Approved Feb. 25, 87
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Vice-Chairman, Frank Buehler at
Chairperson

1:30 a.m./p.m. on February 19, 1987 in room 423-S of the Capitol.

All members were present except:
Chairman Littlejohn, excused.

Committee staff present:
Bill Wolff, Research
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Michael Byington, Kansas Planning Council on Developmental Disabilities Services
Debra Brummer, President/ State Committee of Blind Vendors
Representative Joan Wagnon, Bill Sponsor
Mark Intermill, Director of Kansas Coalition on Aging
Ms. Ila Majors, Older Women's League
Ralph Turner, Silver Hair Legislator
Dr. Ron Harper, Secretary of Kansas Department on Aging
Irene Hart, Director of Sedgwick County Department on Aging
Frank H. Lawler, State Legislative Committee/ American Assoc. Retired Persons
Ms. Marjorie Jantz/ Johnson County Commission on Aging/Ks. Advisory Council on Aging
Jean Sakumura, Kansas Association of Home Health Agencies

Vice-Chairman called meeting to order inviting those with bill requests to speak.

Michael Byington, Planning Council on Developmental Disabilities Services gave handout to members, (see Attachment No.1), for details. In the interest of time, he stated the written request would be adequate information for members to determine this legislation request. It is a bill for civil rights for the disabled. We need an act, he said, which shall serve as a guide in defining basic, minimum rights afforded to the disabled. The attachment is our Council's proposal, and we respectfully request the introduction of it.

Ms. Debra Brummer, President of State Committee of Blind Vendors, (Randolph Sheppard Act). We ask this legislation be introduced. This would clarify language in current state law to be consistant with the Federal law. It would change the word "preference" to "priority", which is consistant with Federal law, eliminate the exemption for third class cities, which is also consistant with the law, will provide expansion of business enterprise programs which provide employment opportunitites for blind persons in Kansas allowing them to become tax payers. (Attachment No. 2)

Rep. Pottorff moved to introduce both these bills and ask they be returned to this committee, seconded by Rep. Neufeld, motion carried.

Vice-Chairman welcomed all the Nurses attending the meeting this date. He also introduced his wife, and his sister and friend who attended the meeting.

Representatives O'Neal, Whiteman and Weimer presented sub-committee report on HB 2015.

See (Attachment NO.3), for details of proposed amendments, i.e., Page 2, lines 54-59 change language to read, "Prior to providing a new vocational program serving the mentally retarded or the expansion of an existing vocational program serving the mentally retarded the facility providing such program shall submit in writing to the secretary of SRS a plan which indicates whether additional residential programing will be needed to support the new or expanded vocational program and if additional residential programming is needed how such residential programming will be provided. No such facility shall be established without the approval of the Secretary of SRS. Page 3, lines 112-117 would have identical wording.

Discussion on HB 2015 sub-committee report:-

The Department of SRS has quickly responded to request of sub-committee for an idea of an outline of what they would be requiring, for information for this committee. It is as follows: -
1) The plan for day and residential programs must indicate intended compliance with SRS licensure requirements as stated in current Kansas SRS regulations for licensing of (Non-Medical) community based agencies providing services to handicapped adults.
2) The plan must be in written form and must include a statement of intent that the vocational provider will provide, either directly or through a contractual agreement with another provider, increased residential programming as needed for those individuals being served in the providers vocational programs.
3) Funding and licensure are contingent on having an approved plan.

Rep. O'Neal moved to have this committee adopted, seconded by Rep. Gatlin. A lengthy discussion ensued, i.e., yes, the intent of sub-committee was to have the SRS to approve or reject the plan that is proposed for facilities; if this isn't the case, then what is the purpose of the written plan if not for approval or disapproval.

Mr. Al Nemec, from SRS answered questions i.e., presently the SRS has the authority to determine the capacity under which centers operate, also the licensing, and funding. This language would not change that. New or expanding facilities would have to still be approved by SRS.

At this point Vice-Chair entertained vote on the motions to adopt committee report. Vote taken, committee report accepted favorably on HB 2015.

Rep. Weimer moved to pass HB 2015 favorably as amended, seconded by Rep. Shallenburger, motion carried. Rep. Blumenthal recorded as NO vote.

Hearings began on HB 2226:-

Representative Joan Wagnon gave hand-out to members, (see Attachment 4 and 4-A), for details. She stated Rep. Rex Crowell is co-signer of this legislation, but he is detained in other committee business. She stated is highly unlikely government budgets can continue to absorb costs for the increasing number of older, poorer elderly in nursing homes, so states and the federal government are looking for alternatives to stop the flow of many going unnecessarily into nursing homes where costs are high. HB 2226 is not a panacea for long term care problems facing the elderly, but it is a way to begin to address the problem using new concepts, and ways to gather needed information on which to base a comprehensive state-wide effort. Fiscal note may be $150,000, but could be up to $300,000. This proposal is different in that the state will provide partial funding for in-home care on a sliding scale, (based on the ability of the individual to pay), for a group of people who are not Medicaid eligible. The Attachment 4-A indicates an Oregon Project.

Mark Intermill, Kansas Coalition on Aging gave printed testimony to members, (see Attachment No.5), for details. The Bureau of Census estimates that in the year 2040 there will be six times as many 85 year olds as there were in 1980. While most older residents live independently and are active, there is a significant portion that are in need of assistance. The public policy question that he brings to attention of this committee today is to know that families provide a great deal of long term care services, up to 80%, but as the mothers and daughters-in-law are returning to the work place, there are fewer and fewer to provide this care, and other alternatives must be sought. We must try to effectively meet the growing need for long term care services for the elderly, he said, and favorable passage of HB 2226 will begin an effective beginning.

Ila Majors, Older Women's League gave hand-out. (Attachment No.6). She spoke in support of HB 2226, saying they hope to find answers to the following; 1) the demand for services, 2) cost effectiveness to the state in providing needed programs; 3) effectiveness in enhancing the life style of Kansas elderly; 4) effectiveness of sliding scale fee; 5) the ability to solve problems that will occur in the field under test operation; 6) data necessary to determine whether a plan should be implemented state-wide.

Hearings continue on HB 2226:

Ms. Majors continued saying, If you are rich, you can obtain services and pay for them. If you are poor you can often obtain services. If you are somewhere in between you are out of luck. We hope this bill, she said, will help to keep people from becoming poverty ridden and we can help them retain their dignity by paying what they can afford on the sliding scale fee plan. She urged for favorable passage.

Mr. Ralph Turner, Silver Haired Legislator spoke in support of HB 2226, (Attachment No.7). This bill will establish demonstration projects for in-home care for senior citizens; establishing the in-home care demonstration projects council. We feel, he said these projects will demonstrate the scope of the need for a program to be established in a cost effective manner. He cited statistics in regard to private pay residents in nursing homes today and the costs that could be saved if they were allowed to stay in their own homes longer and have the care services required for their well being. There is a growing need for assistance to enable our older citizens to retain their sense of worthiness and independence. The time is now.

Dr. Ron Harper, Secretary of Department on Aging gave hand-out, (see Attachment No.8) for details. This legislation if enacted, would fund three demonstration projects of in-home care for senior citizens, one in a small city, one in a mid-size city, and one in a large city. Each project would be required to provide homemaking; home management; simple personal care; simple nursing; transportation to and from health care providers; and support for the primary caregiver. Further, it would be authorized to set a sliding fee scale based on ability of individual to pay, and a seven-member advisory council would be established. He stated their Department would be willing to provide any additional information they could in effort to assist committee of Public Health and Welfare in its deliberations.

Irene Hart, Director of Sedgwick County Department on Aging gave hand-out, (see Attachment No.9), for details. She offered to share their experiences in offering programs in several areas, i.e., developing the "continum of care", or a range of services designed so older people in need can easily access the service which best suits their needs at an affordable cost. She asked, who sets fee scale, and how is it adjusted; is gross income considered, are medical expenses allowed as deductions; who determines financial eligibility and payment; who bills the client; who collects the money; is service terminated if the client can't or won't pay their share; is the cost unit the same in every location"; which services are not amenable to unit costing or sliding fee scale; are private, not-for-profit providers allowed; who orders the level of services to be provided? These questions can all be answered. She recommended that one department be given the responsibility and authority and resources to develop and coordinate this needed system. She recommended the following:-1) KDOA should operate the program through area agencies; 2) sufficient planning staff should be added to design and develop a proper program; 3) standard definitions of services should be substituted for ones specified in the language of bill; 4) State Advisory Council on Aging could be substituted for program advisory council; 5) support should be maintained for the last dollar and sliding fee scale concepts.

Frank Lawler, Vice Chairman, AARP, gave hand-out, (see Attachment No.10), for details. Their legislative committee believes HB 2226 is representative of needs of many members across the state, and they support it. Enactment of HB 2226 will enable elderly served by the pilot projects to remain in their own homes rather than be institutionalized. To leave their homes is the single greatest fear of the elderly relative to long-term care. Access to appropriate in-home health care is desperately needed. Data that will be generated from these pilot programs will allow for future development of programs around the state.

Marjorie Jantz, Johnson County Commission on Aging gave hand-out, (see Attachment No.11), for details. She said their group supports the proposed legislation in HB 2226, which would provide much needed information about extending in-home care in a cost effective manner. Programs implemented could benefit all Area Agencies in the state. We understand the financial constraints the Legislature is feeling, but hope you will consider funds for these demonstration projects as an investment for the entire state which will eventually create large savings in the long run.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 /a.m./p.m. on February 19, 1987.

Hearings continue on HB 2226:-

Jean Sakumura, Ks. Association of Home Health Agencies, gave testimony, (see Attachment No.12), for details. She stated the printed text had been prepared by Lydia Neu, Legislative Chairman of Ks. Assoc. of Home Health Agencies. Their group is in support of this concept, and this demonstration project will show: 1) cost effectiveness of home delivery of services; 2) significant savings to the state to subsidize one's care at home over total care of client because their savings have been unduly depleated. 3) provision of care for elderly Kansans that meet their needs; 4) allow clients to remain in their own homes with additional help from friends, family, at a cost savings to the state. She cited an example of an 80 year old lady who was able to remain in her home longer than would have been earlier possible without the help she received. A cost savings of $61,088 was realized over a period of 4 years. This cost difference being between the nursing home costs and cost of the aide that was given her by a Home-Health Aide.

Vice-Chair thanked all conferees and members for their indulgence and we would plan to continue hearings Monday, February 23rd, on HB 2226. There were several conferees who agreed to return.

Meeting adjourned.

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE COMMITTEE

Date 2-19-87

NAME	ORGANIZATION	ADDRESS
Clifford Amstutz	KSNA - Dist. IV	Box 237, Hesston, KS.
Georgia Bowser	KU Med Center	2618 W. 43rd #2, KC, KS 66103
Linda Cleland	Student Nurse - Cloud County	803 N 7th Seneca, KS 66538
Brenda Beikman	Student Ns. - Cloud Co.	R.R. 1 Clifton KS 66937
Teresa Taylor	KUMC / RN	2332 N. 88 KCKs 66109
Pat Twenter	KUMC RN/N.S	1016 W. 71st Ter KCMO 64114
Kathleen Steele	KUMC - BSN student	7725 Oakland K.C. KS 66112
Julia Madrigal	KUMC - Student Nurse (BSN)	2535 Metropliton K.C KS 66106
Arlene M. Wessel RN	KSNA District 13	900 N. maple, Frankfort KS 66427
Jan Bergman RN	KSNA Dist 13	1011 Nemaha, Seneca, Ks. 66538
Irene Hart	Sedgwick Co Dept on Aging	510 N Main Rm 306 Wichita 67203
Lois Johnson	ADRDA Colby, Ks	McDonald, Ks 67745
Diana Pfannenstiel	KSNA	2513 Timber Dr. Hays, KS. 67601
Lee Kirkpatrick	BCCC Nursing	P.O. Box 82 Eureka, Kansas 67045
Betty Frey Cu	Kansas Masonic Home WSU Student	RR #3 Valley Center, Ks 67147
Bonnie Tandoe RNC	WSU student	Rt 2 Newton Ks 67114
Mary Cochran	KSNA	3614 Holly Lane Top Ks 66604
Carla A-Lee	KSNA - Professor WSU	Box 43 Wichita State Univ. Wichita 67208
Donna Hass	Washburn Univ. Nrsg Student	7128 Woodcraft Way Topeka-66
Penny Garber	Washburn University Nursing Student	3637 SE 40 Hwy W19C Topeka-07
Donald A. Heichel	"Can Do - Will Do" Bulletin	2006 SE Iowa-City-07
Karen Lallman	"Can Do - Will Do"	1925 SE 30th 05
Ruthella McBRIDE	Southeast KANSAS AREA AGENCY on Aging	Box 269 Chanute

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE COMMITTEE

Date 2-19-87

NAME	ORGANIZATION	ADDRESS
Irving E. Peterson	Retired SHL. Riley Co KS	2817 Tatarrax Dr Manhattan KS
Barbara Blaesser	KUMC School of Nursing	Rt. 1 Box 273 Meade, Kansas 66861
Darlene Hall, RN	S-V Home Health Mktg.	1500 SW 10th Topeka Ks
PAT BREER	Clinicare Home Health	11316 W. 69th Terr. Shawnee Ks.
Lois BREER.	General Public	Orlando, Fla.
Shannan Pfeffer	KUMC Nursing student	KCKS
Margie Marinelli	KUMC Nursing student	KCK
Michele Melendrez	KUMC. Nursing Student	O.P., Ks. 66212
Kathy McKittrick	KUMC School of Nursing	KC MO 64111
Anne Rees	Older Women's League	O.P. Ks 66212
Marjorie Jantz	Jo. Co. Comm. on Aging OWL	Prairie Village, Ks.
Lucy Gibson	AARP St. Leg. Comm.	Topeka, Ks.
John O. Miller	AARP " " "	Topeka, Ks.
Ila Major	Jo Co Older Women's League OWL	Ov. Pk. KS 66212
Frank Lawler	AARP State Legislative Comm	Lenexa, Ks
Ralph Linn	SILVER HAIRED LEGISLATOR	Lawrence, KS
Mark Intermill	Kansas Coalition on Aging	1145 Buchanan Topeka KS
Joanne M. Hoefer	Chairman on Legislation KSNA - District VII	48 Eastwood Drive Hutchinson, Ks. 67502
Norma R. Gourley	Board Member KSNA Dist II	2501 No 80th Street Kansas City, KS 66109
Jerry E. Hoefer	Candidate Nursing Home Administrator	48 Eastwood Drive Hutchinson, KS 67502
Carolyn Marshall	KSNA - Dist IV	121 W. 9th Halstead Ks 67056
Norma Klein	KSNA - Dist IV	Box 63 Durham, Ks. 67438
Maureen Wedel	KSNA Dist IV	823 Spruce Halstead Ks 67056

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE COMMITTEE

Date 2-1987

NAME	ORGANIZATION	ADDRESS
Barbara Helton	Southeast Ks. Area Agency on Aging	Box 269 Chanute Ks 66720
Cleda L. Meyer	KSNA	Rt 1, Box 177 Herington, Ks. 67449
Kimberly A. Cisneros	KSNA	Marymount College, Salina
Sara Steppuhn	KSNA	Marymount College, Salina
Tom Hitchcock	Bd. of Pharmacy	Topeka
Joan Rettig	KSNA	Topeka, KS
Naomi Copplemon	Student Stormont-Vail School of Nursing	Muscotah, Ks 66058
Doris Glaze	Student Stormont Vail School of Nursing	RR#2 Box 111 Mayetta, Ks 66509
Helen German	Stormont Vail School of Nursing	Topeka
Kathy Haffner	Fort Hays State School of Nsg	211 W 4th Hays, KS 67601
Margaret Ruiz	Fort Hays State University School of Nrs.	720 W 42th Apt 4-A Hays KS. 67601
Beth Williams	KSNA	5514 NE 36 Topeka
Deb Rowen	CCCC - Concordia, Ks. student nurse	801 Matthew, Concordia 66901
LaVerne Parker	Washburn School of Nsg	1825 Brook Lawrence, Ks 66044
Barbara Buchanan	BCCC	12 Harris Dr. Rose Hill, Ks. 67133
Connie Golobay	BCCC/Butler Co. Comm College	1215 Helen, Augusta. Ks. 67010
Kathryn Scharff	KUMC - School of nursing	3602 Rainbow Blvd #202, KC, Ks 66103
Laura Gale	" " "	" " "
Harmony Dodd	Washburn School of nursing	1937 ATWOOD Topeka 66604
Angela DeWitt	Washburn University School of Nursing	Rt 2 Box 66 Scranton, KS 66537
Carolyn Lawson	Washburn Univ. School of Nsg.	915 Lindenwood Topeka, Ks. 66606
Molly Daniels	Ks Dept on Aging	Topeka
Trish Irvine	Jo. Co. Human Resources & Aging Dept.	Olathe, Ks.

→

Annice Davis White   Jo. Co AAA   130 N Cherry
Olathe, Ks 66061

~~Marceline Taylor~~
Marceline Taylor   311 Chandler
Topeka Kansas

Nickie Stein, R.N., M.Ed   KSNA   1607 College
Topeka 66604

Jean Wagner

Tom Love

Mary Beth McCarthy   K.U.

Nadereh Nasseri, KUSN

Amy Welliver, KUSN   431 CAMBRIDGE, KC. KS 66103

Connie Stevens   Butler Co. N.A.   El Dorado, Ks.

Linda Thorne   2911 Central Park Apt B-22
Topeka, Ks. 66611   Washburn University

Esther L. Jackson   RR 1 Box 21   Whiting Ks   Graduate Nurse Washburn University

Lurana Day   202 E. 14th Ellis, KS 67637   Grad. Nurse Wichita State
R.N. Consult. LTCF

KANSAS PLANNING COUNCIL

~~JOHN CARLIN~~ Mike Hayden
Governor
~~RICHARD MORRISSEY~~ Dorothy Olkeson
Chairperson
~~JANET SCHALANSKY~~ John Kelly
Executive Secretary

on

DEVELOPMENTAL DISABILITIES SERVICES

Fifth Floor North
State Office Building
Topeka, Kansas 66612
Ph. (913) 296-2608

TO: House Public Health and Welfare Committee

FROM: Michael J. Byington
Member, Kansas Planning Council on Developmental Disabilities Services

DATE: February 19, 1987

SUBJECT: Bill request

Planning for services to persons having developmental disabilities, and for persons having any or all types of disabilities for that matter, is often done in a non-focused manner in Kansas. Each time significant legislation is considered with reference to the rights of the disabled, -ie- the Kansas Guardianship Act or the Kansas Civil Commitment Act, to mention only a couple of examples, it becomes necessary to re-invent the wheel with reference to what the bottom line, basic rights of the disabled should be. What is needed is an act which shall serve as a guide to the makers of state policies, procedures, and regulations, as well as to Legislators, in defining basic, minimum rights afforded to the disabled. The attached legislation is the Council's proposal with reference legally defining these rights. We ask that it be introduced as a bill.

Several other states have enacted such legislation, and this proposal has been compiled after the study of legislation from other states. This act is not intended to describe services, only rights. The act does not direct that the State of Kansas implement any new programming. There is no fiscal note.

PHrW
Attm. #1
2-19-87

BILL OF RIGHTS

FOR DISABLED PERSONS

DRAFT

Section 1. A disabled person shall be defined as: any person with a physical, developmental, mental, or emotional impairment which would substantially limit one or more major life activities such as learning, communication, mobility, self and health care, socialization, employment, housing, and recreation. This would include any individual who is so limited as a result of having a record of such an impairment or being regarded as having such an impairment. Major areas of disability include but are not limited to : vision, hearing, sensory, mobility, respiratory, and/or mental impairments, mental illness, learning disabilities, deafness, head trauma, chronic, disabling, life threatening, and/or terminal illness, intractable pain, job related injuries, aging, epilepsy, and substance abuse.

Section 2. It is the policy of the State of Kansas that:

(a) Persons with disabilities have the right to appropriate treatment, education, and habilitation services for such disabilities. Functional services include: self care, receptive and expressive language, learning, mobility, self direction, capacity for independent living, and economic self sufficiency.

(b) Persons with disabilities have a right to services and programs which meet standards designed and monitored to assure the most favorable outcomes.

(c) Persons with disabilities have the right to normalized community housing to the maximum extent possible.

(d) The disabled person has the right to equal opportunities in recreation and leisure time activities.

(e) The disabled person has the right to petition for and receive all protections and remedies provided by law.

(f) Persons with disabilities shall have the right to information about and access to, protection, assistance, and representation independent of any state agency which provides treatment, education, other services, or habilitation.

(g) Disabled persons have the right to a qualified, involved guardian and/or conservator when this is required to protect their personal well-being and interest.

(h) Disabled persons have the right to assume responsibility for their own lives, make decisions, and solve their own problems to the maximum extent possible.

(i) The disabled person has the right to a decent standard of living.

(j) Disabled persons have the right to hold a competitive job, perform productive work, and/or to engage in other meaningful occupations to the fullest possible extent of their capacities; they have the right to receive equitable pay and benefits for their labor.

(K) Disabled persons have the right to be informed of the rights afforded them through this Act in the manner most understandable by them.

(l) Disabled persons have the right to a comprehensive diagnosis and evaluation adapted to the cultural background, primary language, including American sign language, and ethnic origin of the person.

(m) Disabled persons have the right to re-evaluation and review of the individual treatment, habilitation, and program plan to assure progress, modify objectives if needed, and to provide guidance and remediation techniques.

(n) The rights of persons having disabilities as set forth in this act are to be considered consistent with, and in addition to, any Constitutional or other rights otherwise afforded to all persons.

Section 3. This act shall be used as a guide in the development of all state policies, procedures, regulations, and legislation, and no policy, procedure. regulation, or legislation shall be enacted which purposefully, knowingly, or willfully violates the rights set forth herein.

Section 4. This act shall be known as the Kansas Bill of Rights for Disabled Persons, and shall take effect from and after its publication in the statute book.

State Committee of Blind Vendors

February 19, 1987

House Committee of Public Health and Welfare
State Capital Building
Topeka, KS 66604

Dear Committee Members:

The State Committee strongly recommends introduction of this very important bill.

This legislation, if passed, will promote the expansion of the Business Enterprise Program, which provides remunerative employment opportunities for blind persons in Kansas, thus allowing them to become tax payers in Kansas.

This bill will make the language in KSA 75-3337 et seq. consistant with the federal Randolph-Sheppard Act, in relationship to the rights of blind persons, licensed by the Division of Services for the Blind, to operate vending facilities im State, City, and County buildings.

This bill changes the word "preference" to "priority" which is consistant with federal law, and eliminates the exemption for third class cities, which is also consistant with federal law.

The Business Enterprise Program is a very viable program, one which costs Kansas tax payers no money, therefore, its expansion can only enhance the state's economy by generating tax dollars through state income tax and sales tax.

For these reasons, the State Committee of Blind Vendors seeks your support to introduce this bill.

Thank you for your consideration.

Sincerely,

Debra Brummer

Debra Brummer, President

PH&W
attm - 2
2-19-87

Randolph Sheppard Vendors
of Kansas, Inc.
1222 S.W. 25th Street
Topeka, Kansas 66611

February 19, 1987

House Committee of Public Health and Welfare
State Capitol Building
Topeka, Kansas 66604

Dear Committee Members,

The Randolph Sheppard Vendors of Kansas Inc. (Business Enterprise Program, vending facility managers) would like to extend their support and urge you to introduce the legislation submitted by the State Committee of Blind Vendors.

Our group feels that passage of this legislation will accomplish the following:

1. It will clarify and strengthen existing legislation KSA 75-3337.
2. It will provide easier expansion of the Business Enterprise Program on state, county, municiple and other properties within Kansas.
3. It will make the language in KSA 75-3337 more consistant with the federal Randolph Sheppard Act.
4. It will enhance the state's economy by providing more potential for increased income and sales tax dollard paid by blind vendors in Kansas.

By virtue of not using any state tax dollars in the Business Enterprise Program of Kansas, the initial and net effect of this legislation's passage will be of a positive nature for blind Kansans and the state's economy.

If, in any way, our group can be of assistance in the passage of this legislation, please let us know.

Sincerely,

Larry E. Waymire
Secretary/Treasurer
Randolph Sheppard Vendors
of Kansas, Inc.

NATIONAL FEDERATION OF THE BLIND OF KANSAS, INC.

7061 Riverview
Kansas City, Kansas 66115
(913) 299-3201

February 17, 1987

TO: MEMBERS OF THE 1987 KANSAS LEGISLATURE

FROM: NATIONAL FEDERATION OF THE BLIND OF KANSAS,
RICHARD EDLUND, PRESIDENT

SUBJECT: LEGISLATION TO STRENGTHEN AND CLARIFY KSA 75-3337

The National Federation of the Blind of Kansas supports the legislative changes as sought by the State Committee of Blind Vendors, of the State of Kansas. These changes will serve to strengthen the Kansas Business Enterprise Program, and will provide additional employment opportuniteis for the blind of our State.

This program, which makes substantial contribution to the economy of our State, has proven itself to be viable, using no state tax dollars, and funded partically by blind vendor assessment, needs legislative enhancement to progress.

This organization hopes that the 1987 session of the Kansas State Legislature will also endorse this legislation, making Kansas as progressive as other states. The National Federation of the Blind of Kansas stands ready to offer any assistance necessary to ensure the passage of the legislation.

NATIONAL FEDERATION OF THE BLIND OF KANSAS, INC.

CAPITOL CHAPTER
2410 Candletree Drive, Apt. 1
Topeka, Kansas 66614
(913) 272-5148

February 17, 1987

House Committee of Public Health
and Welfare
State Capitol Building
Topeka, Kansas 66604

Dear Committee Members:

The Capitol Chapter, National Federation of the Blind of Kansas, wishes to extend its support for the legislation submitted by the State Committee of Blind Vendors, Ms. Debra Brummer, Chair.

This legislation will serve to clarify, and make stronger exsisting legislation KSA 75-3337, which provides for the establishment of vending facilities on state, county, municple, and other properties within Kansas.

This program, which uses no state tax dollars, is possibly the only program administered by the state which continually proves successful. The economic impact of the program will only be enhanced should this legislation be passed, and signed by the governor.

The Capitol Chapter of the National Federation of the Blind of Kansas will assist this committee in any way possible to ensure passage of this legislation.

Sincerely,

William Munck, Secretary/Treasurer
Capitol Chapter, NFB of KS

Kansas Association for the Blind and Visually Impaired, Inc.

TO: House Public Health and Welfare

FROM: Michael J. Byington, Registered Kansas Lobbyist

SUBJECT Bill Request Concerning Blind Vendors in Kansas

DATE: February 10, 1987

The Kansas Association for the Blind and Visually Impaired Inc. requests that a bill be introduced to strengthen K.S.A. 75-3337 et seq. The bill would strengthen the priority blind vendors, trained and licensed by the Kansas Division of Services for the Blind, would have in bidding to operate food service establishments in state, county, and city buildings. This priority has always been the intent of the body of Kansas Law here referenced. In recent years, however, this body of law has proven to be inadequate due mainly to anomalies of wording. The proposed changes would make the law more clear and would make it more consistent with federal statutes concerning blind operated vending facilities.

Attached, please find additional background materials, and drafted wording for the bill. The blind vendors in Kansas had originally been told that this bill would be in the package of legislation introduced by the Kansas Department of Social and Rehabilitation Services. The package of legislation introduced by that agency, however, was reduced significantly at the last minute, and the attached legislation was a piece which was eliminated. I do not know why S.R.S. dropped some of its legislation. I assume it is because of anticipated personnel changes in that agency. I assume S.R.S. chose not to introduce measures it felt would probably be two year bills. The blind vendors in Kansas, however, do not feel that this issue can wait for political re-adjustments. The State's vending program does an excellent job of providing gainful employment for competent blind businesspersons. The program costs the tax payers of Kansas nothing, and in fact, the state benefits financially from the program's operation as is documented in the attachment.

Post Office Box 292 / Topeka, Kansas 66601

The purpose of this bill is to facilitate the establishment of vending stands on property controlled by departments, agencies, or instrumentalities of the state of Kansas. This bill will expand remunerative employment opportunities for the blind and bring state law into greater conformity with corresponding federal law by making the language consistent with that in federal law, thereby preventing cities and counties from denying the blind priority in establishing vending facilities.

Language in the existing law is not consistent with the federal Randolph-Sheppard law which gives blind persons priority status in the operation of vending facilities on federal property. Current language has resulted in difficulties establishing vending stands to be operated by the blind in city and county buildings. For example, a food service contract in an urban county courthouse has been awarded in the past to a private vendor without giving the blind vending facility program preferential opportunity to meet bid specifications. The proposed legislation is more consistent with language in the federal law by giving qualified blind persons priority to operate vending facilities on property of departments, agencies, or instrumentalities of the state of Kansas.

The estimate from the Federal Rehabilitation Services Administration Office of the Blind and Visually Impaired is that at least 75% of the states have laws that give blind persons priority to operate vending facilities on city, county, and state property. Such laws are modeled after the federal Randolph-Sheppard law. As expressed in K.S.A. 75-3337, the state laws have been enacted "for the purpose of providing blind persons with remunerative employment, enlarging the economic opportunities of the blind, and

stimulating the blind to greater efforts in striving to make themsel[illegible] self-supporting...." From 25 to 30 blind persons are usually employed as vending facility managers. Average annual income is approximately $19,500. Assessments are levied against net profits of facilities. The assessments are used to earn matching federal vocational rehabilitation funds at the rate of four federal dollars for each dollar of assessment. The combination of federal and assessment funds is used to operate to vending facility program. Approximately $4,300 of assessment is expected from each vending facility. This can earn $17,200 of federal funds. The total can be applied to vending facility program operating expenses or program enhancements which benefit all of the blind vending facility managers.

Absence of priority in the past has resulted in questions about the right of blind persons to operate vending facilities in city and county buildings and has increased the difficulty of establishing vending facilities to be operated by the blind. The proposal provides for normal binding arbitration procedures with a neutral third party serving as chairperson of an arbitration panel when disputes arise, i.e., when a department or agency fails to comply with the Act or regulations. An example of a dispute is a county's opting to issue a contract for courthouse food service to a private vendor without giving preference or priority to a licensed blind vendor. The proposal establishes a committee of blind vendors whose responsibilities are consonant with those specified in federal regulations.

The effect of passage will make it easier for blind persons to operate vending stands in buildings controlled by departments, agencies, or instrumentalities of the state of Kansas. This will enlarge employment opportunities for the blind and stimulate even more blind persons to become self-supporting.

There is no way to project precisely the number of new vending facilities that will result from this proposal. As current food service contracts in

city, county, and state buildings expire, the vending facility program for the blind will have opportunities to open facilities at those sites. Relocation of city, county, and state employees to new offices offers potential for new vending facilities. It is estimated that approximately four new vending facilities are likely to become available in the next four years. Each site is expected to provide employment for at least one blind person. Vending facilities that result from the proposal are expected to provide an average annual income of $19,500 for the blind managers. An average of $4,300 per facility per year is expected to be assessed against net profits. The assessment is used to operate the vending facility program. No state tax funds are used for this program.

All blind vending facility managers, i.e., usually from 25 to 30, stand to benefit from this proposal by having assessment funds and matching federal funds applied to program operation and enhancement. If the program is forced to rely less on federal funds, there will need to be more reliance on assessment funds as a primary source of program financing.

-Material Provided by Randolph-Sheppard Vendors of Ks. Inc.-

DRAFT
10/8/86

_____ Bill No. _____

By _____

AN ACT concerning vending facilities operated by blind persons licensed by the division of services for the blind of the department of social and rehabilitation services; amending K.S.A. 75-3337, 75-3338, 75-3339, 75-3341, and 75-3342 as amended by L. 1986, Ch. 318, Sec. 137 and repealing the existing sections; also repealing K.S.A. 75-3343.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 75-3337 is hereby amended to read as follows: 75-3337. For the purpose of providing blind persons with remunerative employment, enlarging the economic opportunities of the blind, and stimulating the blind to greater efforts in striving to make themselves self-supporting, blind persons licensed under the provisions of 20 U.S.C. 107, of 1936, and acts amendatory thereto, an act of the congress of the United States of America commonly known as the Randolph-Sheppard vending stand act, shall be authorized to operate vending facilities on any state, county, and city or other property. In authorizing the operation of vending facilities on state, county, and city property ~~preference~~ priority shall be given, ~~so far as~~ wherever feasible, to blind persons licensed by the division of services for the blind of the department of social and rehabilitation services; and the head of each department, ~~or~~ agency, or instrumentality of the state of Kansas in control of the maintenance, operation, and protection of ~~state~~ property shall, after consultation with the secretary of social and rehabilitation services, prescribe regulations designed to assure such ~~preference~~ priority, including exclusive assignment of vending machine income to achieve and protect such ~~preference~~ priority for such licensed blind persons without adversely affecting the interests of the state of Kansas.

Sec. 2. K.S.A. 75-3338 is hereby amended to read as follows: 75-3338. As used in this act, unless the context otherwise requires: (a) The term "state of Kansas" shall include political subdivisions of the state of Kansas, except schools, ~~cities of the third class~~ and townships.

(b) The term "blind person" means a person whose central visual acuity does not exceed 20 over 200, in the better eye with correcting lens or whose visual acuity if better than 20 over 200, is accompanied by a limit to the field of vision in the better eye to such a degree that its widest diameter subtends an angle of no greater than 20 degrees.

(c) The term "vending facility" includes, but is not limited to, automatic vending machines, cafeterias, snack bars, cart service, shelters, counters, and such other appropriate auxiliary equipment as rules and regulations of the division of services for the blind of the department of social and rehabilitation services prescribe and as are necessary for the sale of the articles or services referred to in paragraph (4) of subsection (a) of K.S.A. 75-3339, which are, or may be operated by blind licensees.

Sec. 3. K.S.A. 75-3339 is hereby amended to read as follows: 75-3339. (a) The division of services for the blind of the department of social and ~~rehabilitations~~ rehabilitation services shall:

(1) Make surveys of concession vending opportunities for blind persons on state, county, city and other property;

(2) Make surveys throughout the state of Kansas of industries with a view to obtaining information that will assist blind persons to obtain employment;

(3) Make available to the public, especially to persons and organizations engaged in work for the blind, information obtained as a result of such surveys;

(4) Issue licenses to blind persons who are citizens of the United States for the operating of vending facilities on state,

county, city and other property for the vending of foods, beverages, and other such articles or services dispensed automatically or manually and prepared on or off the premises in accordance with all applicable health laws, as determined by the licensing agency;

(5) Take such other steps, including the adoption of rules and regulations as may be necessary and proper to carry out the provisions of this act.

(b) The division of services for the blind shall, in issuing each such license for the operation of a vending facility, give preference to blind persons who are in need of employment. Each such license shall be issued for an indefinite period but may be terminated by said division if it is satisfied that the facility is not being operated in accordance with the rules and regulations prescribed by such division. Such licenses shall be issued only to applicants who are blind as defined by subsection (b) of K.S.A. 75-3338.

(c) The division of services for the blind, with the approval of the head of the department, ~~or~~ agency, or instrumentality of the state of Kansas in control of the maintenance, operation, and protection of the ~~state, county and city or other~~ property on which the vending facility is to be located but subject to rules and regulations prescribed pursuant to the provisions of this act, shall select a location for such vending facility and the type of facility to be provided.

(d) In the design, construction, or substantial alteration or renovation of each public building after July 1, 1970, for use by any department, agency, or instrumentality of the state of Kansas, except the state park and resources authority and the Kansas turnpike authority, there shall be included, after consultation with the division of services for the blind a satisfactory site or sites with space and electrical and plumbing outlets and other necessary requirements suitable for

the location and operation of a vending facility or facilities by a blind person or persons. No space shall be rented, leased, or otherwise acquired for use by any department, agency, or instrumentality of the state of Kansas after July 1, 1970, except the state park and resources authority and the Kansas turnpike authority, unless such space includes, after consultation with the division of services for the blind, a satisfactory site or sites with space and electrical and plumbing outlets and other necessary requirements suitable for the location and operation of a vending facility or facilities by a blind person or persons. All departments, agencies, and instrumentalities of the state of Kansas, except the state park and resources authority and the Kansas turnpike authority, shall consult with the secretary of social and rehabilitation services or his or her designee and the division of services for the blind in the design, construction, or substantial alteration or renovation of each public building used by them, and in the renting, leasing, or otherwise acquiring of space for their use, to insure that the requirements set forth in this subsection are satisfied. This subsection shall not apply when the secretary of social and rehabilitation services or his or her designee and the division of services for the blind determine that the number of people using the property is insufficient to support a vending facility.

Sec. 4. K.S.A. 75-3341 is hereby amended to read as follows: 75-3341. (a) An arbitration board ~~of three persons consisting of one person designated by the vending facilities advisory committee who shall serve as chairperson, one person designated by the head of the state department or agency controlling state property over which a dispute arises, and a third person who is not an employee of the departments concerned selected by the two~~ shall hear appeals as provided in subsection ~~(b)~~ (c) of this section.

(b) The arbitration board shall consist of one person designated by the state committee of blind vendors, one person designated by the head of the department, agency, or instrumentality of the state of Kansas controlling property over which a dispute arises, and a third person selected by the two. Such third person shall serve as chairperson and shall not be an employee of either party to the dispute.

~~(b)~~ (c) If, in the opinion of the division of services for the blind any department, ~~of~~ agency, or instrumentality of the state of Kansas in control of the maintenance, operation, and protection of ~~state~~ property is failing to comply with the provisions of this act, or any regulations issued thereunder, it shall appeal to the board. The board shall, within 30 days' written notice of appeal, conduct a hearing and render its decision which shall be in writing and shall be binding. If the board determines that the acts or practices of any such department, ~~of~~ agency, or instrumentality of the state of Kansas are in violation of this act, or the regulations issued thereunder, the head of the affected department, ~~of~~ agency, or instrumentality of the state of Kansas shall promptly cause such acts or practices to be terminated, and shall take such other action as may be necessary to carry out the decision of the board. All decisions of the board shall be published in the Kansas register.

Sec. 5. K.S.A. 75-3342 as amended by L. 1986, Ch. 318, Sec. 137 is hereby amended to read as follows: 75-3342. Notwithstanding other provisions of this act, any blind person suffering legal wrong because of any ~~agency~~ action by a department, agency, or instrumentality of the state of Kansas, or adversely affected or aggrieved by such action within the meaning of this act or other relevant statutes, shall be entitled to and shall have standing for judicial review thereof in accordance with the act for judicial review and civil enforcement of agency actions.

New Sec. 6. (a) There is hereby established a state committee of blind vendors. The director of the division of services for the blind shall provide for the biannual election of the committee which shall be fully representative of all blind vendors licensed by the division of services for the blind.

(b) The committee's responsibilities shall include:

(1) Participation with the division of services for the blind in major administrative decisions in policy and program development concerning the vending facility program;

(2) Receiving grievances of blind licensees and serving as advocate for such licensees;

(3) Participation with the division of services for the blind in the development and administration of a transfer and promotion system for blind licensees;

(4) Participation with the division of services for the blind in developing training and retraining programs; and

(5) Sponsorship with the assistance of the division of services for the blind of meetings and instructional conferences for blind licensees.

(c) The actual expenses incurred by the members of the committee attending meetings of such committee or attending a subcommittee meeting thereof authorized by such committee shall be reimbursed by the division of services for the blind.

(d) The secretary of social and rehabilitation services shall adopt rules and regulations concerning the composition of and election to the committee.

Sec. 7. K.S.A. 75-3337, 75-3338, 75-3339, 75-3341, 75-3342 as amended by L. 1986, Ch. 318, Sec. 137, and 75-3343 are hereby repealed.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

HOUSE BILL No. 2015

By Special Committee on Public Health and Welfare

Re Proposal No. 25

12-15

AN ACT concerning vocational programs serving the mentally retarded; placing limitations upon the approval or licensing thereof; amending K.S.A. 19-4001 and K.S.A. 1986 Supp. 75-3307b and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 19-4001 is hereby amended to read as follows: 19-4001. *(a)* The board of county commissioners of any county or the boards of county commissioners of two ~~(2)~~ or more counties jointly may establish a community mental health center~~,~~ ~~and/or~~ *or* community facility for the mentally retarded, *or both*, which shall be organized, operated~~,~~ and financed according to the provisions of this act.

(b) The mental health center may render the following mental health services: Outpatient and inpatient diagnostic and treatment services; rehabilitation services to individuals returning to the community from an inpatient facility; consultative services to schools, courts, health and welfare agencies, both public and private, and conducting, in collaboration with other agencies when practical, in-service training for students entering the mental health professions, educational programs, information and research.

(c) The community facilities for the mentally retarded may render, and a mental retardation governing board which contracts with nonprofit corporations to provide services for the mentally retarded may provide, the following services: Preschool, day care, work activity, sheltered workshops, sheltered domiciles, parent and community education and, in collaboration with other agencies when practical, clinical services, reha-

Attachment 3
2/19/87

P&HW
attm. # 3
2-19-87

lation services, in-service training for students entering pro-
sions dealing with the above aspects of mental retardation,
information and research. It may establish consulting ~~and/or~~ *or*
referral services, *or both*, in conjunction with related community
health, education, and welfare services.

(d) No community mental health center, ~~and/or~~ *or* facility for
the mentally retarded, *or both*, shall be established in ~~said~~ *a*
community after the effective date of this act unless and until the
establishment of the same has been approved by the secretary of
social and rehabilitation services. *No new vocational programs*
serving the mentally retarded nor the expansion of an existing
vocational program serving the mentally retarded shall be ap-
proved unless the secretary of social and rehabilitation services
determines that one or more residential programs would be
available to potential clients of such vocational program.

Prior to providing a program or the facility providing such program shall submit in writing to the secretary of social and rehabilitation services a plan which indicates whether additional residential programming will be needed to support the new or expanded vocational program and if additional residential programming is needed how such residential programming will be provided

Sec. 2. K.S.A. 1986 Supp. 75-3307b is hereby amended to read as follows: 75-3307b. (a) The enforcement of the laws relating to the hospitalization of mentally ill persons of this state in a psychiatric hospital and the diagnosis, care, training or treatment of persons in community mental health centers or facilities for the mentally ill, mentally retarded or other handicapped persons is entrusted to the secretary of social and rehabilitation services. The secretary may adopt rules and regulations on the following matters, so far as the same are not inconsistent with any laws of this state:

(1) The licensing, certification or accrediting of private hospitals as suitable for the detention, care or treatment of mentally ill persons, and the withdrawal of licenses granted for causes shown;

(2) the forms to be observed relating to the hospitalization, admission, transfer, custody and discharge of patients;

(3) the visitation and inspection of psychiatric hospitals and of all persons detained therein;

(4) the setting of standards, the inspection and the licensing of all community mental health centers which receive or have received any state or federal funds, and the withdrawal of li-
ses granted for causes shown;

the setting of standards, the inspection and licensing of all facilities for the mentally ill, mentally retarded or other handicapped persons receiving assistance through the department of social and rehabilitation services which receive or have received after June 30, 1967, any state or federal funds, or facilities where mentally ill, mentally retarded or other handicapped persons reside who require supervision or require limited assistance with the taking of medication, and the withdrawal of licenses granted for causes shown. The secretary may adopt rules and regulations that allow the facility to assist a resident with the taking of medication when the medication is in a labeled container dispensed by a pharmacist. No license for a residential facility for eight or more persons may be issued under this paragraph unless the secretary of health and environment has approved the facility as meeting the licensing standards for a lodging establishment under the food service and lodging act;

(6) reports and information to be furnished to the secretary by the superintendents or other executive officers of all psychiatric hospitals, community mental health centers or facilities for the mentally retarded and facilities serving other handicapped persons receiving assistance through the department of social and rehabilitation services.

(b) An entity holding a license as a community mental health center under paragraph (4) of subsection (a) on the day immediately preceding the effective date of this act, but which does not meet the definition of a community mental health center set forth in this act, shall continue to be licensed as a community mental health center as long as the entity remains affiliated with a licensed community mental health center and continues to meet the licensing standards established by the secretary.

(c) *No new vocational programs serving the mentally retarded nor the expansion of an existing vocational program serving the mentally retarded shall be licensed under this section unless the secretary of social and rehabilitation services determines that one or more residential programs would be available to potential clients of such vocational program.*

Prior to providing a program or the facility providing such program shall submit in writing to the secretary of social and rehabilitation services a plan which indicates whether additional residential programming will be needed to support the new or expanded vocational program and if additional residential programming is needed how much residential programming will be provided

Sec. 3. K.S.A. 19-4001 and K.S.A. 1986 Supp. 75-3307b are

hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

STATE OF KANSAS

JOAN WAGNON
REPRESENTATIVE, FIFTY-FIFTH DISTRICT
1606 BOSWELL
TOPEKA, KANSAS 66604

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: ASSESSMENT AND TAXATION
JUDICIARY
LEGISLATIVE, JUDICIAL AND
CONGRESSIONAL APPORTIONMENT
PUBLIC HEALTH AND WELFARE

Testimony on H.B. 2226

"Each year, tens of thousands of elderly people who are ill or chronically disabled resign themselves to living out their lives in nursing homes. Without children to care for them, unable to afford a nurse or companion they leave their homes confident that pension income, life insurance, Medicare, a Medigap policy or retirement savings will provide adequately for them.

"But each year, tens of thousands of elderly are wrong. A large percentage of them will become impoverished within months." (State Legislatures, Nov/Dec. p.26)

A 1985 Harvard University study reported that almost 50 percent of unmarried 75-year-olds would fall into poverty within three months after entering a nursing home; at the end of a year, that number would become 75 percent. In Kansas the elderly population grew by 12.5 percent from 1975 to 1984, but the growth in Medicaid spending in the same period was 185.8 percent. (Admittedly these medicaid figures include spending for ICFMR facilities, but the rate of growth for the elderly is still staggering.)

It is highly unlikely that government budgets can continue to absorb the costs for an ever increasing number of older, poorer elderly in nursing homes. So states, and the federal government are looking for alternatives--to retard the rate of admission to nursing homes, to control the costs.

Ironically, shifts in government policy which discourage nursing home admissions and encourage home and community based services are just what the vast majority of these people want--to get a little help to stay in their own homes as long as possible.

House Bill 2226 is certainly not a panacea for the long term care problems facing elderly individuals and state governments. But it is a way to begin addressing the problem using new concepts, a way to gather reliable information on which to base more comprehensive, state-wide efforts.

Previous proposals, while supported conceptually, have failed to win final approval partly because of uncertain fiscal impact and flawed service delivery mechanisms. The coalition of groups and

PH&W
2-18-87
attm #4

individuals supporting this proposal hopes to avoid some of these pitfalls by submitting a bill which gives maximum discretion to the Department of Aging to design a service delivery mechanism appropriate for the community in which it is located and consistent with state requirements, and by starting with demonstration projects in three diverse areas so that costs may be controlled.

Please note that the fiscal note is whatever the state provides. Probably the minimum amount required would be $150,000. A more realistic amount would be $300,000. The number served would depend on the amount of funds available, the ceiling on the sliding scale for fees.

I would encourage the use of local matching funds to maximize the amounts of service available for these projects. I don't think any further authorization is needed in the statute in order to utilize matching funds.

Many communities already have some home and community based services available; the mix of available services may depend on local need as well as local funding. The list of services in lines 37 to 39 was meant to be broadly inclusive, and to allow those decisions to be made by project officials and the Department of Aging. Throughout all discussions of this concept, case management was an essential component in order to have both a cost effective and high quality program. Upon rereading of the bill, it is not required and perhaps should be.

You may ask, "What is different about this proposal from what occurs now in many communities?" The answer is that the state will provide partial funding for in-home care, on a sliding scale (based on ability to pay) for a group of people who are not Medicaid eligible in the hopes that this smaller investment of dollars to delay their eventual entry into a nursing home will be more than offset by the savings of the higher nursing home care costs.

There are only two ways to prove this assumption--use another state's experience, or replicate those results in Kansas. HB 2226 will provide Kansas data--and will help clarify for policy makers in Kansas the most effective options in meeting the long term care crisis which is upon us.

OREGON PROJECT INDEPENDENCE

PURPOSE

Oregon Project Independence, financed entirely with state general funds, serves persons 60 years of age and older who have been assessed at being at risk of entering an institution, such as a nursing home, and who are not receiving support or services from the state Medicaid agency except food stamps. A fee for service is charged based on ability to pay. Authorized services include the following, plus others that may be authorized by the Administrator of the Senior Services Division:

- o Home Care - Provides assistance with all activities of daily living (eating/nutrition, dressing, personal hygiene, mobility, bowel and bladder control, and behavior) and either assistance in or provision of feeding. Provides assistance in all self-management activities (medication management, including oxygen; transportation, meal preparation, shopping, housekeeping and laundry). Home care represents a combination of what typically is entitled homemaker and housekeeper services.

- o Chore - Concerned with the health and safety of the person such as heavy household cleaning, minor home repair and yard maintenance.

- o Home Health - Items and services furnished by a Home Health Agency in a person's home.

- o Personal Care - Involved in assistance with more personally intensive areas, such as grooming and personal hygiene, bowel and bladder care not requiring skilled nursing service, first aid and handling of emergencies, plus light housekeeping and other items indicated under housekeeper.

- o Escort - Assistance to the individual who cannot use conventional transport and needs help when going to essential services.

The state contracts its funds to the 18 Area Agencies on Aging which also administer programs under the Older Americans Act, such as meal programs, transportation, legal services, etc. The Area Agencies mostly subcontract these funds to service providers, although in some rural areas they provide the services directly.

GC:krh
4906P
11/5/85

Attachment 4-A
2/19/87

OREGON'S LONG-TERM CARE SYSTEM
FOR THE ELDERLY AND PHYSICALLY DISABLED

BACKGROUND:

Long-term care in the United States has been greatly transformed in the last twenty-five years. Some of the effects have been positive while others have been negative. It is most probably the case that those in need of long-term care services have a much better chance of receiving them today than they did twenty-five years ago. It is also true, though, that most of these people (especially the elderly) receive long-term care services in nursing homes.

Nursing home care is generally not preferred by the elderly. Most every elderly person, given choices, will choose other forms of long-term care services. Despite this obvious preference, we, as a nation, have adopted policies leading to the placement of more and more people who need long-term care services in nursing homes.

In 1960, approximately 2.3% of the elderly population over 65-years of age were in nursing homes. Today, that percentage is about 5.2% and growing. Depending on which study you wish to quote, if you are 65 years old, your chances of receiving nursing home care at some point in your life could be as great as 40 percent. Unlike other developed countries, which rarely institutionalize more than one or two percent of their elderly, the United States has chosen nursing home care as the primary service for those who have long-term functional problems and must depend upon others for help.

These national long-term care policies have also had an enormous cost impact on the country. In the nine-year period between 1967 and 1976, the average yearly increase in long-term care costs was 22%. This followed the so-called "Miller Amendment" to Medicaid in 1967, which allowed intermediate care nursing homes to receive federal Medicaid funding.

Between 1967 and 1981, unlimited federal funding was available for nursing home care, while community based services (those outside of nursing homes) had very limited federal support. If states chose not to follow federal leadership, and not place their older citizens in nursing homes, they did so at great cost to their state's general fund. In fact, only one state, Arizona, chose a different path.

After 1981, federal Medicaid funding, while still unlimited for nursing homes, became available for nonmedical services outside of nursing homes. This funding, however, has been limited, and strictly controlled by the federal government. While 46 states have taken advantage of this federal community service support, most all have confined their programs to a small segment of the population, and still depend upon nursing homes as the primary long-term care service.

At the core of the problem, is our approach, as a nation, to long-term care: we have defined long-term care as a medical problem; insisted on professional medical long-term care services (either directly provided or supervised); funded these services with state and federal medical dollars; and created a highly regulated system to provide these services, modeled after the acute

medical services available through hospitals and home health agencies. All this we provide for the typical long-term care consumer, whose primary problem is functional, not medical.

While the elderly have a greater incidence of medical problems than the general population, these problems tend to be acute and short-term. Very often, however, the aftermath of these medical problems is to leave the elderly person in need of services to help them function on a day-to-day basis. These services need not be medical (only the United States considers them to be); are usually simple in nature (assistance with eating, dressing and moving are the most common); and do not require either professional medical provision or supervision.

Oregon, like 48 of its sister states chose to accept federal Medicaid funding, and saw a greatly expanded and very expensive nursing home program develop after 1969. Until 1979, Oregon also considered long-term care to be a medical problem and, as a result, generally provided more care than was required, in more restrictive settings (nursing homes), than required.

Since 1979, Oregon has taken several steps in an attempt to provide a more sensible, less expensive system of long-term care to its elderly and disabled citizens. The development and implementation of those steps was not easy; nor is it complete. Even so, progress has been made, and we believe we are on the right path. The path, however, is uncharted, crooked, and has several forks.

4843P/m2
10/29/85

Results of the Oregon System of Long-Term Care

From 1969 to 1979, our primary long-term care service was nursing homes. In 1974, Oregon served 6194 persons in the Medicaid nursing home program. By 1979, this figure had grown to 8079, an increase of 30.43 percent. During this same period, the age 75-plus population (the average age of Oregon nursing home residents is 82 years) grew from 102,039 in 1974 to 116,689 in 1979, an increase of 14.36 percent. Starting in 1979, Oregon embarked on a series of planned actions to reduce the nursing home case load to those who required that level of care, and to serve more people in the community based alternatives.

Without the development and expansion of community based alternatives to nursing homes, and a system of continual support for them, Oregon could have expected either one of two conditions to exist today (1985). Either: 1) nursing homes would have continued to grow at the 1974 to 1979 rate, in which case Medicaid nursing home caseload of 11,029 would have been expected; or 2) nursing homes would have grown at the same rate as their primary users, the age 75-plus population (which in 1985 is 141,378). In this case, we would have expected to see 9781 Medicaid nursing home residents.

The actual number of Medicaid nursing home residents in 1985 is 7638. In other words, Oregon has achieved an absolute reduction in Medicaid nursing home cases of 441 (5.5%) from 8079 in 1979 to 7638 today. If the nursing home growth rate from 1974 to 1979 had continued, 11,029 nursing home cases would have been expected today. Instead, the 7638 actual cases represent a reduction of 3,391 (30.7%). If, on the other hand, without intervention the nursing home caseload had increased at the same rate as the age 75-plus population, then 9781 cases would be expected today. The actual caseload of 7638 is 2143 lower, a reduction of 21.9 percent.

Where have these people gone? At the very least, we would have expected to serve an additional 2143 persons in community alternatives. This would represent maintaining long-term care services for a set percentage of the age 75-plus population. In 1979, about 6162 elderly and disabled persons were served in community based alternatives (average age of 76 years). Today, 9800 persons are served in community based alternatives (average age of 76 years). This represents a growth of 3638 community based long-term care clients, which is more than either the 2143 or 3391 estimates of additional nursing home growth without intervention.

The Oregon system of long-term care strives not to place people in nursing homes unless absolutely necessary. In Oregon, the nursing home has become our placement of "last resort," not "first resort" as it was previous to 1979. In operating a publically-funded long-term care system, two criteria must be met. One is meeting the needs and preferences of the client and we are improving here; the other is meeting the needs of the taxpayers. Has the Oregon system of long-term care been cost-effective, and not spent more of the taxpayer dollars than necessary?

Table 1 shows the results since 1979 of intervention made in Oregon in long-term care. It also shows how successful we have been in meeting the goals of those interventions. The goals were threefold and interrelated:

Comparison of Actual and Expected* Growth
in the Oregon Long-Term Care System for the
Elderly and Physically Disabled
1979 to 1985

Program	Actual Expenditures in 1979 and 1985			Actual Expenditures in 1979 and Expected Expenditures in 1985 Without Intervention		
	Monthly Average Cases	Monthly Average Cost Per Each Case	Total Expenditures	Monthly Average Cases	Monthly Average Cost Per Each Case	Total Expenditures
1979						
Nursing Homes	8,079	$ 550.33	$53,353,393	8,079	$ 550.33	$ 53,353,393
Federal - State Supported Community Based Care	3,412	123.02	5,036,931	3,412	123.02	5,036,931
State Only Community Based Care	2,750	51.32	1,693,565	2,750	51.32	1,693,565
Total	14,241	$ 351.59	$60,083,889	14,241	$ 351.59	$ 60,083,889
1985						
Nursing Homes	7,638	$ 859.79	$78,804,912	9,781	$ 816.80	$ 95,869,450
Federal - State Supported Community Based Care	5,360	272.96	17,556,787	4,131	259.31	12,854,515
State Only Community Based Care	3,540	68.37	2,904,518	3,329	64.96	2,595,022
Risk Intervention Care	900	-0-	-0-	--	--	--
Total	17,438	$ 474.38	$99,266,217	17,241	$ 538.05	$111,318,987

* Expected equals the growth rate of the populaton age 75-plus, and assumes the cost per each case would have been 5% less than the 1985 activity and represents an estimate of conditions that probably would exist in 1985 had not interventions been made in the Oregon long-term care system.

8443P/m4
10/29/85

first, we wanted to reduce nursing home utilization to only those who require that level of care; second, we wanted to maintain a level of effort and serve all clients who had reached a level of impairment that required assistance from others when that assistance could not be given by family or friends; and third, we wanted to reduce the anticipated large amount of public dollars that would have been needed to operate the long-term care system, as it existed previous to 1979.

Table 1 is divided into two columns. The left hand column shows the actual long-term care cases, cost per each case and expenditures in 1975 and again in 1985 for nursing homes, and the two (three in 1985) community based alternative programs. The table shows that Oregon served 14,241 average monthly cases in 1979 at an average cost per each case of $351.59, which required $60,083,889 of public (state and federal) funds.

The bottom half of the left hand column shows Oregon's actual expenditures in 1985. This part of the table (lower left column) shows that in 1985, Oregon will serve 17,438 average monthly cases at an average monthly cost of $474.38 per each case, at a public cost of $99,266,217.

The right column of Table 1 shows what would have been expected in Oregon had intervention not been made. The upper half of the right column is the same as the left column and simply shows 1979 expenditures. The lower half of the right column shows the estimate of 1985 expenditures without interventions. These estimates are based on two criteria:

1. Without intervention, we have estimated that all of the long-term care programs would have maintained a level of effort and grown by the same rate as the population age 75-plus. This is probably a conservative estimate since the growth of nursing homes cases before 1979 exceeded the population age 75-plus growth.

2. Without interventions, we also estimated that the cost per each case would be 5% less in 1985 than was actually experienced. This is a more difficult estimate to make. We know that the rapidly rising cost per each case between 1979 and 1985 are due to two factors:

    a. First, as part of the intervention made since 1979, we have reduced from the publicly funded, long-term care caseload, several hundred clients who were not impaired enough to meet the service eligibility criteria. Many of these clients were served by the risk intervention program (volunteers). Reducing low cost cases from the caseload will, of course, cause the average cost per case to rise.

    b. Second, the impact of the Medicare DRG program (a regulated set payment by days and diagnosis in hospital) has caused more highly impaired persons to enter the long-term care system. Since these people entered the system sooner than they otherwise would have and required more care, this has also caused the cost per each case to rise.

    Since the second factor (Medicare DRGs) would have occurred in any case, it is very difficult to factor out the effect of our own intervention of reducing the caseload to those in most need of service. We, rather

arbitrarily, chose a 5% reduction from the 1985 actual cost per each case. We feel that this, too, is a conservative estimate, and is more likely somewhere between three and five percent.

The lower right hand column shows that without intervention, we could have expected 9781 clients in nursing homes and 7460 clients in community based alternative services for a total 17,241 average monthly cases at an average cost per each case of $538.05, requiring $111,318,987 public dollars.

A comparison of the bottom line of Table 1 shows that in 1985, we were serving 197 more clients that we would have without intervention at an average lower total cost per each case of $63.67, requiring $12,052,770 less tax dollars. The obvious conclusion is that Oregon, since 1979, has served more clients at less cost in long-term care. It has done this primarily by moving people away from nursing home placements when these were not necessary, and providing services in a more independent setting.

Table 1 reflects the result of several actions taken since 1979 by Oregon in long-term care. The sum total of these actions define the present long-term care system, and provide the basis for our future development and refinement.

4843P/m6
10/29/85

The Components of the System

1. Case Management:

Oregon employs 185 case managers statewide to assure appropriate services are provided to clients. Besides determining financial and service eligibility, they also certify for food stamps, prepare plans of care and arrange placements and other needed service or equipment. They are required to review each case every six months (twelve months in nursing homes) to assure that the plans of care are being followed and to reassess clients to certify that services meet the clients' needs. About 50 of these case managers are assigned special tasks that will be discussed later. All case managers are either employes of the state or local government.

2. Pre-Admission Screening:

Oregon employs 26 Registered Nurses (RNs) and Masters of Social Work (MSW) assigned to 13 pre-admission screening teams. They are charged with assessing an average 480 applicants for nursing home care each month, who are either Medicaid eligible or who will be Medicaid eligible within three months. These teams have been in place, statewide, since 1980 and divert about 21% of the applicants to services in the community. Their priorities of screening are: 1) hospital referrals (same day screening is achieved in most cases); 2) community referrals; and 3) nursing home referrals of private clients who have spent down to Medicaid. Pre-admission screening teams are also employes of either state or local government.

3. Relocation:

About 16 of the 185 case managers are assigned to relocation (this may often be a part-time assignment in rural areas). They are charged with the task of assisting residents in nursing homes, who no longer require that level of care, to move back to community settings. Relocation workers have all received intensive training on the prevention of transfer-trauma, and the average relocation takes from 30 to 60 days. Since April of 1982, Oregon has relocated 3457 nursing home residents, representing 22.08% of all Medicaid nursing home discharges. The results of these relocations have been extremely encouraging. Studies in 1983 and 1985 both show about 90% of those relocated have remained out of nursing homes for a year; about 5% have had to return to nursing homes; and about 5% have died (a lower death rate than that experienced by the general age 75-plus population).

4. Diversion and Resource Development:

About 16 of the 185 case managers are assigned to this task. They are charged with working with clients who have been diverted from nursing homes (by Pre-Admission Screening teams), to assure they are appropriately placed in community settings. They acomplish this by developing community resources if none are available, or by recruiting providers of services (especially adult foster homes). The case managers consult with these providers to assure their ability to provide appropriate care.

5. Risk Intervention

Twelve of the 185 case managers are employed as risk intervention workers. They are charged with the task of providing case management services for elderly and physically disabled individuals who do not meet the financial or service eligibility criteria for publically funded services. Generally, they perform the same duties as other case managers, but must assure the provision of services are from other community resources than those that are funded by the state or federal government. They work closely with families, volunteers, neighbors, churches and other local organizations. Since its inception in 1983, this program has proven to be popular and successful.

6. Protective Services

About five of the 185 case managers are employed in arranging the provision of short-term services to elderly and physically disabled adults who require protection. Such services are provided to about 500 persons each year. These case managers also investigate abuse complaints in both nursing homes and community settings. About 300 community abuse complaints and 600 nursing home abuse complaints are investigated each year.

7. Client Care Monitoring:

The state of Oregon employs 22 persons (20 RNs and 2 MSWs) to perform three specific tasks to assure clients are appropriately served and protected.

a. Federally required inspection of care for all clients in nursing homes receiving Medicaid services to assure services provided are adequate, appropriate, and of acceptable quality. This service, though not federally required, is also provided for all clients in community based alternatives.

b. Utilization Review of all clients in nursing homes to assure the appropriate level of payment.

c. Documentation of abuse or poor care that may lead to sanctions of care providers. Besides decertification, delicensure or fining of providers, Oregon employs three intermediate sanctions that are the result of Client Care Monitoring documentation and the investigation of abuse complaints by case managers.

(1) An immediate suspension of all Medicaid admissions to nursing homes and community services, when care conditions appear unsafe or of unacceptable quality;

(2) Denial of all or part of the reimbursement for care when that care was not provided (we will, for example, not pay for care when a medically preventable "bed sore" appears); and

(3) Cancellation of the provider contract, when conditions cannot be improved, or the provider has a record of several incidents of poor care over a period of time.

The Client Care Monitoring function has only been operational since August 1985. In the first three months of operation, they provided documentation for the cancellation of one nursing home contract, and the suspension of admissions in two other nursing homes.

8. Services to Clients

All services purchased by the state of Oregon for the benefit of elderly and disabled clients are provided through contract with service providers. In some cases, these contracts are with local governments as will be discussed later. The following general types of services are purchased:

a. Nursing Home Care

Oregon purchases care for Medicaid clients in just about half of the 15,256 available nursing home beds. By far, the greatest percentage of this care is in intermediate care nursing homes. In fact, only 187 Medicaid clients out of 7638 are receiving skilled nursing home care. Oregon has a retrospective reimbursement system and pays 100% of all costs below the 75th percentile. We are presently investigating different options for providing a "case-mix" or client specific reimbursement system. The occupancy rate for Oregon nursing homes is presently lower than 90 percent.

b. Non-medical Substitute Homes

Oregon purchases care in two types of non-medical substitute homes. Both of these types of homes provide board and room, and assistance with the activities of daily living such as eating, dressing and moving.

1) Adult Foster Homes

These facilities are limited to five or less clients and provide care in a "home-like" setting. The average number of clients in these facilities is about two. This resource is the one most often used by clients who have been relocated from nursing homes who have neither a home to return to, nor relatives available. All foster homes which provide care for public or private clients are licensed by the state of Oregon (effective April 1, 1986).

2) Residential Care Facilities

These facilities are similar to adult foster homes, only larger. They provide care for six or more clients. The number of publically funded clients in these facilities has been declining for the past few years.

c. In-Home Services:

Oregon purchases services in this category from two types of service providers.

(1) Contracts are negotiated with local in-home service agencies through a "Request for Proposal" (RFP) process that give successful agencies exclusive service provision rights in selected areas of the state.

(2) The case managers also assists the clients in arranging for needed services in a "client employed" in-home service program. In this case, the service provider is actually employed by the client. The state makes the payment for services on behalf of the client and also insures that both the employe and employer's share of the FICA (Social Security) payments are made. Oregon has a State law that specifies that providers in the client employed program are not employes of the state.

In-home services are the most flexible services provided to clients. While there are definitions of what types of services may be provided and standards of services that are enforced, the goal is to provide whatever service the client needs in order to remain in their own home and as independent as possible. Such services may include something as simple as grocery shopping or as complex as home health. Most all of the services purchased in this program provide nonmedical assistance with the activities of daily living.

d. Transportation Service:

Because Oregon is a rural state, transportation services are a major problem. Oregon purchases a great amount of transportation for senior and disabled clients who have mobility problems. We also rely very heavily on volunteer transportation networks that are available in every area of the state.

e. Nutrition Services:

There are 181 congregate meal sites and 41 Home-Delivered Meal providers in Oregon. Except in the extremely sparsely populated southeastern part of the state, meals are available to Oregon's elderly on a regular basis.

f. Financial Services:

Cash payments under the Oregon Supplemental Income Program and food stamps are arranged for eligible clients.

The Organization of the System

All of the "components of service" listed above are financed through the Oregon State Senior Services Division, which is a state agency under the umbrella of the Oregon Department of Human Resources. The Senior Services Division was created by the Oregon legislature on October 1, 1981, and has the responsibility of providing needed services to eligible clients in the least restrictive setting available.

The creation of the Senior Services Division in 1981 combined programs that previously existed in three separate state agencies; and was the direct result of an intensive lobbying effort by Oregon senior organizations. It is modeled after a joint federal-state demonstration project that was conducted in Southwestern Oregon between 1978 and 1981.

At the local level, each Area Agency on Aging has the option of managing some of the programs (transportation, nutrition and some in-home services) or all of the programs (except Client Care Monitoring), if they are under a local general purpose government. There are 18 Area Agencies on Aging in Oregon and ten of these agencies manage all of the programs available at the local level.

4843P/m11
10/29/85

System Resources

The Oregon Senior Services Division has a biennial budget of $252 million. Of this amount, about $95 million are state general funds and $157 million are federal. Of the federal funds, $20 million are provided through the Older Americans Act, $3 million are Social Service Block Grant (Old Title XX) funds, and $134 million are Medicaid funds. Oregon has maintained a state funded (no federal dollars) community based alternative care program (mostly in-home services) since 1975. This program is known as "Oregon Project Independence," and every legislative session since 1975 has shown its commitment to this program by increasing its appropriations (from $1 million in the 1975-77 biennium to $6.6 million for the 1985-87 biennium). Services are provided under Oregon Project Independence on a sliding-fee basis, and it is often matched with local funds (though this is not required). It is available for all persons over the age of 60 years, who meet the service eligibility criteria. This program is under the management of the Area Agencies on Aging. Older Americans Act funds are also all under the management of Area Agencies on Aging and is the primary source of funds for transportation and nutrition programs.

Oregon was the first state to take advantage of Medicaid funds for community alternative services when they became available in 1981 under Section 2176 of the Reconciliation Act (what has been termed Home and Community Based Waivers). These funds were approved for three years starting on December 23, 1981 and a subsequent three years were granted in February 1985. This program has made the difference in being able to achieve the results shown earlier in long-term care.

System Operations

The operation of the Oregon Senior Services Division is not an easy task. At the management level, the state Senior Services Division is accountable for all expenditures and programs, most of which are managed by local Area Agencies on Aging under general purpose local governments. While safeguards were built into the enabling legislation to prevent overexpenditures as a result of poor local management, these have not yet had to be applied.

The major problem in the management of the system is getting the four primary groups (the state Senior Services Division; the local Area Agencies on Aging; the service providers; and the senior and disabled advocates) to agree on issues and directions to be taken. During the first three years, this problem was very severe; however, subsequent actions have much improved the situation and the atmosphere among the groups is more condusive for building a better system of care.

System operations for the provision of services to clients has presented a different set of problems. The ability to operate a system such as Oregon's is directly related to having a reliable and valid assessment instrument to measure client impairment levels and determine service eligibility. Although such an instrument was developed in 1979, it has not been as sophisticated as we desired. An on-line refinement of that assessment instrument is almost complete, and will be available soon.

In order to assure that, throughout the state, clients are eligible, needs are being met, and care is cost-effective and in the least confining situation, we have established an outcome-oriented process of program performance review. The review methods combine on-site assessments, by central office staff of randomly sampled clients; analysis of performance statistics; and interviews of local management.

Long-term care is a dynamic system; clients are constantly entering and leaving the programs (the turnover rate in nursing homes is 5% per month). Clients are also constantly changing their levels of care, requiring either more, less or different services. This requires a strong case management and pre-admission screening component, both of which we are lucky to have.

The Oregon Long-Term Care System is not completed, nor has it been refined to always run smoothly. Progress, however, is being made, and the results, to date, show we are headed at least in the right direction, though perhaps not exactly on the right path.

4843P/ml3
10/29/85

KANSAS COALITION ON AGING
TESTIMONY IN SUPPORT OF HB 2226

My name is Mark Intermill. I am the Director of the Kansas Coalition on Aging. The Kansas Coalition on Aging is comprised of thirty organizational and a number of individual members. Our organizational policies require that we gain the unanimous consent of our members on an issue before we can support it. Consequently, we have a limited number of legislative priorities. However, over the years that I have been associated with KCOA, first as a board member and now as director, there has always been support for the establishment of a program of community based long term care.

Old age is a condition to which I aspire. If I am successful in my pursuit, I will attain the age of 85 in the year 2040. The Bureau of Census estimates that there will be six times as many 85-year-olds in 2040 as there were in 1980. In Kansas, the fastest growing age group between the years of 1970 and 1980 were persons over the age of 75. Despite the fact that this age group accounted for less than 5% of the state's population in 1970, they accounted for 18.4% of the state's population growth during the 1970s.

While most of our oldest residents live independently and are active in community affairs there is a significant portion of this age group that is in need of assistance. The Needs Assessment section of "Long Term Care Services of Older Kansans: A Comprehensive Plan", published in December, 1986 by the Kansas Departments of Aging, Social and Rehabilitation Services, and Health and Environment, projects that 14.8% of persons age 75-84 and nearly 40% of people 85 and older require some type of assistance in home management activities such as shopping, chores and meals.

The public policy question that we are here to discuss today is how should this population be served. We know that families provide a great deal of the long term care services provided. It is estimated that 80% of the long term care services are provided by families. Most of that care is provided by daughters and daughters-in-law. As women enter the work force, their availability as providers of familial long term care is interrupted. As our society becomes more mobile, and in Kansas, as young people move away from the communities where they grew up, the extended family becomes a less viable provider of care.

In order to effectively meet the growing need for long term care services, we must have a comprehensive and coordinated system of long term care. Such a system would include community services as well as those provided in adult care homes. We believe that the passage and the implementation of the provisions of HB 2226 will provide Kansas with the experience necessary to determine whether a program of coordinated community services is an efficient and effective means of providing long term care. The Kansas Coalition on Aging urges your support of this bill.

P&R
2-19-87
Attm. #5

Older Women's League
NATIONAL OFFICE
1325 G Street, N.W., Lower Level B, Washington, DC 20005
(202) 783-6686

Testimony Presented To

The House Public Health and Welfare Committee

Concerning HB 2226, or

Kansas Senior Independence Act

February 19, 1987

The problem of the enormous increase in the proportion of the elderly in our society is mind boggling. What to do with all these old people? What to do with us, because we are these people. Do we have the right to expect independence and dignity in our old age, with just a little bit of help or do we have to enter the group of indigent and then perhaps help will be available. Our old people are frail but not necessarily sick. They would live a happier life in their own homes.

But how do we manage this when money is so scarce? We cannot afford to just keep on pouring money into the same old services. We need some new answers. This is what we hope to secure with this bill.

We want legislators to make plans based upon facts secured through the operation of these three demonstration sites for a three year period.

We hope to find the following:

1. The demand for services.
2. The cost effectiveness to the state.
3. The effectiveness in enhancing the life style of our elderly.
4. The effectiveness of the sliding scale fee.

P&HW
2-19-87
Attm. #6

5. The abiltity to solve the problems that will come up right in the field under test operations.?

6. The data necessary to determine whether we should implement a similar program state wide?

We, in the Older Women's League, became interested a little over a year ago in bringing this issue before you.

We started having meetings of interested people from various groups. Those people were drawn from the Silver Haired Legislature, the Kansas Legislative Committee of AARP, the Kansas Coalition On Aging. In addition we had legislators, educators, nurses, and social workers. The people who worked out the bill were truly representative of all those who are concerned with the problems of the elderly.

We met sometimes in Topeka and sometimes at home. We worked out every detail of the plan but then we learned that a bill must be simple and that regulations would come later with the help of the in-home care projects council maybe better called the Kansas Elder Independence Council.

If you are rich, you can obtain services and pay for them. If you are poor you can often get services. If you are somewhere in between you are out of luck unless you 'spend down' until you are poor and then eligible for services. We hope that with this bill we can keep people from becoming poverty ridden, that we can help people retain their dignity by paying what they can afford to pay on the sliding scale fee plan. The time has come when we must begin to pay for services if we wish to retain them, at least pay something. We hope that in the long run this will be a saving to

ıe government.

We must stop thinking of the elderly as being sick and needing nursing care. Our elderly are fairly healthy. They are just frail and need a little help doing that which was so easy to do a few years before.

Is there anything else we can do but care for those who worked so hard to make our system work? The citizens of the state of Kansas are looking to its leadership to be responsible in providing a system allowing for human dignity throughout the entire span of life. We cannot just toss these human beings away. We don't know what to do, so lets give this demonstration project a trial and find out for sure what the problems and the successes are. Let's see some hard facts with this program.

Ralph Turner
S-308 Windsor Place
Lawrence, Kansas 66044
(913) 843-5875
February 19, 1987

Before the House Public Health and Welfare Committee.
H.B. 2226 - Establishment of demonstration projects for in-home care for senior citizens; establishing the in-home care demonstration projects council.

Members of the Committee - I am Ralph Turner, Delegate from Douglas County to the Kansas Silver Haired Legislature. I am currently, President of the Board of Directors of the Kansas Silver Haired Legislature. I appreciate having the opportunity to appear before this Committee and speak for H.B. 2226.

During the 1985 and 1986 sessions of the Kansas Silver Haired Legislature the number one priority of the legislature was the establishment of a comprehensive and coordinated community long term care system in the State of Kansas. In 1986 the bill pertaining to this issue was passed, Yes-115, no-3. In 1986 the bill passed 118-yes, no-0.

As stated previously the Silver Haried Legislature supports H.B. 2226. It is felt that projects will demonstrate the scope of the need for the program, the effectiveness of the program in enhancing senior citizens' life style, the cost effectiveness to the state of the program and the collection of data upon which future decisions can be based. This is the most economical approach to take at this time.

The population trends in Kansas and the United States indicate that, in the next three years, more people will attain old age than ever before. In the last decade the fastest growing age group in Kansas was that group of persons over the age of 75. In 1980, there were 132,852 Kansans over the age of 75, an increase of 21,069 over the 1970 population. Although they were only 4.9% of the population in 1970, this group accounted for 18.4% of the state's population growth during the decade. The needs of

PH&W
Attm # 7
2-19-87

persons in this group, particularly those who have difficulty performing activities "Frail Elderly" of daily living, vary considerably from those of younger age groups.

Because of soaring health-care costs, the elderly spend proportionately more out of pocket today on medicine than they did in 1965 when medicare began. With the population aging and demand for nursing home care increasing, more resources will be needed.

Of the private paying residents in nursing homes today, 70% will be added to the Medicaid rolls at some point in their life. One recent study found that 2 of 3 elderly Americans who live alone would run out of money after only 13 weeks in a nursing home. As this occurs, and as the state's population ages and nursing home rates increase, we can expect increased expenditures of state funds on nursing home care. Gerontologists estimate that as many as 70% of the persons who reside in nursing homes would not have to live there if adequate geriatric assessment services and community based long term care services were available. When given an option, most older persons faced with the need for long term care will choose to receive services in their own home rather than move into an institution. Community based care is a less expensive and more attractive option than institutionalization in many instances.

In the course of the volunteer work I do with the Lawrence Senior Center, I have occasion to go into the homes of older citizens and assist them in completing applicatoins for Low Income Energy Assistance. In all cases, the individual's sole income was Social Security and was less than $400.00 per month. With the assistance of Home-Delivered meals (one per day) and some home health care, they were getting along very well and stated so to me and far happier than if they were in a nursing home.

To me, the State of Kansas, is faced with a question of public policy regarding the provision of long term care for the state's most vulnerable residents. Will state support of long term care continue to be directed almost exclusively toward nursing homes? Or will Kansas policy makers respond to the desire of its older residents to continue to live in their own homes as well as recognize the reduced cost of providing supportive services in that setting?

There is a growing need for assistance to enable our citizens to retain their sense of worthiness and independence as they age. The time is now. The citizens of the State of Kansas are looking to its leadership to be responsible in providing a system allowing for human dignity throughout the entire span of life.

Attached to my written statement is a recent newspaper article that describes a project that is now going on in Missouri, that appears to function along the line that I believe is contemplated in H.B. 2226. I realize that you already have plenty to read, however, I feel this gives some idea that H.B. 2226 outlines a good approach to the problem. I know I speak for the Silver Haired Legislature and all other organizations that work with senior citizens, we hope the Committee will vote the bill out favorably.

THANK YOU.

"● Having them use their hip and back muscles, place weight on right arm and have them begin to lift by dragging the left arm, head and torso up to a sitting position

"● Now have them place both hands on the floor at their left side

"● Have them place their right foot flat on the floor in front of the right ankle

"● Now twist and lift, using the hip muscles so that they turn slightly to the left and rest on their left knee and right foot

"● Have them keep hands on the floor and bend the toes of the left foot under to grip the floor

"● Using the hip and leg muscles, have them push up, lifting buttocks up first

"● If the person needs assistance, stand behind, place arms around the chest and pull up while they are pushing up with arms and legs."

"In our own personal network, we have friends, neighbors, family, churchgoers. They (trainees) choose the people they would help. We emphasized to our trainees that they didn't have to know everything and they didn't have to be experts."

—Dr. Burton P. Halpert

Caregivers

continued from pg. 1-I

A section on incontinence offers help and hope. Good results have been achieved in teaching people how to regain continence. One task in this section is the series of exercises, directing step-by-step how to strengthen the bladder muscles. Neither equipment nor youthful vigor is needed.

Without diminishing the troubles of aging families or rural America, what is a marriage of academia and social work took place at a fortuituous time. Although the scrutiny for federal funds for anything is demanding, the project fitted both the Reagan administration's interest in self-sufficiency and using private volunteer groups. The Missouri pilot received a $91,000 federal grant from the Administration on Aging in 1983. In September, the AOA awarded the center another grant, this time for $150,000, to replicate the Missouri design across the country.

The base level of a roughly four-tiered pymamid will be made later this month at the workshops at the Westin Crown Center hotel: Teams will be trained for each of the participating states. Each will also make a preliminary plan for statewide dissemination. When they return home, they will select one or more rural demonstration counties to test the project by training a local team, thus plugging into the extension service, the volunteer homemakers council and the Area Agency on Aging. The county team prepares the third tier, 10 to 15 volunteer information providers (appropriately shortened to VIPs) from the homemaker clubs, and, finally, each of those volunteers makes contact with two caregivers. It's expected to be finished by October of next year, when teams and VIPs in each state will meet, discuss what they've done and see how it fits into preliminary plans. Follow-up workshops will be held next January in Kansas City in preparation for trainers to put the program into each county in their states.

The inspired stroke in the project is to get the training into the Cooperative Extension Services and affiliated National Extension Homemakers Council. With 32,000 clubs nationwide, the latter has half a million members, 50 percent of whom are women 60 years and older. Moreover, they have standing and validity in rural communities. When members tell friends there really is something that can be done about incontinence or high blood pressure, their friends will listen. And that's the first door which must be unlocked if ordinary men and women are to use the best information available about how to take care of aging family members at home.

There is no magic carpet to fly husbands or wives or children over the drudgery and sometimes misery of the difficult times of old age. There are some ways to handle it more easily than others. The UMKC Center on Aging Studies, having put them down on paper in plain English, is going to be instrumental in helping thousands pass them along to friends and neighbors.

Manual available

The self-teaching resource manual, *Information for Care Givers of the Elderly,* is available at the UMKC Center on Aging Studies for $7. The instructor's manual is also available for $10. The phone number of the center is 276-1747.

STAR FORUM

Sunday, January 11, 1987 Page 1

There's help for the helpers, too

By Jean Haley
a member of the editorial staff

Early in *Walden*, Henry David Thoreau reflected on the shackles of custom and observed that "The mass of men lead lives of quiet desperation." It's an apt description of the way a person often feels taking care of an aged relative.

Though the caregiver most likely will be a woman, gender has little to do with the frustration. The truth is that how to care for the elderly—bathing or medicating or communicating—is not an automatic skill, even for willing and loving children. But to a greater or lesser degree, someone in nearly every family eventually is going to have to do it. Right now, about 80 percent of all home health care given to the frail elderly is provided by family members.

In rural areas, reliance on the family necessarily is even more intense than in the city. Many services simply don't exist in the country and in small towns. Getting to what is available is not easy since there's no public transportation. And the rural tradition of self-reliance paired with isolation inhibits families from seeking outside help. Now the financial reverses and shuddering changes affecting rural life have given a new dimension to the migration of bankrupt farmers looking for work: Most are the middle-aged who are the traditional helpers that aging parents and grandparents turn to for a little help. What's left is a gaping hole.

With a new project, the Center for Aging Studies at the University of Missouri-Kansas City is breaking new ground to help spouses and others who tend the frail elderly. It teaches. It uses friends and neighbors to spread crucial information. And it's relatively cheap and easy.

Called the Volunteer Information Provider Program, it was tested in late 1984 and 1985 in rural Missouri. Its success astounded its modest creators, Dr. Burton P. Halpert, an educator and gerontologist, and Share Bane, a certified family therapist. The research associate for the center team is Tessa Sharp. Instead of the 126 caregivers they expected to leave behind in rural Missouri, there are now more than 1,000. Their 63 trainees passed on their newly acquired skills and knowledge to many more than the two persons each the educators had set as the goal.

One result of that test was a manual so readable the average lay person will feel good after studying it instead of more frustrated for being unable to understand silly jargon. There's also an instructor's manual.

Another result is that this month, the UMKC Center on Aging Studies will give this system to the rest of the country. Seminars will be held Jan. 19-22 and Jan. 26-29 for teams from 25 states and the District of Columbia. Seventy-seven people will be trained to use the manuals and learn how to train others to teach family caregivers. The goal is for it to work like a pyramid, as the Missouri pilot did on a small scale, with the seminar teams composed of representatives of the state aging department, Co-Operative Extension Services and the National Extension Homemakers Council. They'll go home and train others, who eventually will train volunteers who will reach more caregivers. Major elements are the ever-widening circle of trained volunteers, each of whom can reach many people in his or her own circle of friends and associates.

Halpert, recently honored by the Kansas City Regional Home Health Association for the innovative research/practical project, noted in an interview that the project does depend on volunteers but also it simply uses much that people already are familiar with. Its objectives are to reduce the stress families have in caring for their older adults and to capitalize on established community-based networks. He emphasized the informality of passing facts from trainees to caregivers.

"In our own personal network, we have friends, neighbors, family, churchgoers," Halpert explained. "They (trainees) choose the people they would help. We emphasized to our trainees that they didn't have to know everything and they didn't have to be experts.

"They could share the information in the home, during coffee at a restaurant, while walking down the street.

"There was a serendipitous aspect to it," he added. "A lot of those women had been out of school for 30, 40, 50 years. The fact that they would be able to survive three days of training, get all this expertise, they felt in greater control over their own lives.

"A number of them, right after we finished training, they experienced problems with family members; they began to use the information."

When Halpert and Bane refer to "caregiving," they don't necessarily mean nursing someone who's recovering from heart surgery or convalescing from a broken hip, although it may include such situations. More common, even normal, is the household where the elderly wife helps her impaired husband daily to get from room to room, oversees his medications, deals with his depression. Or it is the middle-aged daughter who acts as a daily "visiting nurse." Or the daughter-in-law who takes care of a nearly bedfast, though not ill, elder.

What's in the Center on Aging Studies training speaks to the entire continuum of caregiving, from occasional to full-time in residence. The fat manual looks at everything from facts of aging ("As a normal part of aging there are changes in the musculo-skeletal system . . . changes in the spine affect stability, balance and movement.") to how best to teach touchy friends.

You're a salesperson, the manual suggests. You need to know your "customer."

"Instead of saying: 'I have some information on stress relaxation I would like to share with you,' " the instruction manual advises, a person might try "I attended a workshop where I learned a quick and easy way to relax and lower my blood pressure. If you're interested, I would love to demonstrate it to you sometime."

Doing a thing makes a person more comfortable even with a simple task. Some are not simple in context. For example, what if Mary Smith gets home after grocery shopping to find her husband has fallen. He's not hurt. But he can't get up. He outweighs his wife by about 70 pounds.

Here's a sample of what she needs to know, and can learn from this project:

"If the older person has some strength and you think they can get up with assistance, the following technique is useful:

"● Have the person lie on his/her side (preferably left side)

"● Put their left arm under the side of the head, stretched straight upward; have them bend their knees

"● Place their right hand on the floor in front and a few inches away from their chest

See Caregivers, pg. 6-I, col. 4

Ron Harper

TESTIMONY ON H.B. 2226
TO THE
HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE
BY
KANSAS DEPARTMENT ON AGING
FEBRUARY 19, 1987

Bill Summary:

An Act providing for the establishment of demonstration projects for in-home care for senior citizens; establishing the in-home care demonstration projects council.

Bill Brief:

Funds three demonstration projects of in-home care for senior citizens, one in a small city, one in a mid-size city and one in a large city.

Requires each project to provide (1) homemaking, (2) home management, (3) simple personal care, (4) simple nursing, (5) transportation to and from health care providers, and (6) support for the primary caregiver.

Authorizes a sliding fee scale based on ability to pay.

Establishes a seven-member advisory council.

Testimony:

Home care has been a priority concern of aging advocates in Kansas for several years. The Older Kansans Senior Care Program, which was proposed in 1984, is still a popular idea in 1987.

The Kansas Department on Aging has assisted with several studies which evaluated the need for in-home services.

In 1978 the Department of Social and Rehabilitation Services, Department of Health and Environment, and Department on Aging collaborated on a study of home care services.

The number one recommendation of that study was a three year demonstration project:

> It will serve as a mechanism for coordinating services to the elderly in a comprehensive and easily utilized manner, while at the same time, provide valuable data on cost, service needs, delivery, and coordination upon which to base future health planning efforts for the increased elderly population in Kansas (p. 12).

The proposal used the Wisconsin Community Care Organization Project as a model. Wisconsin now has a statewide Community Options Program.

PHHW
2-19-87
attm. #8

In 1980, there was a cabinet level subcommittee on long term care. The Subcommittee was comprised of the Secretaries of the Departments of Aging, Health and Environment, Social and Rehabilitation Services and Transportation, in addition to the Director of the Division of the Budget and the Chancellor of the University of Kansas.

The Subcommittee on Long Term Care developed the State's initial Medicaid waiver proposal for the Home and Community Based Services (HCBS) Program.

In 1984, an analysis of services provided through the Home and Community Based Services Program found:

> The costs to Medicaid for HCBS services are significantly lower than the $606 average cost to Medicaid for intermediate care facilities.

In 1981, an interim Special Committee on Public Health and Welfare studied alternatives to nursing home services. The Committee reached the following conclusions:

> ...the development of alternative long-term care services is desirable. The Committee recognizes that a statewide system can not be developed at one time and believes that initiation of services at the local level through pilot programs would give the state an opportunity to evaluate such programs as they are developed.

Since 1981, the Plan for the Health of Kansans produced by the Statewide Health Coordinating Council, has included a chapter on long term care. The Statewide Health Coordinating Council analyzed existing services and found the following:

> Service gaps appear to exist in the long-term care continuum because few services, with the exception of intermediate nursing home care, are widely available across the state.

The Plan recommended that: "Long term care service gaps should be eliminated through the development or expansion of formal and informal care services."

In 1984, the Kansas Medical Society, Kansas Department of Health and Environment, Kansas Department on Aging, and Kansas Department of Social and Rehabilitation Services agreed to a Joint Position Statement on Long Term Care. That statement recommended:

> A continuum of long term care service should exist in Kansas communities so that there are alternatives to institutional care.

In 1986, the Kansas Legislature passed, at the initiative of this committee, a resolution (HCR 5052) which requested a comprehensive plan on long term care to be jointly developed by the Secretaries of Aging, Health and Environment, and Social and Rehabilitation Services. That study concluded:

> Kansas families need help to keep older disabled relatives out of nursing homes. Unavailability of services is the most common reason that requests for help are unfilled; and the reason services are unavailable is the lack of funding.

The study also found that existing gaps and barriers keep most people from getting the services which they need. The report states:

> Medicare home benefits cover only acute care, Medicaid home and community based services are limited by income and resource tests. Title XX homemaker services are underfunded and Older Americans Act funding for in-home services equals only 10% of the funding for homemakers.

The HCR 5052 study is the latest of several studies of long term care which can help this Committee make an informed decision on H.B. 2226.

One of the recommendations in the HCR 5052 plan may be important as you consider the cost of H.B. 2226. State dollars could go further if local matching funds were required. Every state dollar would ensure two dollars for the program assuming a 50% match.

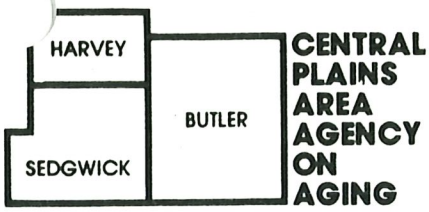
The requirement of local matching funds, either from fee income on a sliding scale basis from those being served or from local mill levies or other sources would enhance the local committment to ensuring successful demonstration projects. It also should be added that case management would be a necessary essential component of such demonstration projects.

Recommended Action:

The Kansas Department on Aging is willing to provide additional information in an effort to assist the Committee in its deliberations.

LD:mj
2/18/87

#9



Sedgwick County, Kansas
Department on Aging

Room 306

COUNTY COURTHOUSE, 510 N. MAIN • WICHITA, KANSAS • TELEPHONE (316) 268-7298
INFORMATION & ASSISTANCE (316) 268-7824

Testimony For HB2226

Good afternoon. My name is Irene Hart and I'm Director of the Sedgwick County Department on Aging. We not only administer aging mill levy funds in Sedgwick County, but also provide special assistance in casework, outreach, and case management; in information dissemination; and in the development of alternative housing models and shelter counseling.

In addition, we are the Central Plains Area Agency on Aging which covers Harvey, Sedgwick, and Butler Counties. The CPAAA is one of eleven Area Agencies on Aging in Kansas which operate in conjunction with the Kansas Department on Aging to develop a "continuum of care" in each community using all available resources. My problem today is to confine my remarks to HB2226 and not expound at length on the issues of community-based long term care.

To aid you in your consideration of this bill, I'd like to summarize our experience in three specific areas:

1) Developing the "continuum of care", or a range of services designed so that older people in need can easily access the service or program which best suits their situation at an affordable cost.

PH+W
atm. 9
2-19-1987

We have used Older Americans Act, state nutrition, United Way, county mill levy, foundations, fees, contributions, volunteers, and every other resource we could think of to develop a continuum of care targeting in particular the frail elderly. Since every funding source has its own constraints, we have worked with eligibility requirements based on age, income, functional status, location of residence, availability of family, availability of volunteers, ability to pay, and severity of need. We've learned about the need to establish a basic level of services, an expanded level of services, and the specialized set of services which assist frail elders in obtaining what they need to remain in dignity and safety in the least restrictive environment.

County mill levies have the greatest flexibility of all funding sources with which we've dealt. Programs, policies, and eligibility requirements are determined locally and services are designed to fit in the local community context. We have experimented with a variety of targeting or screening mechanisms to insure the most effective use of public funds; one avenue we pursued was the sliding fee scale subsidizing with mill levy the share not paid by the client. The following are some of the questions which must be answered in order to implement a sliding fee program:

1. Who sets the fee scale? How often is it adjusted?
2. Is gross income considered, or are deductions such as medical expenses allowed?
3. Are the categories broad and few, or narrow and many?

4. Who determines financial eligibility and payment?

5. Who bills the client, and who collects the money?

6. What if a client can't or won't pay their share? Is service terminated?

7. Is the unit cost the same in every location?

8. Which services are not amenable to unit costing or sliding fee scale?

9. Are private, not-for-profit providers allowed? Or, must the service be provided by the model project agency?

10. Who orders the level of service to be provided, such as the number of homemaker hours? The providing agency? The funding source? The client?

These questions can all be answered, but obviously indicate the need for a coherent and well-designed program. If an in-home services program is considered for implementation this year or in the longer term, it is crucial that planning staff be provided to KDOA so that the program is designed to be most effective and that quality answers be found to questions such as those outlined above.

2) Case Cocrdination Advisory Board (CCAB)

The CCAB has operated in Sedgwick County for the last four years. Its membership is composed of agencies and organizations

including the five area hospitals; public, private, and not-for-profit agencies; nursing homes; the Wichita Branch of the Medical School; and volunteers (membership list attached).

The CCAB formed for several reasons: to design and implement the set of services which assist frail elders in obtaining needed services; to identify gaps and barriers in basic and expanded direct services; and to try to coordinate the various and fragmented services for older people into a responsive, easily accessible community system. The Board is chaired by a United Way volunteer, and the Sedgwick County Department on Aging provides staff support.

The CCAB has undertaken many activities, such as establishing policies and procedures for community case management, developing a common assessment tool, and sponsoring routine community staffing meetings for multi-problem frail elderly, to mention only a few. In short, the CCAB has designed a system which "fits" Sedgwick County. We tried for years to get state agencies to coordinate at the State level, gave up, and did it locally with whatever discretion was available.

Based on our experience with the CCAB, there are two recommendations I would like to make:

A) Give the authority and responsibility for coordination of state funded aging services to <u>one</u> department (I'd recommend KDOA); and

B) move forward on the design and implementation of a statewide

in-home care program to take advantage of the county-based systems and while the local design process can still be affected.

3) HCR 5052 - Comprehensive Plan for Long-Term Care Services of Older Kansans.

The 1986 Legislature directed the Secretaries of Aging, SRS, and H & E to write a long-term care plan by the end of 1986. A committee was formed to develop the plan, which was finally approved by the secretaries and presented to the governor and Legislature. I was a member of this design committee.

The plan contains some useful information about the quantity and variety of aging services statewide. Hard data on the needs of frail elder Kansans was not available, because the information is kept in non-comparable forms. Some of the recommendations in the report are innovative, specific, and appropriate, but most are nebulous, probably to protect each department and its budget authority. The plan is a good example of a product in which everyone has responsibility and no one has authority.

Again, I recommend that one department be given responsibility, authority, and the resources to develop and coordinate a statewide system of in-home care for frail and vulnerable older Kansans. The issue has languished for ten years since KDOA was created. More Kansans are getting older and are living longer; they are out-living their families and their resources. It is time for leadership and to move forward to address this situation, which

will only increase in magnitude and severity.

In reference to HB 2226, I make the following specific recommendations:

1. KDOA should operate the program through its Area Agencies on Aging to maximize local planning, local resources, and to retain senior citizen input;

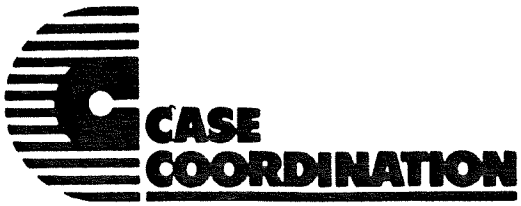
2. Sufficient planning staff should be added to KDOA to design and develop the program properly;

3. Standard definitions of services should be substituted for the ones specified in the bill;

4. The State Advisory Council on Aging could be substituted for the program advisory council so that the system woud not be further fragmented; and

5. Support should be maintained for the last dollar and sliding fee scale concepts.

Thank you for allowing me to testify before this committee and I'd be happy to answer any questions or provide additional information.



Sedgwick County Department on Aging

CASE COORDINATION ADVISORY BOARD

Senior Services, Inc.
KU School of Medicine
Sedgwick County Department on Aging
Central Plains Area Agency on Aging
Wichita / Sedgwick Community Health Department
State Department of Social & Rehabiliation Services
The American Red Cross
Prairie View, Inc
United Way Volunteer
Gerontology
Kansas Elks Training Center
Share-A-Home
Gray Panthers of Wichita
Catholic Social Services Inc.
Cerebral Palsy Research
Social Service and Admissions
The Lorraine Center
Edgerton Foundation
Independent Living Center
St. Joseph Medical Center
VA Medical Center
Wesley Medical Endowment Foundation
Kansas Guardianship Program
Senior Companion Program
Wichita Presbyterian Manor
Riverside Hospital
St. Francis Hospital
Hospice of Wichita
Kansas Masonic Home Health
Guadalupe Health Station
Mennonite Housing Rehabilitation Services

Suite 501 • 510 North Main • Wichita, Kansas 67203 • (316) 268-7824

AARP

1986-1987
KANSAS STATE LEGISLATIVE COMMITTEE

CHAIRMAN
Mr. James V. Behan
P.O. Box 339
110 Shone
Satanta, KS 67870
(316) 649-2960

VICE CHAIRMAN
Mr. Frank H. Lawler
9404 Wenonga Road
Leawood, KS 66206
(913) 648-0013

SECRETARY
Mr. Oscar M. Haugh
1512 University Drive
Lawrence, KS 66044
(913) 843-7613

Tuesday, February 17, 1987

Rep. Buehler Vice-

The ~~Hon. Edward C. Rolfs~~, Chairman &
Members of the House Committee on ~~Taxation~~ PH+W
Room 519-S, Capitol Building
Topeka, Kansas 66612

Subject: H.B. No. 2226

Mr. Chairman and Members of the Committee:

My name is Frank Lawler and I'm here representing the American Association of Retired Persons State Legislative Committee and approximately 311,000 AARP members in Kansas.

Attached hereto is a copy of AARP's "Kansas Facts for You to Remember--1987. Listed therein are the legislative priorities arrived at by the State Legislative Committee from surveys of 49 chapters statewide.

The second priority listed is for legislation to "Expand and coordinate community in-home services offering quality alternatives." Also, "Control and expand health care services for low income Kansans" Our Committee considers H.B. No. 2226, An Act providing for the establishment of demonstration projects for in-home care for senior citizens; establishing the in-home care demonstration projeccts counsel as the our recommended priority legislation.

The State Legislative Committee believes this bill is representative of our members across the state, and as evidenced by the wide sponsorship of the bill. In addition this bill has the support of the Legislative Committee of Overland Park, Kansas Chapter No. 2333 of which I am President.

PH+W
2-19-87
Attm. #10

The State Legislative Committee is familiar with the report titled "Long-Term Care Services of Older Kansans--A

Comprehensive Plan." We endorse that plan. Because there has been no specific bill introduced to implement the plan we feel HB 2226 is a step in harmony with the plan and merits our fullest support and recommendation for favprable action by your committee.

With nearly 450,000 elderly Kansans 60 years of age or over and representing 18 percent of our state population[1] and of which over 40,300 are within the poverty level,[2] then this bill is the most appropriate available and whose approval should not be delayed. The earlier this bill can become effective the sooner those in need of in-home services will have that option. The undesirable alternative would be to force upon any of the needy into the excessive and unnecessary cost of nursing home care.

With enactment of HB-2226 those elderly served by the pilot projects will be able to remain in their own home rather than be institutionalized which is the single greatest fear of the elderly relative to long-time care.

Having access to the appropriate in-home health care will enable the elderly needing such response to maintain their dignity and independence. Researchers are finding that being in control, and the desire for such control...among the elderly men and women living in a convalescent home made them happy, increased their alertness , and perhaps most dramatically lowered their mortality rate over a period of 18 months by 50% compared with residents of homes where they did not get the experience of increased control.[3] Martin Seligman of the University of Pennsylvania found that, "in general people come to feel hopeless and helpless when faced with traumatic events (such as having to leave their homes to enter nursing home care) and over which they have had little or no control."[4] Also, "the loss of control under extreem stress seems to trigger a physiological response that can lead to disease."[5]

Considering the budget crunch for 1988, the two obvious alternatives are to cut spending or raise taxes. Cutting costs will deprive hundreds, if not thousands, of a needed continuium of health care services. To raise taxes AARP recommends employing such progressive taxes as the income tax but not such re-

gressive taxes such as sales, property and excise taxes. The latter being particularly burdensome upon the elderly with shrinking fixed real income due to reductions in services, higher deductables and increased living costs.

One of the principal advantages for enactment of HB-2226 is the availability of data to be generated by the demonstration projects. It will be upon the development of dependable data from three projects that succeeding legislatures will be able to better determine their actions in providing long-term care services in succeeding years.

1. "Statistical Profile of Elderly in Kansas", American Association of Retired Persons, 1909 K St., Washington, DC.
2. Ibid.
3. Daniel Goleman, NY Times, "Feeling in control: key to mastering health", Kansas City Times Newspaper, Thursday, October 16, 1986, Page B-5.
4. Ibid.
5. Ibid.

Frank Lawler, Vice Chairman
Kansas State Legislative Committee
American Association of Retired Persons

COMMENTS SUPPORTING H.B. 2226
FOR KANSAS ELDER INDEPENDENCE

A couple of years ago as our Aging Commission tried to plan for the future, we were convinced that we would soon see a marked increase in need of in-home services for the elderly. We began at that time to warn our County Commissioners that we would need to emphasize services which would help our older citizens remain in their homes. We now know that we were right and that the need will continue to increase. To augment the federal and state funds we receive, we have had to go back to the Board of County Commissioners with requests for emergency funds for home delivered meals, and for additional staff persons, such as a care coordinator and a person to recruit and coordinate volunteers to deliver meals and shop for groceries for seniors.

So we support whole-heartedly the proposal presented in H.B. 2226, which would provide much needed information about extending in-home care in a cost effective manner. We look with anticipation to the help which the proposed pilot programs for in-home care could give us. The programs implemented could be of benefit to all the Area Agencies in the state. Our Area Agency could learn from Wichita or Topeka, should they be chosen as the large city project, and also from Phillipsburg or Baxter Springs or Kiowa, which might be the small community demonstration, which would be comparable to the small communities in Johnson County. These demonstration projects would provide all Area Agencies with new ideas and with definitive information about project costs. This would be a saving in funds and time to all concerned, no matter what their size or source of resources.

We understand only too well the financial constraints the Legislature is feeling. We would hope that you will

PHHCW
2-19-87
attm. #11

consider that the funds you allocate for these demonstration projects are an investment for the entire state which will result in eventual savings in caring for citizens of Kansas who don't want to go, don't need to go into nursing homes, if they have some help to remain in their homes. We also hope that you will not find it necessary to use funds which would otherwise be allocated for Nutrition programs and other Supportive Services for Kansas senior adults.

Marjorie Jantz

Marjorie Jantz
Prairie Village
Member: Jo. Co. Commission on Aging
Older Women's League
Ks. Advisory Council on Aging

KANSAS ASSOCIATION OF HOME HEALTH AGENCIES
2803 Claflin Rd. • Manhattan, Kansas 66502
(913) 537-0685

Kansas Association of Home Health Agencies Testimony on House Bill 2226

The Kansas Association of Home Health Agencies Testimony on House Bill 2226 supports the concept of in home service to senior citizens.

The number of elderly Kansans are growing rapidly and in the same respect the number of elderly Kansans entering the Welfare rolls are also increasing. In areas where needed in-home services are not provided, the people are forced to go into nursing homes for recuperation and support. Many of these people could have been seen at home at a significantly lower cost. And, even more significantly, people who do have moderate savings for their old age see it rapidly diminish due to the high cost of nursing home care --- care that is oftentimes more than what they require. With their savings gone, they find themselves forced to go on Welfare. One example is of an elderly 80-year-old lady who was unable to remember to care for herself. She could not remember to take her medication, she became poorly nourished and she did not keep herself clean. She had no children. Instead of entering the nursing home she had an RN to monitor her blood pressure and got a routine established so she'd take her meds. A home health aide got her hair unmatted and gave her a bath 3x/week. This lady was homebound but enjoyed her own modest, familiar surroundings and occasional visits from neighbors. We were able to help this lady stay in her home for 4 years. The cost of the home visits was $11,232 over the 4 years. The cost of a nursing home stay would have been $72,320. A savings of $61,088 for 1 person over 4 years.

The in-home service demonstration project will show:

1. The cost effectiveness of home delivery of services.
2. Significant savings to the State to subsidize one's care at home over total care of client because savings had been unduly depleted.
3. Provision of care for our elderly Kansans that meet their needs.
4. Allowing clients to remain in their own homes with additional help from their friends and family. Again a cost savings to the State.

We would like to recommend that when this bill is implemented, that consideration be given to the areas where agencies have begun implementation of such support services.

Thank you for your support,

Lydia Neu

Lydia Neu, Legislative Chairman
Kansas Association of Home Health Agencies

P&W
2-19-87
Attm. #12

KAHHA—The Heart of Home Health Care