Approved 1-25-89
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30/~~a.m.~~/p.m. on January 24, 1989 in room 423-S of the Capitol.

All members were present except:

Rep. Ben Foster, Excused

Committee staff present:

Emalene Correll, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Lee Graybeal, Independent Living Specialist, Topeka Resource Center for the Handicapped.
Elizabeth Taylor, Ks. Federation of Licensed Practical Nurses, Inc.
Representative Carol Sader

Printed testimony only from:-Michael Byington, Helen Keller National Center for Blind/Deaf
Marceil Lauppe, Douglas County Visiting Nurses Association
Judith Davis, Home Parenteral Services, K.City, Kansas
Darlene Hall, Home Health Services, Inc., Stormont-Vail
John F. Kelly, Executive Director, Ks. Planning Council on Developmental Disabilities Services

Chairman called meeting to order thanking all concerned for their patience on **HB 2012.**

HEARINGS CONTINUED ON HB 2012:

Lee Graybeal, Independent Living Resource Center, offered hand-out, (Attachment No. 1 and 1-A). Ms. Graybeal gave some background on her personal education. She learned at a very early age to self-direct her care. She has lived independently for 6 years and hires an attendant to give her personal care. Just a few years ago there were fewer restraints in regard to attendant care. SRS acted as payer, and now she has sympathy for the Department of SRS since she goes through that procedure herself. She does support **HB 2012**, feels it puts things back to the way she remembers it as it was and as it should be. She highlighted concerns, i.e., Lines 42,43, being independent means more than just living outside confines of an institutional setting. Lines 48-50, training should be done by the consumer she believes. Lines 74-78, reliable assessment and evaluation of consumer control program users. She feels as written **HB 2012** allows choices for the consumer. She noted this is a good start, and even though there are only 50 - 100 consumers currently, they feel more and more people will becoming self-reliant as they are given the opportunity. She read from Attachment 1-A in regard to Rules from Federal Register, then answered questions.

Elizabeth Taylor, Kansas Federation of Licensed Practical Nurses, Inc. offered hand-out. (Attachment No.2.) It is their position that no licensed procedures, either nursing or medical should be performed by those not duly trained and credentialed under existing state law to perform such procedures. Some say this is needed because of shortage of Registered Nurses, however, there is available a large number of competent and committed licensed Practical Nurses who have been put into other areas of care or even displaced out of health care field. In 1987 a special compromise was made to allow non-licensed personnel to function in nursing capacities for school children with special needs. Which groups will be recipients

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 /a.m./p.m. on January 24, 1989

HEARINGS CONTINUED ON HB 2012:Elizabeth Taylor continued:-

of unskilled care next? Currently, the nurse providing many of these nursing functions is the Licensed Practical Nurse under supervision of the Registered Nurse. Those physically handicapped who are capable of handling their own decisions, will find there are skilled, trained, and licensed personnel available to serve the needs of this population. The Licensed Practical Nurse works under the supervision of a Registered Nurse and can be hired to perform the nursing functions discussed in these hearings, at a reasonable cost, while still affording the consumer protection under the Nurse Practice Act.

She answered questions, i.e., the bill doesn't prohibit the Licensed Practical Nurse from operating under the direction of the RN's, it just says that anyone can, and that is what we disagree with; there are some medical tasks, we feel, should be performed only by trained nursing staff, not untrained personnel.

HEARINGS CONCLUDED ON HB 2012:

Chairman made comments in regard to **HB 2012**, i.e., hearings on this bill have been one of the most extensive held in this committee; the bill is very complex, and he said he had reviewed every piece of testimony trying to compile some basics. We are looking at, i.e., persons who have been screened and determined eligible and in need of Nursing Home Care; they can be given a choice of Home and Community Based Services, based on a regime of care provided. Careful consideration needs to be given to these needs, to regulations imposed on our State Agencies; the desires of the recipients who can be self directing in their care; evaluate the services as to medical and non-medical services.

Chair urged all members to review testimony presented these past four days. Policy set here, he said, could have far reaching ramifications. He said we will not discuss the bill yet this date, but will give members time to study it and come back tomorrow and discussion will begin on HB 2012.

Please note the following attachments were given as printed testimony, only, from persons unable to return after being scheduled and not heard.
Attachment No. 4, Michael Byington, Helen Keller Center for Deaf/Blind.
Attachment No. 5, Marceil Lauppe, Exec. Director, Douglas County Visiting Nurses Association.
Attachment No. 6, Judith A. Davis, Home Parenteral Services, KC, Ks.
Attachment No. 7, Darlene Hall, R.N., Home Health Services, Stormont-Vail
Attachment No. 8, John Kelly, Ks. Planning Council on Developmental Disabilities Services.

At this time Chair recognized Rep.Sader for a bill request. She noted this bill is the same in substance that she had introduced in 1988 Session and it will address the problem of abuse of the elderly in a residential setting. She noted there may be a companion bill introduced that will speak to the Institutional Setting on same concerns. She outlined the bill and urged for introduction of it. This is a growing problem, she said, and a quiet problem since the abuse is being committed by the care takers of the elderly. (See Attachment No.3, for details).

Rep. Branson made a motion to have the bill introduced and returned to this committee. Motion seconded by Rep. Wiard. Discussion ensued, i.e., fiscal note was of concern, and Rep. Sader noted she had been informed the investigative process could be done with staff already in place, so there should be no fiscal impact at all. Vote taken, motion carried.

Chair adjourned meeting at 2:15 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date Jan 24, 1989

Name	Organization	Address
KEITH G. ANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
[illegible]	SRS	600N Kansas
DON FOUND	SRS BUDGET	TOPEKA
Linda Lubensky	Ks. Home Care Assoc.	LAWRENCE
Janet Schalansky	SRS, Adult Serv	Topeka
DICK MORRISSEY	KDHE	TOPEKA
GREG LESSER	KDHE	TOPEKA
George Goebel	AARP Capital Area Task Force	Topeka
FRANCES KASTNER	Ks Physical Therapy Assn	Topeka
Catherine C Saal	SRS, Medical Programs	0508 6285
Terri Roberts	KSNA	Topeka
LaWanda Barnes	KSNA	Topeka

TOPEKA RESOURCE CENTER FOR THE HANDICAPPED

TOPEKA RESOURCE CENTER FOR THE HANDICAPPED

West Tenth Professional Building
1119 West Tenth, Suite 2
Topeka, Kansas 66604-1105

Telephone
913-233-6323

TESTIMONY IN SUPPORT OF HOUSE BILL NO. 2012,

by Lee Graybeal, Independent Living Specialist
Topeka Independent Living Resource Center, Inc.

I find House Bill No. 2012 to have very exciting possibilities. As the Interim Study found, the HCBS program was in need of providing options for those consumers able to be self-directed with their care. I believe the study was thorough and the bill was written with a good amount of insight into the problem.

Of course, no one in this room could argue with the fact that not every consumer of the HCBS program could or would even want to be responsible for their own self-directed care. These could include the frail/elderly, emotionally ill, or mentally confused. This bill does not address those persons.

This bill does address consumers much like myself: persons very much mentally aware to make day to day decisions with regards to their own personal care. This bill also addresses the notion that the severely disabled need more than a bath and hot meal to make them an active part of the community-at-large. You must consider what to expect after one eats.

The following areas addressed in House Bill No. 2012 will enhance the independence of consumers who have the desire to, and are screened as being capable of self-directed care:

(A) Lines 42-43. Being independent does not mean to just live outside the confines of an institution. Interacting and participating with friends and neighbors is a very important part of independence. Being unable to leave your own home because of problems with transportation or not returning correspondence due to an inability to hold a pencil, would be just as confining. This section recognizes that some consumers with more severe limitations may need assistance with such duties.

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(B) Lines 48-50. Training the person who will be there the most, the consumer, only makes sense. Taking this basic self awareness (encompassed in lines 47-48) away from consumers capable of understanding their own needs only enhances unnecessary dependence.

(C) Lines 74-78. In this way, I believe the PCA turnover rate will decrease. Finding a better match in the beginning should make for a better working relationship. Also, knowing that the consumer has the authority to both hire and fire encourages responsibility from the worker.

Advocating greater consumer control in this section of the HCBS program leaves a couple of areas of responsibility to SRS. One is the question of reliable assessment and evaluation of consumer control program users. The obvious answer to this would be a screening team comprised a of nurse, case manager, and I.L. Specialist. The other area of concern is that of consumer attendant management training and attendant orientation inservices. I believe that the best resources available to assist with these are the Independent Living Centers across Kansas. Many have pre-existing programs in place which cover a variety of things, such as: training programs for consumers on how to advertise, interview, train, time management, fire, etc of their PCA's; inservices for PCA's on the importance of communication, general job duty possibilities, attitudes, setting limits; and of course follow-up services for both. These programs are generally run by professionals who have overcome the pitfalls of attendant care management in their own lives. Who better to understand the problems and help find the solutions to both consumers and PCA's?

In conclusion, House Bill No. 2012 speaks of greater options for HCBS consumers willing and able to direct their own care. I believe this bill was not written as a mandatory sentence for all consumers and should not be construed as such. Amendments stating who will provide the screening and assessment, and who will provide training for consumers and inservices for attendants should clear up some present confusion. As a professional and private consumer I strongly support House Bill No. 2012.

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Proposed Regulations

In consideration of the foregoing, the Coast Guard proposes to amend Part 117 of Title 33, Code of Federal Regulations as follows:

PART 117--DRAWBRIDGE OPERATION REGULATIONS

1. The authority citation for Part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 49 CFR 1.46; 33 CFR 1.05-1(g).

2. In § 117.821, paragraph (b)(4) is revised as follows:

§ 117.821 Atlantic intracoastal waterway, Albemarle sound to Wrightsville Beach, North Carolina

* * * * *

(b) * * *

(4) S.R. 50 bridge, mile 260.7, at Surf City, NC, between 7:00 a.m. and 7:00 p.m., must open if signaled on the hour.

* * * * *

Dated: June 15, 1988.

A D. Breed,

Rear Admiral, U.S. Coast Guard, Commander, Fifth Coast Guard District.

[FR Doc. 88-14423 Filed 6-24-88; 8:45 am]

BILLING CODE 4910-14-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 440

[BERC-407-P]

Medicaid Program; Coverage of Personal Care Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to amend Medicaid regulations on personal care services furnished to a recipient. The regulations would clarify the types of services that may be covered, specify the supervisory requirements for personal care service attendants, and provide for review and reauthorization of the plan of treatment at certain intervals by the physician.

The proposed changes are intended to ensure consistency among States in coverage of personal care services and to improve program management at both the State and Federal levels.

DATE: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5:00 p.m. on August 26, 1988.

ADDRESS: Mail comments to the following address:

Health Care Financing Administration
Department of Health and Human Services
Attention: BERC-407-P
P.O. Box 26676
Baltimore, Maryland 21207

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building
200 Independence Ave., SW.
Washington, DC

or

Room 132, East High Rise Building
6325 Security Boulevard
Baltimore, Maryland.

In commenting, please refer to file code BERC-407-P.

Comments will be available for public inspection as they are received, beginning approximately three weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION CONTACT: Thomas Hoyer, (301) 966-4607.

SUPPLEMENTARY INFORMATION:

I. Background

A. General

Personal care services are noninstitutional, medically-oriented tasks of types discussed in section (C) below, that are necessitated by a recipient's physical or mental impairment. They primarily involve "hands-on" assistance with a recipient's physical dependency needs (as opposed to purely housekeeping requirements). These tasks performed in the recipient's home by a personal care attendant are similar to those that would normally be performed by a nurse's aide if the recipient were in a hospital or nursing home. The purpose of personal care is to accommodate the need for relatively unskilled maintenance or supportive nursing care furnished in the home.

B. Statute and Regulations

The Medicaid program funds a variety of medical and remedial services set forth in title XIX of the Social Security Act (the Act). In addition to the specific services authorized by sections 1905(a)(1) through (20) of the Act, section 1905(a)(21) permits the Secretary to specify other medical and remedial services as Medicaid-covered. Under this authority, the Secretary has included personal care sevices, as described in regulations at 42 CFR 440.170(f).

The regulations, however, define personal care services only in very general terms, and state that personal care services in a recipient's home means "services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is—

(1) Qualified to provide the services;

(2) Supervised by a registered nurse; and

(3) Not a member of the recipient's family.

A more specific personal care definition has for many years been included in Medicaid program guidelines. In order to clarify the regulations, we now propose essentially to incorporate the elements of the guidelines' more detailed personal care definition as part of the regulations themselves.

C. Current Policy

Currently, 22 States include this optional benefit in their Medicaid plans. Under current Medicaid policy (Medicaid Assistance Manual, section 5-140-00, "Personal Care Services in Recipient's Home", issued in 1979), personal care services are characterized as services that primarily involve direct patient care. This hands-on patient care can include activities such as assisting with administration of medications, eyedrops, and ointments as well as providing needed assistance or supervision with basic personal hygiene, eating, grooming, and toileting. It does not, however, include skilled services that are appropriately furnished only by a registered nurse, licensed practical nurse, therapist, or similar health professional.

While the primary function of the personal care attendant is to provide direct patient care, the attendant, under current policy, may also perform incidental household or chore services necessary to prevent or postpone institutionalization of the recipient. These services may include maintaining a safe and clean environment in areas of the home used by the recipient, for example, changing of bed linens, light housecleaning, rearranging furniture to assure that necessary supplies or medication are accessible to the recipient, and laundering essential to the comfort and cleanliness of the recipient. These services may also include services that ensure the recipient's nutritional needs are met, such as the attendant's assistance with meal preparation (which may include grocery shopping) and washing utensils used to prepare and serve the recipient's food during the attendant's visit.

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D. Program Experience

Existing longstanding guidelines in section 5-140-00 of the Medical Assistance Manual clearly state that under the personal care benefit, "[a]ny household tasks performed should be purely incidental to the patient's health care needs," and that homemaker services furnished in isolation "* * * are not reimbursable under title XIX * * * because they are not medical needs." Although these clarifying provisions appear in the interpretive guidelines, the language of the current regulation is more general. Most States have implemented personal care services in a manner that is consistent with the guidelines; however, some States have claimed FFP for services of a purely housekeeping nature. Therefore, in order to ensure appropriate attention to patient care, and to ensure that this benefit is consistently implemented in the manner that we intended, we are clarifying the regulations to apply the concepts contained in the longstanding interpretive guidelines.

We are also taking this opportunity to make certain additional clarifications in the personal care services definition that we believe are appropriate. For example, although the current regulations require personal care services to be "prescribed by a physician in accordance with the recipient's plan of treatment," they do not specifically address the need for reassessment of the recipient's plan of treatment by a physician once it is established. Thus, once a physician prescribes personal care services, the benefit conceivably could be available indefinitely and the services provided remain unchanged, even if the recipient's condition changes. In addition, the regulations require that services be provided by an individual who is "qualified," and who is "not a member of the recipient's family," but do not define these terms, which have been subject to varying interpretations. We believe that revisions are needed in the current regulations to clarify these elements of the personal care services definition.

II. Provisions of the Regulations

To address the problems discussed, we are proposing the following changes to the regulations:

A. Clarification of Types of Covered Services

We would amend the regulations to clarify the types of services that would be covered as personal care services. The regulations would specify that the personal care benefit can include incidental household and chore services, but only when they are furnished as an integral but subordinate part of a program of personal care furnished directly to the recipient (that is, the services are directly related to a recipient's medical needs and are furnished in conjunction with, but subordinate to, direct patient care).

Under the revised 42 CFR 440.170(f), personal care services would include those tasks directed at the recipient or his or her immediate environment that are medically-oriented (that is, direct patient care, as well as those household and chore services that are furnished as an integral but subordinate part of the personal care furnished directly to the recipient). The services may be furnished in the home (which does not include a hospital, skilled nursing facility (SNF), intermediate care facility (ICF), intermediate care facility for the mentally retarded (ICF/MR), or other institution as defined in 42 CFR 435.1009). Services also may be furnished in connection with occasional brief trips made outside the home for the purpose of enabling the recipient to receive medical examination or treatment on other than an inpatient basis, or for shopping to meet the recipient's health care or nutritional needs. The regulations have always described this benefit as personal care services "in the recipient's home"; therefore, we are limiting coverage to include only brief, occasional trips outside the home, in order to preserve the character of the benefit as primarily involving services furnished in the recipient's place of residence (as indicated previously, FFP is not available under this benefit for individuals who reside in institutional settings). (We note that in situations where the services provided predominantly involve extensive travel outside the home, the optional transportation benefit (42 CFR 440.170(a)(3)(iii)) permits coverage of the services of an attendant to accompany a recipient on travel needed to secure the recipient's medical examination or treatment).

Personal care services would not include skilled services that may be performed only by a health professional. In order to address the problem we have experienced under current regulations with respect to household chores, we would specify in the revised § 440.170(f) that household or chore services would be included when furnished as an integral but subordinate part of the personal care that is furnished directly to the recipient. Household or chore services would be considered an integral part of a recipient's personal care when the services are directly related to a condition or medical service reflected in the recipient's plan of treatment and are furnished in conjunction with a direct personal care service. We propose that household or chore services would be considered a subordinate part of a recipient's personal care if they account for no more than one third of the total time expended during a visit for personal care services delivery. We believe that such a time limit is necessary in order to express clearly in the regulations our intended characterization of personal care services as services that primarily involve direct patient care, and to facilitate application of this policy. However, we welcome comments on possible criteria that could ensure that household or chore services are covered as personal care services only when they are incidental to direct patient care. We note that services not meeting these requirements might be covered under Medicaid in the context of a home and community-based services waiver under section 1915 of the Act. More generally, these services are (and traditionally have been) covered under social services programs, including Title XX of the Act (Block Grants to States for Social Services), under which a State has the option to use Federal funds to provide funding for homemaker services.

B. Qualifications and Supervisory Requirements

The current requirement, under 42 CFR 440.170(f) that personal care services must be provided by an individual qualified to provide the services would be clarified to specify that the State will determine what, if any, qualifications the attendant must meet. The current definition simply says that services provided by a "member of the family" are not covered and does not specify who is included in the term. The revised regulation adopts the definition of an "immediate relative" used in Medicare regulations located at 42 CFR 405.315(a). Thus, the current term "member of the recipient's family" would be defined as: (1) Husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepbrother, and stepsister; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; (6) grandparent and grandchild. We invite comments on the use of this proposed definition in connection with personal care services, especially as to whether this definition

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may limit availability of the services in any geographic areas.

The current requirement for supervision by a registered nurse would be expanded to require a visit to the recipient at least once every 3 months in order to assess the recipient's health, the quality of personal care services received, and the recipient's need for continued care, and to review the recipient's plan of treatment.

However, this supervision requirement would at the same time be made more flexible, by allowing States to have the supervision performed by either a registered nurse or other licensed practitioner of the healing arts acting within the scope of practice as defined under State law. The latter category is one that is currently employed in Medicaid regulations regarding coverage of laboratory services (§ 440.30(a)), licensed practitioner services (§ 440,60(a)), diagnostic services (§ 440.130(a)), preventive services (§ 440.130(c)), and rehabilitative services (§ 440.130(d)).

C. Plan of Treatment

We would amend § 440.170(f) to provide for physician review and reauthorization of the recipient's plan of treatment and review of the medical records at least once every 6 months when the need for services continues beyond 6 months. (The physician would not be required to visit the recipient in order to perform the review and reauthorization. Compensation for the physician's services would be determined by the State.) We would also require that the personal care services that the recipient needs be included in the plan of treatment. These proposals would provide greater assurance that such care meets the recipient's needs and is furnished only to those who require it. This is the same type of requirement now in effect for institutional and home health services.

III. Regulatory Impact Analysis

Executive Order (E.O.) 12291 requires us to prepare and publish an initial regulatory impact analysis for a proposed rule that meets the criteria of a "major rule". A rule is major if its implementation would be likely to result in:

(1) An annual effect on the economy of $100 million or more;

(2) A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

(3) Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, we usually prepare and publish an initial regulatory flexibility analysis consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that the proposed rule would not have a significant economic impact on a substantial number of small entities.

This proposed rule would not have an annual effect on the economy of $100 million or more. However, only a few States account for most of the personal care service expenditures under Medicaid. We assume that this rule will have an effect primarily on those States and the providers of personal care services in those States. Further, although neither States nor the individual recipients receiving personal care services are small entities under the RFA, the providers of those services are. Although we do not believe that this proposal will have a significant impact on affected States and entities, we are voluntarily providing the following analysis, which, in combination with the preamble of this proposed rule, fulfills the objectives of E.O. 12291 and the RFA.

Generally, States with higher overall expenditures have more recipients receiving services. However, per capita expenditures also may vary significantly among States depending upon the State plan and operational definition of personal care services.

To the extent that personal care services are being claimed when direct patient care is not required, we expect that clarifying the definition of covered personal care services could save money in Federal Medicaid expenditures. In FY 1985, total Federal and State Medicaid expenditures for personal care services came to over $800 million. Costs and savings attributable to these regulatory changes are difficult to estimate with certainty, because we do not have detailed data on personal care expenditures and patient conditions from the 22 States that cover those services. Moreover, we cannot predict what changes States might make in their arrangements for services.

Requiring greater physician review of personal care services, as well as more frequent supervisory visits to recipients receiving those services, would result in additional Federal and State program expenditures that could at least partially offset the savings from more closely controlled coverage. We are unable to estimate these potential costs, because we do not have specific data on the number of recipients who receive personal care services, the periods over which those services are furnished, or the frequency with which visits currently are made. However, the number of these recipients could be quite large (possibly on the order of 300,000 at any given time). Thus, the additional expenditures could be substantial. This may, in part, be offset, however, by the increased termination of services that are no longer necessary, made possible by the increased level of physician review. An additional effect of increased physician review would be a potential for improved quality of care, by assuring greater consistency between services furnished and recipient need.

As noted earlier, States may consider the option of utilizing home and community-based services. Under a home and community-based services waiver, States have flexibility in defining services, subject to Federal approval, and provided that recipient health and safety are adequately protected.

Also, section 1102(b) of the Social Security Act requires the Secretary to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds located outside a metropolitan statistical area. We have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

IV. Information Collection Requirements

These proposed changes do not impose information collection requirements. Consequently, they need not be reviewed by the Executive Office of Management and Budget (EOMB) under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*).

V. Response to Comments

Because of the large number of comments we receive on proposed regulations, we cannot acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments received timely and respond to the major issues in the preamble to that rule.

List of Subjects in 42 CFR Part 440

Grant programs-health, Medicaid.

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C93
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42 CFR Chapter IV would be amended as set forth below:

Part 440 is amended as follows:

PART 440—SERVICES: GENERAL PROVISIONS

Subpart A is amended as follows:

1. The authority citation for Part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 440.170 is amended by revising paragraph (f) to read as follows:

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

* * * * *

(f) *Personal care services.* Unless defined differently by a State agency for purposes of a waiver granted under Part 441, Subpart G of this chapter, and except as specified in paragraph (f)(4) of this section, "personal care services" means medically-oriented tasks, directed at the recipient or the recipient's immediate environment, that are necessitated by his or her physical or mental condition. The following requirements apply:

(1) The services are prescribed by a physician in accordance with the recipient's plan of treatment and are included in that plan, and, when the need for the services continues beyond 6 months, the plan of treatment is reviewed and reauthorized by a physician at least once every 6 months.

(2) The services are furnished by an individual who—

(i) Meets any applicable qualifications for the provision of these services that the State chooses to establish;

(ii) Is not an immediate relative of the recipient, as defined in 42 CFR 405.315(a); and

(iii) Is under the supervision of a registered nurse (or other licensed practitioner of the healing arts acting within the scope of practice as defined under State law) who, at least once every 3 months—

(A) Visits the recipient to assess his or her health condition, the quality of personal care services received, and the need for continued care; and

(B) Reviews the recipient's plan of treatment.

(3) The services are furnished—

(i) In the recipient's home, which does not include a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, or other institution as defined in § 435.1009 of this Subchapter; or

(ii) In connection with occasional brief trips made outside the home for the purpose of enabling the recipient to receive medical examination or treatment on other than an inpatient basis, or for shopping to meet the recipient's health care or nutritional needs.

(4) "Personal care services" do not include—

(i) Skilled services that require professional medical training; or

(ii) Household or chore services, unless furnished as an integral but subordinate part of the personal care that is furnished directly to the recipient.

(5) For purposes of paragraph (f)(4)(ii) of this section, household or chore services are considered—

(i) An intergral part of a recipient's personal care if the services are directly related to a medical condition or service reflected in the recipient's plan of treatment, and are furnished in conjunction with direct patient care; and

(ii) A subordinate part of a recipient's personal care if the services account for no more than one-third of the total time expended during a visit for personal care services delivery.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: November 3, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: February 4, 1988.

Otis B. Bowen,

Secretary.

[FR Doc. 88-14374 Filed 6-24-88; 8:45 am]

BILLING CODE 4120-01-M

VETERANS ADMINISTRATION

48 CFR Parts 809, 810, 814, 816, 828, 852, and 870

Acquisition Regulations; Packaging Requirements; Estimated Quantities

AGENCY: Veterans Administration.

ACTION: Proposed regulations.

SUMMARY: The Veterans Administration (VA) is proposing to amend the Veterans Administration Acquisition Regulation (VAAR) to clarify the VA's right to repackage shipments at the contractor's cost should noncompliance with packaging requirements occur, and to allow contractors to bid for Department of Memorial Affairs annual monument requirements at less than 75 percent of the annual estimated quantity. These amendments will enhance competition and increase supply sources which should lower costs. This regulation also contains certain technical amendments to correct erroneous references, reflect new organizational titles, correct erroneous terminology and delete duplicative coverage already provided for in the Federal Acquisition Regulation (FAR).

DATES: Comments must be received on or before July 27, 1988. Comments will be available for public inspection until August 8, 1988.

ADDRESSES: Interested persons are invited to submit written comments, suggestions, or objections regarding these regulations to the Adminstrator of Veterans Affairs (271A), Veterans Administration, 810 Vermont Avenue, NW., Washington, DC 20420. All written comments received will be available for public inspection only in the Veterans Services Unit, Room 132 at the above address, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays), until August 8, 1988.

FOR FURTHER INFORMATION CONTACT: Marsha J. Grogan, Acquisition Policy Staff (93), Office of Acquisition and Materiel Management, (202) 233-3784.

SUPPLEMENTARY INFORMATION: The VA is proposing revision of two clauses in VAAR 852.210-76 and 852.216-70.

The clause at 852.210-76 is revised to clarify the VA's right to either reject or repackage shipments that do not comply with specified packaging requirements and charge the contractor for the actual cost of the repackaging.

A new paragraph is added to the estimated quantities clause at 852.216-70 to allow bids from contractors for less than 75 percent of the Department of Memorial Affairs annual requirements for monuments.

Executive Order 12291

Pursuant to the memorandum from the Director, Office of Management and Budget, to the Administrator, Office of Information and Regulatory Affairs, dated December 13, 1984, this final rule is exempt from sections 3 and 4 of Executive Order 12291.

Regulatory Flexibility Act (RFA)

Because this proposed regulation does not come within the term "rule" as defined in the RFA (5 U.S.C. 601(2)), it is not subject to the requirements of that act. In any case, this change will not have a significant impact on a substantial number of small entities because the provisions are primarily clarifications of existing procedures which will not significantly impact the private sector.

Paperwork Reduction Act

This proposed regulation requires no additional information collection or

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KANSAS FEDERATION OF LICENSED PRACTICAL NURSES, INC.
Affiliated with NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.
933 Kansas Avenue, Topeka, KS 66612 913-354-1605

January 23, 1989

TO: House Public Health and Welfare Committee
FR: Elizabeth E. Taylor, Legislative Consultant to KFLPN

RE: Opposition to HB 2012

Thank you for the opportunity to present the opinion of the Kansas Federation of Licensed Practical Nurses in opposition to the provisions of HB 2012. It is our strong position that no licensed procedures either nursing or medical should be performed by those not duly trained and credentialed under existing state law to perform such procedures. Further it is our fear that allowing this type of provision of health care to certain populations says to the public and to those groups that they do not deserve the same level of skilled health care provided to others.

Some might argue that these changes are needed due to the current nurse shortage. In contrast, there is a sizeable supply of available, competent, and committed Licensed Practical Nurses who have been transferred into other areas of health care service or displaced out of the health care field. While their basic preparation is not intended to prepare them to enter the critical care and specialty areas, on-site training, continuing education and years of experience have allowed them to be the appropriate care giver in the situations we are discussing today. These nurses are both duly trained and credentialed.

In this instance we are told that the basic philosophy is one of self-direction. For those physically handicapped who are capable of handling their own decisions, skilled, trained, and licensed personnel are available to serve the needs of this population. The Licensed Practical Nurse under the supervision of a Registered Nurse can be hired to knowledgably perform the nursing functions discussed in these hearings at a reasonable cost while still affording the consumer protection under the Nurse Practice Act.

During the 1987 Legislature KFLPN presented testimony both to the Public Health and Welfare Committees of the House and Senate and to the Kansas State Board of Nursing on allowing non-licensed personnel to function in nursing capacities for those school children with special needs. KSNA and others testified that this was a special compromise to keep these children in school and that this compromise would extend to this population only. Agreeing with the problem at hand, KFLPN still presented its opinion that this precedent was a poor one and unworkable in the long-range health care plan. We maintain that this still holds true. Today, however, we hear from the groups of physically handicapped capable of handling their own concerns that with even those medical procedures, decisions for hiring and training caregivers of this medical and nursing care should be left to them. Extending this "lower level of health care" even beyond the original compromise is unacceptable. Which special group will be placed into a category of unskilled care next?

Currently, the nurse providing many of these nursing functions is the Licensed Practical Nurse under supervision of the Registered Nurse. These valuable resources has provided this type of care throughout the last half century and today stands ready to continue in this capacity. Kansas licenses approximately 7,000 Licensed Practical Nurses. They should be utilized to provide the care for which they were trained rather than allowing untrained health care to be given.

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Speaks to Presidential Setting only!

9 RS 0432

HOUSE BILL NO. _____

By

AN ACT relating to abuse, neglect and exploitation of certain adults; requiring reports thereof by certain persons; directing investigations thereof by the department of social and rehabilitation services; directing other persons and public and private agencies to assist therein; providing for protective services; declaring certain acts to be unlawful and providing penalties therefor; repealing K.S.A. 39-1421 to 39-1429, inclusive.

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

Section 1. As used in this act:

(a) "Adult" means an individual 18 years of age or older alleged to be unable to protect their own interest and who is harmed, vulnerable to harm or threatened with harm through action or inaction by either another individual or through their own action or inaction. Such term shall include: any individual residing in their own home or residing in the home of another individual.

(b) "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, cruel punishment, omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm, anguish or illness.

(c) "Neglect" means the failure or omission by one's self, caretaker or another person to provide goods or services which are necessary to ensure safety and well-being and to avoid physical or mental harm, anguish or illness.

(d) "Exploitation" means taking unfair advantage of an adult's physical or financial resources for another individual's personal or financial advantage by the use of undue influence,

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coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.

(e) "Fiduciary abuse" means a situation in which any person who has the care or custody of, or who stands in a position of trust to, an elderly or dependent adult, takes, secretes, or appropriates their money or property, to any use or purpose not in the due and lawful execution of such person's trust.

(f) "In need of protective services" means that an adult is unable to provide for or obtain services which are necessary to maintain physical or mental health or both.

(g) "Services which are necessary to maintain physical or mental health or both" include, but are not limited to, the provision of medical care for physical and mental health needs, the relocation of an adult to a facility or institution able to offer such care, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from health and safety hazards, protection from maltreatment the result of which includes, but is not limited to, malnutrition, deprivation of necessities or physical punishment and transportation necessary to secure any of the above stated needs, except that this term shall not include taking such person into custody without consent except as provided in this act.

(h) "Protective services" means services provided by the state or other governmental agency or by private organizations or individuals which are necessary to prevent abuse, neglect or exploitation. Such protective services shall include, but shall not be limited to, evaluation of the need for services, assistance in obtaining appropriate social services, and assistance in securing medical and legal services.

(i) "Caretaker" means a person who has assumed the responsibility for an adult's care or financial management or both. Such assumption of responsibility may be voluntary, by contract or by order of a court of competent jurisdiction.

(j) "Secretary" means the secretary of social and rehabilitation services.

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(k) "Report" means a report of abuse, neglect or exploitation under this act.

(l) "Law enforcement" means the public office which is vested by law with the duty to maintain public order, make arrests for crimes, investigate criminal acts and file criminal charges, whether that duty extends to all crimes or is limited to specific crimes.

Pursuant to section 8, no person shall be considered to be abused, neglected or exploited or in need of protective services for the sole reason that such person relies upon spiritual means through prayer alone for treatment in accordance with the tenets and practices of a recognized church or religious denomination in lieu of medical treatment.

Sec. 2. (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, the chief administrative officer of a medical care facility, an adult care home administrator, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a law enforcement officer, a licensed podiatrist, a family counselor, a registered occupational therapist, a probation officer, a licensed home health agency, the executive director of an entity which provides homemaker services and an employee of a financial institution, who has reasonable cause to believe that an adult is being or has been abused, neglected or exploited, or is in a condition which is the result of such abuse, neglect or exploitation, or is in need of protective services shall report, within six hours from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. Other state agencies receiving reports that are to be referred to the department of social and rehabilitation services, shall submit the report to the department within six hours, during normal work days, of receiving the information. Reports shall be made to the department of social and rehabilitation services during the normal working week days and hours of operation. Reports shall

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be made to law enforcement agencies during the time social and rehabilitation services are not in operation. Law enforcement shall submit the report and appropriate information to the department of social and rehabilitation services on the first working day that social and rehabilitation services is in operation.

(b) The report made pursuant to subsection (a) shall contain the name and address of the person making the report and of the caretaker caring for the involved adult, the name and address of the involved adult (reported), information regarding the nature and extent of the abuse, neglect or exploitation, the name of the next of kin of the involved adult, if known, and any other information which the person making the report believes might be helpful in the investigation of the case and the protection of the involved adult.

(c) Any other person having reasonable cause to suspect or believe that an adult is being or has been abused, neglected or exploited, or is in a condition which is the result of such abuse or neglect or is in need of protective services may report such information to the department of social and rehabilitation services. Reports shall be made to law enforcement agencies during the time social and rehabilitation services are not in operation.

(d) Any person required to report information or cause a report of information to be made under subsection (a) who knowingly fails to make such report or cause such report not to be made shall be guilty of a class B misdemeanor.

Sec. 3. (a) Anyone participating in the making of any report pursuant to this act, or in any follow-up activity to or investigation of such report or any other report of abuse, neglect or exploitation of an adult or who testifies in any administrative or judicial proceeding arising from such report shall not be subject to any civil or criminal liability on account of such report, investigation or testimony, unless such person acted in bad faith or with malicious purpose.

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(b) No employer shall terminate the employment of, prevent or impair the practice or occupation of or impose any other sanction on any employee solely for the reason that such employee made or caused to be made a report, or cooperated with an investigation, under this act. A court, in addition to other damages and remedies, may assess reasonable attorney fees against an employer who has been found to have violated the provisions of this subsection.

Sec. 4. (a) The department of social and rehabilitation services upon receiving a report that an adult is being, or has been abused, neglected, or exploited, or is in a condition which is the result of such abuse, neglect or exploitation, or is in need of protective services, shall:

(1) Make a personal visit with the involved adult:

(A) Within 24 hours when the information from the reporter indicates imminent danger to the health or welfare of the involved adult;

(B) within three working days for all reports of suspected abuse, when the information from the reporter indicates no imminent danger;

(C) within five working days for all reports of neglect or exploitation when the information from the reporter indicates no presence of imminent danger.

(2) Complete, within two weeks of receiving a report, a thorough investigation and evaluation to determine the situation relative to the condition of the adult and what action and services, if any, are required. The evaluation shall include, but not be limited to, consultation with those individuals having knowledge of the facts of the particular case. When a criminal act has appeared to have occurred under K.S.A. 21-3401 to 21-3428, and amendments thereto, law enforcement shall be notified immediately and if the alleged perpetrator is licensed, registered or otherwise regulated by a state agency, such state agency also shall be notified immediately.

(3) Prepare, upon completion of the evaluation of each

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case, written findings which shall include a finding of whether there is or has been abuse, neglect or exploitation, recommended action, a determination of whether protective services are needed, and any follow-up.

Sec. 5. (a) The secretary of social and rehabilitation services shall maintain a statewide register of the reports received and the findings, evaluations and the actions recommended. The register shall be available for inspection by personnel of the department of social and rehabilitation services.

(b) Before any person is identified as a confirmed perpetrator of abuse, neglect or exploitation, the person will be given due process prior to having such person's name entered into the statewide registry.

(c) Neither the report nor the written evaluation findings shall be deemed a public record or be subject to the provisions of the open records act. The name of the person making the original report or any person mentioned in such report shall not be disclosed unless the person making the original report specifically requests or agrees in writing to such disclosure or unless a judicial proceeding results therefrom. No information contained in the statewide register shall be made available to the public in such a manner as to identify individuals except such information identifying the names of confirmed perpetrators may be disclosed to a caretaker.

Sec. 6. In performing the duties set forth in this act, the secretary of social and rehabilitation services may request the assistance of the staffs and resources of all appropriate state departments, agencies and commissions and may utilize any other public or private agencies, groups or individuals who are appropriate and who may be available. Law enforcement shall be contacted to assist the department of social and rehabilitation services when the information received on the report indicates that an adult, residing in such adult's own home or the home of another individual, is in a life threatening situation.

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Sec. 7. (a) Any person and public or private agency, including but not limited to hospitals, schools, attorneys, physicians and other social services agencies shall provide the department of social and rehabilitation services with the necessary records to assist in investigations.

(b) Any person, department or agency authorized to carry out the duties enumerated in this act shall have access to all relevant records.

Sec. 8. (a) If the secretary finds that an adult is in need of protective services, the secretary shall provide the necessary protective services if the adult consents. If the adult fails to consent and the secretary has reason to believe that the adult lacks capacity to consent, the secretary shall determine whether a petition for appointment of a guardian or conservator, or both, should be filed. The secretary may petition the district court for appointment of a guardian or conservator, or both, for an adult pursuant to the provisions of the act for obtaining a guardian or conservator, or both.

(b) If the caretaker of an adult who has consented to the receipt of reasonable and necessary protective services refuses to allow the provision of such services to the adult, the secretary may seek an injunction enjoining the caretaker from interfering with the provision of protective services to the adult. The petition in such action shall allege specific facts sufficient to show that the adult is in need of protective services and consents to their provision and that the caretaker refuses to allow the provision of such services. If the judge finds that the adult is in need of protective services and has been prevented by the caretaker from receiving such services, the judge shall issue an order enjoining the caretaker from interfering with the provision of protective services to the adult.

Sec. 9. If an adult does not consent to the receipt of reasonable and necessary protective services, or if such adult withdraws the consent, such services shall not be provided or

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continued, except that if the secretary has reason to believe that such adult lacks capacity to consent, the secretary may seek court authorization to provide necessary services, as provided in section 10 of this act.

Sec. 10. (a) If the secretary finds that an adult is being or has been abused, neglected or exploited or is in a condition which is the result of such abuse, neglect or exploitation and lacks consent to reasonable and necessary protective services, the secretary may petition the district court for appointment of a guardian or conservator, or both, for the adult pursuant to the provisions of the act for obtaining a guardian or conservator, or both, in order to obtain such consent.

(b) In any proceeding in district court pursuant to provisions of this act, the district court shall appoint an attorney to represent the adult if the adult is without other legal representation.

Sec. 11. Subsequent to the authorization for the provision of necessary protective services, the secretary shall initiate a review of each case within 45 days to determine where continuation of, or modification in, the services provided is warranted. A decision to continue the provision of such services shall comply with the consent provisions of this act. Reevaluations of the need for protective services shall be made not less than every six months thereafter.

Sec. 12. The authority of the secretary under this act shall include, but is not limited to, the right to initiate or otherwise take those actions necessary to assure the health, safety and welfare of an adult, subject to any specific requirements for individual consent of the adult. The secretary may establish a toll-free telephone number for the reporting of instances of abuse, neglect or exploitation under this act.

Sec. 13. Any actions taken under this act shall be consistent with providing protective services and accommodations in a manner no more restrictive of an individual's personal liberty and no more intrusive than necessary to achieve

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acceptable and treatment objectives.

Sec. 14. K.S.A. 39-1421 to 39-1429, inclusive, are hereby repealed.

Sec. 15. This act shall take effect and be in force from and after its publication in the statute book.

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1-24-9

January 18, 1989

Michael Byington, MA, RDT, O&M Inst.
Helen Keller National Center
for Deaf/Blind Youths and Adults
The Kansas Project
Services for the Blind
Biddle Building, First Floor
300 S. W. Oakley
Topeka, Kansas 66606

COMMENTS ON ATTENDANT CARE NEEDS OF DEAF/BLIND

RELATING TO HB 2012

One of the Objectives of the Helen Keller National Center Project in Kansas, in summary, is to provide consultation to improve services to deaf/blind individuals in the State so that they may live as independently as possible in their local communities. (Reference HKNC Grant Objective II, Activity "B") In the interest of this function, we are monitoring legislation such as HB 2012. This bill would clearly assist many Kansans who are both hearing impaired and visually impaired in living more independently and maintaining self-determination.

This is a permissive bill. It does not force anyone to participate in the system. It simply makes the option of self-directed attendant care assistance available to those who choose this option. The HKNC Kansas grant serves deaf/blind Kansans at all functional levels. Some of our clients, due to other disabilities in addition to deaf/blindness, would not be able to supervise those who are providing their assistance or care. Many people with whom we work, however, are individuals who possess all normal mental capabilities; they simply happen to have lost some or all of their hearing and vision at sometime during their lives. Obviously, if one loses both sight and hearing, one is going to need some special assistance which qualifies under HB 2012. Under the current system, however, if the individual happens to be poor and thus on Medicade, they have little control over the assistance provided.

For individuals who are severely disabled, whether that disability is deaf/blindness, quadriplegia, of any other condition, stimulation and interaction with the community is extremely important. Under the current medicade funded attendant care system, a disabled individual can not receive attendant care outside of his/her residence. If a severely disabled person

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should choose, for example, to eat in a restaurant, and if that individual happens to need assistance to accomplish this task, they can not ride to the restaurant with their attendant, and they can not use that attendant for services in that area. Currently, a disabled individual can send their attendant to the bank to do their business for them, but they can not legally have the attendant help them get there so they can do their own business. Thus, most certainly, the Interim Study Committee should be commended for including transportation services within the bill.

Currently, the result of Medicade funded attendant home care is that of forcing the severely disabled individual to be a prisoner in his/her own home. This bill begins to make some avenues away from this.

With reference to some of the concerns brought out by conferees on January 18, 1989, I shall offer a few responses.

The terms "supervision" and "training" were used rather interchangeably by a number of conferees. These two terms are certainly not the same. There is training which certainly might be provided by a nurse, physician, or other health professional. For people serving my clients, this training might include how to communicate through Rochester spell-in-palm or how to use a teletouch. For the person working with the spinal cord injured quadriplegic, the training might include the care of skin ulcers or proper lifting/pivoting techniques during transfers. None of this training, however, should remove supervision from its rightful owner, the consumer. The consumer must have the right to hire and fire. I would ask that Committee members place themselves for a moment in the position of the consumer. Suppose you suddenly became very severely disabled. Would you want to chose the person who helps you wash your genitals, helps you find tampons in the supermarket, or assists you in selecting hemroid medicine, or would you prefer that S.R.S. choose this person for you? Would you think you were the best judge of the help you needed, or would you want a nurse to tell you what you needed and when you needed it? Would you prefer to have help to go to the bank and do your own banking, or would you prefer to have someone go to the bank and do the banking for you? Under the current system, you do not have a choice. The only option currently available is the more restrictive one.

That brings us to the question of who should decide when a person is competent to manage their own affairs as opposed to when they should not have this option. To even ask this question is, in a sense to discriminate. It assumes that, because the person has become sensory or physically impaired, there is greater reason to assume they are not competent that, for example, those of you sitting on this Committee. If a legitimate question of competence for self-management does arise, however, let us not re-invent the wheel; there is already a system available for determination of such things, and that is the Kansas Guardianship laws.

Now certainly, if any of us suddenly became severely disabled, we would welcome an assessment team to advise us as to what we need in order to have appropriate care. I think we would draw the line, however, if we had to live with the recommendations of that team whether we like them or not. This bill does not preclude assessment, it simply leaves the control with the consumer, if that is the consumer's choice.

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As to the concern that this bill will result in situations such as untrained brick layers administering complex cancer treatments, there is nothing in this bill which requires Medicade recipients to abandon the way things are currently working. If nurse or physician training is necessary for a given procedure, then the nurse or physician will make this known to the individual. There is nothing in this bill to preclude such training from occurring.

In closing, I would ask you to consider that people who have lost hearing and sight, or the use of limbs, or the ability to move, have already lost quite a bit. These losses can be overcome, but they are still losses. Let us not continue to also force such people to give up dignity and self determination on top of what has already been lost.

cc. HKNC FILE

Attm #4
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1-24-9

TO: HOUSE COMMITTEE ON PUBLIC HEALTH & WELFARE

FROM: MARCEIL LAUPPE, RN
Executive Director
Douglas County Visiting Nurses Association, Inc.
336 Missouri, Lower Level
Lawrence, Kansas 66044

DATE: January 18, 1989

SUBJECT: HOUSE BILL 20-12

As a nurse working in home health care for 20 years, I have a strong committment to help all individuals maintain or attain the highest level of independence possible. I support the disabled population and agree a change in the nurse practice act is in order. However, I **can not** support this bill.

This bill states on line 28(b) and 33(a) that basic services shall include health maintenance activities. Health maintenance activities as defined in in section (d), beginning with line 46 has major problems.

Line 46 — The bill has no limit on activities, which is needed for public protection.

Line 49 — The training and supervision is a professional nursing role certainly not feasible or appropriate use of physicians' time or skills.

Line 49 — Training the individual performing a specific needed task or procedure is a must to assure competence. Second-hand instruction promotes many risks.

I am concerned that the bill seems to address all citizens regardless of competency, understanding or frailty.

I support a bill allowing a skilled professional nurse to teach specific tasks to caregivers, using her discretion that the caregiver can be taught to perform specific tasks or procedures efficiently and effectively, and then supervising that care given until in the nurses' professional judgment, the caregiver is competent to perform the care or procedure for the specific task.

PH+CW
attm #6
1-24-9

Judith A. Davis, R.N., M.N.
Home Parenteral Services
114 Abbie Avenue
Kansas City, Kansas 66103
(913) 371-5105

Testimony on HB2012 - Proposed Amendment to the Kansas Home Practice Act.

Chairman Littlejohn and members of the House Public Health and Welfare Committee,

I have been a registered nurse for almost 18 years. I have worked in a variety of health care settings from intensive care, to patient and professional education, to cardiovascular, to home care. I currently have nearly 6 years experience in home infusion therapies; and I want to thank you all for allowing time for me to speak with you today because the basic issue being discussed is one which is so important to me.

The issue, as I see it, is the availability of quality, affordable, long-term in-home care to all who need it; an issue that all nurses support.

Quality, affordable maintenance health care in the home or designated residence should be made available for all those who require these services to sustain a reasonable level of independence. If one looks at care plans of nursing students and rehabilitation nurses, one finds that the goal of nursing intervention is to help the client reach his/her optional functional level within the parameters of the disease process. Nurses are not opposed to patient independence; nurses are supporters of the same goals that the disabled in our state are seeking. However, the pathway toward reaching these goals is where the professional health care provider and these disabled in need of services diverge.

Keeping the aforementioned goals in mind, I would like to discuss "quality care".

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Our society as a whole and health-care professionals in specific have worked long and hard over the years to establish, legislate, and certify standards of quality health care to protect the infirm in our society. Nurses and physicians are licensed after passing entry-level quality standards of care testing protocols. Nurse-aids are certified by their employers after demonstrating quality standards of maintenance care. Furthermore, nurses and physicians are required to obtain a designated number of continuing education credits each 2-3 years to maintain competency to fulfill licensure requirements. On top of this, some nurses and physicians achieve even higher standards of care delivery by becoming certified in their specialities.

The Joint Commission on Health Care Organizations, nationally recognized for setting high standards of health care, has a voluntary certification program. Most home-health providers and services are eagerly pursuing the accreditation process voluntarily to further substantiate their commitment to quality home care services. All of our society's and health care professionals' quests for measurable and documentable standards of quality care will be nullified if HB2012 is allowed to pass as it stands, allowing unprofessionals, unskilled, and minimally trained persons to practice unregulated and unmonitored nursing care in the uncontrolled home environment for compensation. Allowing "PCA's" to be excluded from the Kansas State nurse practice act removes the last remnant of protection of our most vulnerable section of society against unethical, unskilled, self-serving and inappropriate purveyors of "care".

Yes, I did say self-serving. Already, in a reasonably controlled home health environment, abuses of the patient by unvested health care providers exists. I'm not addressing the hideous examples sited in the news media, such as a caregiver chopping up the patient with an ax. Those crimes are the "one-in-a-million." I'm referring to less obvious and unreported abuses such as: a private caregiver using a patient's credit cards for personal purchases; a private caregiver eating most of the food provided to the patient by his family, leaving a virtually starved patient; a private caregiver oversedating the client to keep her quiet so the caregiver could watch T.V. These examples of abuse (and there must be myriad untold examples) were found by licensed health care providers or by family members in time to prevent permanent damage to the patients. These abuses happen now, in a "controlled" home care environment. The potential for abuse is boundless if unscreened, unskilled, unregulated, and unmonitored "attendants" are allowed to perform nursing care activity without legislated limits and controls for the purpose of earning money.

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I will now address our current home health care environment. Home care has undergone vast changes in the last 5-10 years. These changes are due to the more complex patient needs that result from striving to dismiss patients earlier from hospitals and to keep them out of skilled facilities to save third-party payors' expenses. Many of these changes are long-awaited, good, and welcomed. however, the changes have created a "high-tech", specialized care environment never before seen in our country. This new environment requires assessment planning, teaching, monitoring, and evaluation by highly specialized health care providers with quality-control standards in place. Specifically I will now address my own specialty of home infusion therapy. you might say that my services will not be used by the disabled population; but the following facts will be enlightening:

a. 9,500 patients nationally are receiving TPN, (Total Parenteral Nutrition) (I.V. nutrition for those who connot absorb food) chronically.

b. 28,000 patients receive enteral nutrition (through a stomach tube) Many are end-stage cancer of totally disabled with strokes, ALS, MS, etc.

c. 95,000 patients receive I.V. antibiotics in the home. Many are those acquiring infections from chronic disability problems such as pneumonia, urinary tract infections, or bed sores.

d. 11,000 patients receive chemotherapy (for cancers). Many are elderly or partially disabled by their disease and require continuous care.

e. 12,000 patients receive infusible pain control for chronic pain associated with cancer and debilitating neuromuscular disorders.

f. In the Kansas City area in 1988;

   150 patients received TPN - chronically (or long-term)

   880 patients received antibiotics

   150 patients received chemotherapy

   100 patients received pain control

   300 patients received enteral nutrition

g. Infusion therapies are expected to grow 27.5% per year over the next 5 years.

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Most of these therapies until 5 years ago, were delivered in the hospital by specially trained nurses because there is a measured risk incurred upon delivery. To deliver these services chronically in the home by minimally trained attendants who are not assessed as to competency by an R.N.s, and who are not monitored by qualified R.N.s is to subject a significant number of patients to poor and dangerous care.

Yes, I do currently teach family members and close friends of patients to do the above therapies in the home. And this is why I'm willing to do it:

1. Family members and close friends have a "vested" interest "called love" in these patients that comes with quality care built in. A hired, unskilled provider's only interest may be collecting money from the patient. If documentation of quality and appropriate monitoring for consistency and compliancy is not required, incentive to perform well is low.

2. I am an RN experienced in patient education (I've even published in the area) patient assessment, monitoring, and evaluation. The patient and care giver are constantly assessed as to outcome of therapy, compliancy, and consistency in performance of care activities as mandated by the Joint Commission of Health Care Organization's standards.

3. I have a vested interest in the performance of my patients and caregivers in that the better they do, the better I look as a professional health care provider.

If the solution to the problem of providing long-term home maintenance caregivers at reasonable cost is to create "new categories of providers" (and I personally doubt that this solution is viable), these providers must, for quality and safety purposes be:

1. Screened by professional nurses as they will be giving care that is solely within the nurses realm,

2. Taught by nurses the appropriate nursing interventions to deliver maintenance care (a physician cannot teach nursing care),

3. Monitored and evaluated by nurses along with the patient to insure knowledge consistency, and compliancy in the delivery of care.

4. Tested as to their competency level to achieve some documentation of learning.

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5. Limited on their delivery of health maintenance activities to discourage abuse.

6. Legislated under the nurse practice act as a home care provider; not excluded from it.

The passage of HB2012 as it stands, in my opinion, will result in a watered-down care delivery system that at its best is mediocre. Because the goal of mediocrity is quickly and easily obtainable, and usually cheap in the short haul, it is a seductive solution to a challenging problem. We cannot allow ourselves to be seduced by a quick-fix solution. We are health-care providers and you as responsible legislators must insure a solution that maintains and promotes quality, home health care. We cannot legislate and relegate mediocre health care to those disabled in our society who certainly deserve better.

Again, I thank you Chairman Littlejohn and committee members for allowing the time for me to present my concerns. I welcome any questions you may have of me.

Respectfully,

Judy Davis, R.N., M.N

P.S. I must state this, or I will not be able to sleep at night! Creating "new categories of providers" is rarely a viable answer to problems encountered within professional services. Although the cost of each individual new provider would be less than existing providers, the broad and unlimited interpretations of these two proposals will create an unestimable number of "home care providers" throughout the state that, when added together, may present a staggering blow to the Kansas State Health Care funds. We may end up paying a very high price for a very low level of care throughout the state.

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In Summary:

1. Available quality affordable long-term, in-home care is a reasonable expectation.

2. Maintaining patient independence is deservable.

3. Regulated quality control of health care has been long sought after and should not be undone.

4. The disabled and infirm in our society must have safeguards against abuse.

5. Home health care environment has undergone vast changes and may now be quite advanced and "high tech" requiring highly skilled care providers.

6. High-tech therapies will be increasingly utilized by the chronically disabled population thus requiring a higher level of maintenance care.

7. Maintenance health care is within the nursing realm and providers of such should fall under the auspices of the Nursing Practice Art for quality control and safety.

8. We must not settle for mediocre home health care.

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1-18-9

Stormont-Vail
HOME HEALTH SERVICES, INC.

TO: HOUSE COMMITTEE ON PUBLIC HEALTH & WELFARE

FROM: DARLENE HALL, RN.

DATE: 1-18-89

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I COME BEFORE YOU TODAY AS THE DIRECTOR OF STORMONT-VAIL HOME HEALTH AGENCY AND A CONCERNED NURSE WHO HAS PRACTICED FOR 32 YEARS.

I ATTENDED THE 1988 LEGISLATIVE INTERIM STUDIES CONDUCTED THIS SUMMER THAT RESULTED IN THE INTRODUCTION OF HOUSE BILL 2012.

AS A NURSE, I ADVOCATE INDEPENDENCE AND HAVE GREAT EMPATHY WITH THE DESIRE OF THE DISABLED FOR THE DIGNITY PROVIDED THROUGH AUTONOMY AND CONTROL. LINES 46 THRU 50 OF HB 2012 ARE OF GRAVE CONCERN. THIS LANGUAGE WOULD ELIMINATE THE NEED FOR ANY ELEMENT OF JUDGEMENT BY A HEALTH CARE PROFESSIONAL IN THE SELECTION OF THE CARE GIVEN, THE APPROPRIATENESS OF THE TASKS, THE TRAINING FOR THOSE TASKS, AND THE ASSESSMENT OF CARE. SUCH A POLICY ALLOWS FOR POTENTIALLY ABUSIVE AND DETRIMENTAL SITUATIONS IN THE HOME SETTING.

WHAT MAY APPEAR TO BE A SIMPLE PROCEDURE IN THE HOSPITAL OR OFFICE OF A PHYSICIAN CAN TAKE ON A NEW HUE IN THE HOME SITUATION. ADAPTATIONS ARE OFTEN NECESSARY AND THEREFORE THE INVOLVEMENT OF A HEALTH CARE PROFESSIONAL IS IMPERATIVE.

PH&W
Attm #7
1-24-9

1000 SW 10th Street • Topeka, Kansas 66604-1104 • (913) 354-6946

THE KANSAS HOME CARE ASSOCIATION PROPOSES CERTAIN MODIFICATION TO THE NURSE PRACTICE ACT WHICH WOULD ALLOW THE RN TO DELEGATE NURSING TASKS TO A DESIGNATED UNLICENSED PERSON (WHO IS PAID FOR SERVICES RENDERED) IN THE HOME. THE PROPOSAL CALLS FOR A PHYSICIAN ORDER TO TEACH THE SPECIFIC CARE GIVING TASKS, THE CONCURRENCE WITH THE PHYSICIAN THAT THE TASKS CAN BE SAFELY PERFORMED BY THE UNLICENSED CARE GIVER AND DOCUMENTATION THAT THE PERSON HAS BEEN TRAINED TO PREFORM THE DELEGATED TASK. THE EVALUATION IS SPECIFIC TO THAT TASK AND THAT PATIENT ONLY.

IN MY OPINION, THIS IS A REASONABLE ALTERNATIVE TO THE ORIGINAL LANGUAGE OF HB 2012. IT HAS BEEN MY EXPERIENCE THAT EACH PATIENT PRESENTS WITH A UNIQUE SET OF PROBLEMS. THE PROPOSAL OF THE KANSAS HOME CARE ASSOCIATION STRENGTHENS HB 2012 BY INCORPORATING A QUALITY ASSURANCE MECHANISM INTO THE CONCEPT OF SELF DIRECTION AS A PROTECTION FOR THE PATIENT'S SAFETY AND WELFARE.

WE IN THE HEALTH CARE FIELD, AND ESPECIALLY THOSE OF US IN HOMECARE ARE COMMITTED TO MEETING THE NEEDS OF OUR PATIENTS WHILE MAINTAINING A HEIGHT LEVEL OF QUALITY. WE ARE READY TO MEET THE ENORMOUS CHALLENGE OF THE RAPIDLY GROWING DEMAND FOR LONG TERM CARE SERVICES.

WE MUST FIND INNOVATIVE SOLUTIONS WHILE PURSUING COST EFFECTIVE MANAGEMENT.

I URGE YOU TO CONSIDER THE QUALITY OF LONG TERM CARE WHEN CONSIDERING HOUSE BILL #2012. THANK YOU FOR YOUR CONSIDERATION.

Attm #7
2
1-24-9

KANSAS PLANNING COUNCIL on DEVELOPMENTAL DISABILITIES SERVICES

MIKE HAYDEN
Governor

JAMES BLUME
Chairperson

JOHN KELLY
Executive Director

Fifth Floor North
Docking State Office Building
Topeka, Kansas 66612-1570
VOICE-TDD
(913) 296-2608

Testimony for House Committee
on Public Health and Welfare
concerning
House Bill 2012
(Proposal Numbers 37 and 40)

On behalf of the Kansas Planning Council on Developmental Disabilities Services (KPCDDS), I wish to thank Chairperson Littlejohn and members of the House Committee on Public health and Welfare for this opportunity to lend our support to the philosophy of House Bill 2012.

The KPCDDS was created by K.S.A. 74-5501 in response to Federal Legislation. Our mission is to improve the quality of life, maximize the developmental potential, and assure the participation of persons with developmental disabilities in the privileges and freedoms available to all Kansans.

Due to advances in science and technology we now know how to prevent or lessen the rehabilitating effects associated with many disabilities. Thus, we can now eliminate some of the unnecessary stresses a disability may place on individuals and families. Adequate, affordable and reliable personal care assistance is one such stress which could be reduced through enactment of House Bill 2012.

House Bill 2012, clearly recognizes that not all persons with a severe disability require the level of in-home service traditionally delivered by medical-model personnel. That individuals with very severe disabilities are capable of providing self-direction to a personal care attendant so as to meet their own needs. We must all recognize that current regulations are in many instances denying and/or alienating some service recipients from the very programs designed to provide assistance. Individuals capable of self-directing their care must be allowed where appropriate to provide such direction to their attendant, in many instances the medical community as a whole has not prepared for the numbers of individuals in this category needing in-home services. Perhaps it is as it should be. Kansas nurses, a highly respected and academia minded profession should not waste their skills dressing, bathing and opening the mail for individuals with disabilities. As we face a national and state shortage for nurses it seems unthinkable to continue to request medical-model services be applied to individuals which clearly require a less medically-directed service.

Clearly, the time has come for the state to formally recognize the growing number of persons needing in-home attendant care referral that are not medically ill and who simply need some personal care

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1-24-9

intervention not currently available through the Department of Social and Rehabilitation Services.

To recap we suggest that you strongly endorse a recommendation which could discriminate between persons medically ill and those because of a disability are prevented from performing personal care needs; endorse recommendation that would not reduce funding to the medically ill to support less medically orientated services and provide for a statewide attendant referral system that persons who are not recipients of SRS services can access.

Thank you for the opportunity to present this information.

John F. Kelly
Executive Director
296-2608

January 23, 1989

Attm # 8
SB 2
1-24-9