communicated that the prescription must be dispensed as written/communicated, or if the Federal Food and Drug Administration has determined that the generic product is not bioequivalent to the brand name product. This law differs from Ohio's in that Kansas pharmacists are not mandated to use the least expensive product, it is up to the pharmacist's discretion to use generic products.

The required posting of pharmaceutical prices would benefit the older and the general Kansas population in several ways. If such a law were enacted, consumers would not only be able to compare the cost of generic vs. brand name drugs within a given pharmacy, but they would also be able to compare prices between pharmacies. Required posting of prescription prices would encourage price competition, which, in turn, should lead to reduced prices as pharmacies compete for customers.

A Kansas statute similar to those passed in the aforementioned states would inform consumers and prevent them from paying more for prescriptions than is necessary. The elderly can not afford not to know about prescription prices.

DEMOGRAPHIC FACT SHEET ON OLDER KANSANS

KANSAS DEPARTMENT ON AGING
January, 1986

POPULATION BY AGE GROUPS IN KANSAS: 1980 & 1990

Total Population: 2,363,208 (1980) and 2,463,400 (1990)

Age Group	1980 Population	1980 % of Total	1990 Population	1990 % of Total
65+	306,263	12.96%	334,300	13.6%
75+	132,852	5.62%	154,200	6.3%
85+	33,455	1.42%	40,800	1.8%

MALE AND FEMALE POPULATION BY AGE GROUP: 1980

	Male		Female	
	Number	% of Age Group	Number	% of Age Group
60+	171,675	41.6%	240,624	58.4%
75+	46,683	35.1%	86,169	64.9%

KANSANS 65 YEARS OF AGE AND OLDER AS A PERCENTAGE OF THE POPULATION IN KANSAS:

AREA		% OF POPULATION 1980	1990
STATEWIDE		12.96%	13.6%
Urban and Rural and Size of Place			
URBAN		12.0%	
Inside Urbanized Areas	10.2%		
Central Cities	11.0%		
Urban Fringe	9.3%		
Outside Urbanized Areas	14.2%		
Places of 10,000 or More	12.2%		
Places of 2,500 to 10,000	18.1%		
RURAL		14.9%	
Place of 1,000 to 2,500	19.5%		
Other Rural	13.6%		

Source: U.S. Census General Population Characteristics
Kansas: 1980 PC 80-1-B18 Vol. 1
and Department of Census Update

JTPA OLDER WORKER PROGRAM
FY-85 PLACEMENTS

PLACEMENT INFORMATION

	TOTAL
A. Number of Persons Placed	220
1. Age of Persons Placed	
a. 55-64	N/A
b. 65-69	N/A
c. 70-74	N/A
d. 75+	N/A
2. Age of Oldest Person Placed	N/A
3. Age of Youngest Person Placed	N/A
4. Sex of Persons Placed	
a. Female	141
b. Male	79
B. Racial/Ethnic Characteristics of Persons Placed	
American Indian/Alaskan Native	2
Asian or Pacific Islander	0
Black (Not Hispanic)	18
Hispanic	5
White (Not Hispanic)	195
C. Number of Persons Placed in Permanent Positions	
1. Part-Time Positions (Less than 32 hours/week)	115
2. Full-Time Positions (32 or more hours/week)	105
D. Other Characteristics of Persons Placed	
1. Displaced Homemaker	6
2. Veterans	55
3. Handicapped	19

Counties Served: Sedgwick, Harvey, Butler, Cowley, Sumner, Riley, Clay, Dickinson, Geary, Pottawatomie, Wabaunsee, Crawford, and Neosho.

Source: Report #020 JTPA Kansas Quarterly Summary of Participants' Characteristics

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1/17/86

OLDER KANSANS EMPLOYMENT PROGRAMS
FY-85 PLACEMENTS

PLACEMENT INFORMATION

	TOTAL
A. Number of Persons Placed	433
1. Age of Persons Placed	
a. 55-64	321
b. 65-69	85
c. 70-74	20
d. 75+	7
2. Age of Oldest Person Placed - 76	
3. Age of Youngest Person Placed - 55	
4. Sex of Persons Placed	
a. Female	226
b. Male	207
B. Pre-Placement Income	
a. Less than $390/Mo.	186
b. $390 - $487/Mo.	56
c. $488 - $637/Mo.	56
d. $638+/Mo.	135
C. Number of Persons Placed in Temporary Positions	
1. Part-Time Positions (Less than 34 hours/week)	97
2. Full-Time Positions (32 or more hours/week)	28
D. Number of Persons Placed in Permanent Positions	
1. Part-Time Positions (Less than 32 hours/week)	198
2. Full-Time Positions (32 or more hours/week)	110

Counties Served: Sedgwick, Harvey, Butler, Cowley, Sumner, Riley, Clay, Dickinson, Geary, Pottawatomie, Wabaunsee, Crawford, and Neosho.

Source: Monthly Program Reports State Fiscal Year 1985

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1/15/86

KINDS OF SERVICES FUNDED BY TITLE III-B FUNDS

- Advocacy
- Assessment/Screening
- Case Management
- Chore/Handyman
- Companion Sitter
- Coordination
- Counseling
- Education/Training
- Escort
- Guardianship
- Health Clinics
- Health Screening
- Home Health
- Homemaker
- Hospice
- Information/Referral
- Legal
- Newspaper/Newsletter
- Outreach
- Personal Care
- Physical Fitness
- Program Development
- Radio Reader
- Recreation
- Repairs/Renovation
- Resident Care Representative
- Senior Center Facilities
- Senior Olympics
- Shopping Assistance
- Transportation
- Visitation
- Wellness

KANSAS DEPARTMENT ON AGING

	FY-1986 Legislative Appropriation*	FY-1986 Governor's Revision	FY-1987 Governor's Recommendation
Total Budget	$12,039,735	$11,765,629	$11,668,638
State Funds:			
Nutrition and Nutrition Transportation	$ 853,263	$ 658,142	$ 787,888
In-Home Meals	475,232	449,860	461,137
Senior Employment	100,000	100,000	100,000
Administration - State	519,461	510,998	628,734
Total State Funds	$ 1,947,956	$ 1,719,000	$ 1,977,759
Attendance & Publication Fee	$ 400	$ 400	$ 500
Federal Funds:			
Older Americans Act Social Services	$ 2,725,163	$ 2,725,163	$ 2,723,885
O.A.A. Nutrition - Congregate and Home-Delivered	4,598,145	4,598,145**	4,467,307
U.S.D.A.	1,777,786	1,732,636	1,825,476
JTPA	500,385	500,385	304,329
Special Grants	38,681	38,681	11,227
O.A.A. Special Programs	99,503	99,503	84,922
O.A.A. Administration	351,716*	351,716*	273,233
Total Federal Funds	$10,091,379	$10,046,229	$ 9,690,379

Local Resources used to fund portions of the nutrition program in FY-1986 & FY-1987.

Project Income

Other Local Resources

*Includes one time funding for Alzheimer's Task Force ($50,000).

**Includes $274,562 for AAA Administration.

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KANSAS IN-HOME NUTRITION
PARTICIPANT CHARACTERISTICS
STATE FISCAL YEARS 1983, 1984, AND 1985

	1985	
Total Persons Served	1,188	N/A
Total Persons Served Age 75 or over	753	63%
INCOME STATUS OF PERSONS SERVED		
- Less than 75% Poverty Level	359	30%
- At or Below Poverty Level	661	56%
- At or Below 125% of Poverty	957	81%
- Above 125% of Poverty	231	19%
RACE/ETHNICITY CHARACTERISTICS OF PERSONS SERVED*		
American Indian/Alaskan Native	2	.2%
Asian or Pacific Islander	0	0
Black (Not Hispanic)	148	12%
Hispanic	27	2%
White (Not Hispanic)	1,011	85%

*Does not add to 100% due to rounding.

KANSAS IN HOME NUTRITION
STATEWIDE SUMMARY
FISCAL YEARS 1983-1985

	1983	1984	1985
Number of Persons Served	984	1,084	1,188
Persons Served Age 75 and Over	661	716	753
Total Meals Served	149,815	176,272	194,674
Cost Per Meal	$2.36	$2.14	$2.12

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FINAL RESULTS
KANSAS DEPARTMENT ON AGING
NUTRITION PARTICIPANT CHARACTERISTICS
1985 SURVEY

	Congregate III-C(1)	Home-Delivered III-C(2)
Sex		
Male	35%	27%
Female	65%	73%
Live With		
Spouse	36%	26%
Relative	4%	8%
Alone	58%	65%
Other	2%	1%
Age		
Below Age 60	2%	2%
60-75	46%	30%
Over 75	52%	69%
Income		
Single		
Below Poverty ($415/mo. or less)	35%	44%
Poverty-125% Poverty ($416-519/mo.)	26%	23%
125%-SSBG ($520-$678/mo.)	20%	20%
Over $678/mo.	20%	13%
Couple		
Below Poverty (560/mo. or less)	15%	29%
Poverty-125% Poverty ($561-$700/mo.)	19%	25%
125%-SSBG ($701-$901/mo.)	25%	27%
Over $901/mo.	41%	19%
Transportation (Congregate Only)		
Senior Citizen Van	20%	
Friend/Neighbors	7%	
Personal Car	53%	
Walk	16%	
Other	4%	
Evening/Weekend Meal Preparation (Home-Delivered Only)		
Self		61%
Spouse		16%
Other Relative		11.5%
Friend/Neighbor		5%
Home-Delivered Meal		4%
Do Not Eat		2.5%

Percentages computed for each question based upon the number of actual responses. A total of 10,336 persons compelted the questionnaire; 7,619 Congregate participants and 2,717 Home-Delivered participants.

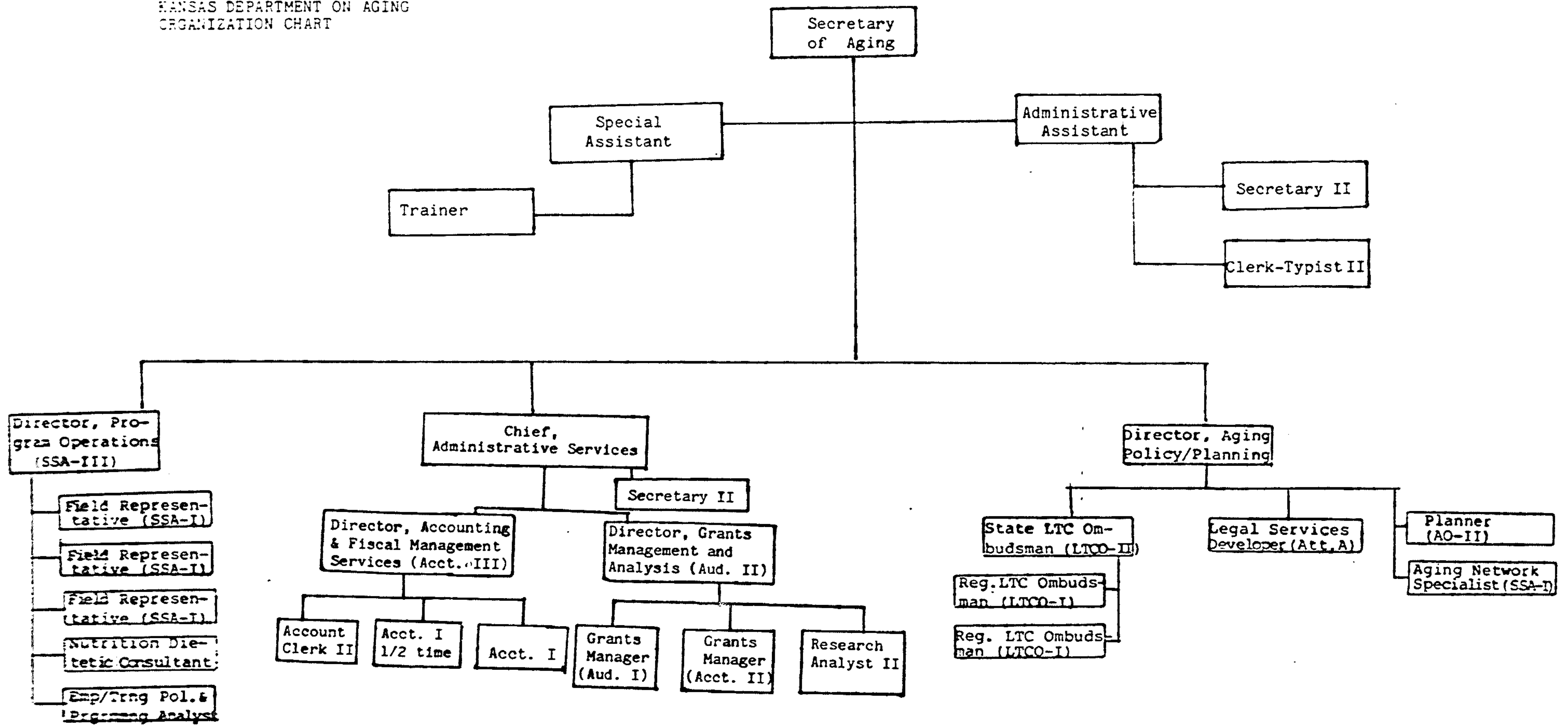
Final Results FY-1985 Survey(2/85)
JS:pal
1/14/86

Population Projections for Kansas
based on July 1, 1980 U.S. Census Data
(Numbers and Percentages)

	Years					
	1980		1990		2000	
	#	%	#	%	#	%
Total U.S. Population	226,504,800		249,203,000		267,461,601	
Total Kansans	2,363,200		2,463,400		2,494,400	
Age 65 and over	306,200	(13.0)	334,300	(13.6)	335,100	(13.4)
65-74	173,400	(7.3)	180,100	(7.3)	164,700	(6.6)
75-84	99,400	(4.2)	113,400	(4.6)	119,700	(4.8)
85+ and over	33,400	(1.4)	40,800	(1.8)	50,700	(2.0)

RLH:rd

KANSAS DEPARTMENT ON AGING
ORGANIZATION CHART



1986 LEGISLATIVE PRIORITIES
OF KANSAS AGING ORGANIZATIONS

CATEGORY	KANSAS COALITION ON AGING	KANSANS FOR IMPROVEMENT OF NURSING HOMES	SILVER HAIRED LEGISLATURE	AMERICAN ASSOCIATION OF RETIRED PERSONS	KANSAS CITIZENS COUNCIL ON AGING
Health				1. Health care cost controls to include more effective planning system, health promotion and wellness programs, and measures to improve purchasing decisions. 2. Expansion and coordination of community based and in-home services, especially for low income Kansans.	
Adult Care	1. 24-hour-a-day licensed nursing care. 2. Older Kansans Senior Care Act - In-home and community based care as alternatives to institutionalization. 3. Maintain access to services through federal and state programs.	1. 24-hour-licensed nurse coverage in all intermeciate care homes. 2. Study of private pay rates and the effect of out-of-state corporations on cost and quality of care.	1. Older Kansans Senior Care Act - In-home and community based care as alternative to institutionalization. 2. 24-hour-a-day licensed nursing care		1. Integrate homemaker/home health aide service administration and training.

1986 LEGISLATIVE PRIORITIES
OF KANSAS AGING ORGANIZATIONS

CATEGORY	KANSAS COALITION ON AGING	KANSANS FOR IMPROVEMENT OF NURSING HOMES	SILVER HAIRED LEGISLATURE	AMERICAN ASSOCIATION OF RETIRED PERSONS	KANSAS CITIZENS COUNCIL ON AGING
Taxes/Income	1. Lid on out-of-pocket expenses under Medicare.		1. Kansas Income Tax Form Check Off. 2. State Sales and Use Tax. 3. Social Security COLA Freeze, and Use of the Trust Fund. 4. Income Tax Credit for in-home elderly care. 5. Kansas State Income Tax Revenues on Social Security to Area Agencies on Aging. 6. Medicaid Personal Needs Allowance.	1. Exemption of Social Security income from state tax.	
Consumer	1. Plain Language Act. 2. Lien Law			1. Consumer savings disclosure and validation act. 2. Develop statewide network of consumer assistance and information. 3. Truth in insurance legislation. 4. Extend 3 day cool-off to health spas, exercise salons and discount buying clubs. 5. Amend Kansas Consumer Protection Act to protect from fraudulent offers or sale of business.	

1986 LEGISLATIVE PRIORITIES
OF KANSAS AGING ORGANIZATIONS

CATEGORY	KANSAS COALITION ON AGING	KANSANS FOR IMPROVEMENT OF NURSING HOMES	SILVER HAIRED LEGISLATURE	AMERICAN ASSOCIATION OF RETIRED PERSONS	KANSAS CITIZENS COUNCIL ON AGING
Transportation			1. Elderly and Handicapped Transportation Act.		
Safety			1. Mandatory use of motor vehicle seat belts.		
Utilities			1. Conservation Rates on natural gas and electricity.		

1986 LEGISLATIVE PRIORITIES
OF KANSAS AGING ORGANIZATIONS

CATEGORY	KANSAS COALITION ON AGING	KANSANS FOR IMPROVEMENT OF NURSING HOMES	SILVER HAIRED LEGISLATURE	AMERICAN ASSOCIATION OF RETIRED PERSONS	KANSAS CITIZENS COUNCIL ON AGING
Other					1. Probate reform to streamline settlement of certain estates. 2. Eliminate age discrimination in employment. 3. Development of flex-time and work reduction programs for older employees. 4. Aging advocates in all State administrative agencies. 5. No surcharge for credit card users.