Approved 1-31-91
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./p.m. on January 24, 1991 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Representative Bill Wisdom
John Alquest, Commissioner of Income Support & Medical Services, SRS
Kathryn Klassen, Director of Medical Services, SRS
Debra Ward RN, Support Systems International, Inc.
Vickie Weaver RN, International Association for Enterostomal Therapy Nursing
Jan Jester RN, CETN, Bethany Medical Center, KC,KS

Chairman Ehrlich called the meeting to order at 10:00 a.m.

Hearings were held on heavy care items - fluidized therapy beds. Representative Bill Wisdom appeared before the committee with concern regarding the possibility of funding being cut for therapeutic beds.

Commissioner John Alquest, SRS, presented position papers regarding coverage of therapeutic beds. The Division of Medical Services recently completed an intensive study of its policy regarding heavy care reimbursement for therapeutic beds. Three groups of professionals (medical, nursing and fiscal) reviewed program experience and relevant research and have unanimously recommended against coverage of these beds. (Attachments 1 and 2) Questions were asked by the chairman if SRS had a criteria that is asked of the patient and nursing home, and if therapeutic beds were prescribed by the physician. Mr. Alquest stated that the assessment of patients' need for beds and approval will be based on medical necessity criteria submitted.

Kathryn Klassen, SRS, briefed the committee regarding questions being asked nurses relating to the diet and care of patients. She felt the therapeutic bed itself was not a healing process, but the care of the patient was most essential. Ms. Klassen expressed concern that the nursing home should have a decision in recommending therapeutic beds to the patients. Question was asked by Senator Hayden regarding the psychological aspect of the patients when the bed is taken away.

Debra Ward of Support Systems International, Inc. presented her statement to the committee and spoke in support of therapeutic beds. Questions were asked regarding the cost of these beds, and an estimated cost of $20,000 was stated. (Attachment 3)

Vickie Weaver RN, K.U. Medical Center and Jan Jester RN, CETN, Bethany Medical Center in Kansas City, Kansas, presented their statements in support of therapeutic beds. (Attachments 4 and 5)

The chairman commented about the need of the committee to inspect a therapeutic bed and a possibility of setting up such a demonstration in the statehouse.

No further discussion was held, and the meeting was adjourned at 11:00 a.m.

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

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 1-24-91

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Jan Jester RN, CETN	Bethany Medical Center
Vickie Weaver RN, CETN	University of Kansas Med center
Laura Severance	Intern - Rep. Carol Sader
Diane Oxford, RN	Kinetic Concepts
Elizabeth [illegible] RN, BSN	Kinetic Concepts
Rep. Bill Wisdom	Kansas House of Rep.
[illegible] Ward	Support Systems Inter.
Christie Bockman	Support Systems Inter.
Judy Williams	Support Systems Inter.
Mike Reilly	Support Systems Int'l
Stephen [illegible]	Support Systems Int.
Katie Klassen	SRS
Sharon Mulgrew	Topeka Convalescent Center
Susan [illegible] RN	Support Systems International
Vera [illegible]	Medicalodge North
Bobbie Jenkins	Medicalodge North
Cheri Curtis	St Josephs Care Center
[illegible]	St. Joseph Care Center
Jo Klausman	
HAROLD PITTS	KCOA

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 1-24-91

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
[illegible] Foster 711 Garfield, Topeka	Hillhaven Corporation
John Alquist	SRS
Jan Hummel RN 711 Garfield Topeka 06	Hillhaven of Topeka
Garry Swords 1010 E Street Tonganoxie, KS	Tonganoxie Nursing Center
Marilyn Bradt	KINH
Ken Bahr Topeka	Ks. Hospital Assn.
Sherri Holliday	Budget Division
Dick Hummel	Topeka
M. Hauver	Cap-Journal
FRANCES KASTNER	Ks Physical Therapy Assn

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Robert C. Harder, Acting Secretary
Division of Medical Services

Position Paper Regarding Coverage of Therapeutic Beds

The Division of Medical Services recently completed an intensive study of its policy regarding heavy care reimbursement for therapeutic beds. Three groups of professionals (medical, nursing, and fiscal) reviewed program experience and relevant research and have unanimously recommended against coverage of these beds. It is anticipated that approval will be a rare event. Attached is a list of issues for providers to address when seeking prior approval from Medicaid for coverage of this service.

Program Experience

Difficulties staff have encountered with this coverage in the past included the following. Documentation of medical necessity and progress were inadequate. Validity of information received was a problem. Issues such as prognosis, rehabilitation potential and activities of daily living, including ability to turn, were not adequately addressed. Some patients were left on beds for over a year with little (if any) progress, and occasionally deterioration. In some of these situations nutritional status was so compromised that it was not likely that healing could take place under the best of circumstances. Scarce Medicaid dollars were, therefore, wasted on beds. Beds appeared to be improperly used by nursing facility staff which raised the question of the quality of training they received from bed company personnel. Inappropriate requests were made for beds to treat wounds laden with eschar (scabs not debrided/removed, as they should be before a bed is used) and small wounds of the extremities. It was our experience that bed companies were difficult to reach by phone (all use paging systems). It was felt that responsiveness was critical to working with and training nursing facility staff.

It was our expectation that bed company personnel would function as case managers interested in more than placement of a bed under a patient. This would involve advocacy for the patient to secure the best wound treatment plan, nursing care, and dietary intake. It was our expectation that these wound experts would be holistic in their approach and be knowledgeable regarding the factors that impact on wound healing and the status of each patient with respect to these factors. It was expected that there would be an aggressive effort to work with and train nursing facility staff, and that requests would be judicious and made with a sense of responsibility regarding scarce Kansas Medicaid health care dollars. It is disappointing that our expectations were not met.

Research

Research articles submitted in support of coverage of special beds was unconvincing. The underlying assumption that the beds were a critical factor in healing was not supported. It was not clear that beds needed to be a part of the healing process.

Senate P H&W
Attachment #1
01-24-91

Cost

Cost was a relevant issue. Bed companies were charging $100 to $150 per day ($3,000 to $4,500 per Medicaid recipient per month) until quite recently when the maximum allowable was reduced to $65/$95 per day ($1,950 to $2,850 per Medicaid recipient per month) depending on bed type. A further reduction to $28 is proposed. This is about what Ohio Medicaid pays. In the recent past, approximately 65 patients were on these beds at any given time. This represents an annual expenditure of ($65 X 65 X 360) $1,521,000 for a therapy we are not convinced is effective. From July through December 1990, $684,313.42 was paid for beds. From July through December 1990, $851,709 was paid for beds.

Conclusion

Adequate nutrition, good nursing and wound care accomplish the goal of wound healing far more cost-effectively if healing is possible. When healing is not possible, medical ethicists recommend humane care rather than a costly high-technology approach.

Recommendations

Restrict coverage of beds by Medicaid. Encourage assessment of patients' need for beds and approval will be based on medical necessity criteria submitted.

1/23/91
JWA

ɛctronic Data Systems Corporation
ᴾ. O. Box 4649
Topeka, Kansas 66604
(913) 273-5700

Heavy Care Provider-Bed

Bed Request Issues To Address:

Type of bed requested

Date Pressure Sore(s) Identified

Patient Location at the time of pressure sore identification

Number of days Medicare has reimbursed for bed

Number of days any other payor has reimbursed for bed

Date bed first placed (regardless of payor)

Medical condition: diagnoses, ability to turn, calorie and protein intake per day, albumin level, prognosis, rehabilitation potential, activities of daily living.

Wound treatment plan in detail

Wound description: location, length x width x depth, photo, Marion classification/color, drainage, odor undermining, stage

Step down plan

Teaching plan for staff at this facility: time, frequency, content

THANK YOU.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Robert C. Harder, Acting Secretary
Division of Medical Services

Position Paper Regarding Coverage of Heavy Care

The Division of Medical Services recently completed an intensive study of its policies regarding heavy care reimbursement for **private rooms, extra nursing care and supplies,** and **head injury care.** Three groups of professionals (medical, nursing and fiscal) reviewed program experience and relevant research and have unanimously recommended against coverage. A separate position paper regarding coverage of therapeutic beds has been prepared.

Program Experience

Additional reimbursements (above and beyond the per diem rate) were requested for **private rooms** for the following reasons: behavioral, typically the resident's inability to get along with a roommate (58%); space for equipment (13%); personal reasons, such as the resident's wishing or needing a private room (8%); psychiatric illness, such as schizophrenia (7%); wound isolation (7%); no reason given (6%). In very few instances was a private room medically necessary.

Additional reimbursements (above and beyond the per diem rate) were requested for **extra nursing care and supplies** for the following reasons: behavior management, using a hoyer lift, turning patients, tube feeding patients, caring for ventilator-dependent individuals, terminal cancer care, unspecified care, bed-to-chair transfers, dialysis, tracheostomy care and dressing changes. Most of these activities are routine and expected care delivered in an adult care home.

Additional reimbursements (above and beyond the per diem rate) were requested for **head injury care.** Many requests did not meet best practice standards because injuries had occurred as long as 40 years ago; some residents were in vegetative states; several did not have head injury diagnoses; and many had primarily psychiatric or behavioral problems.

Cost

$496,333 was spent above and beyond the per diem rate for adult care homes in the period 7-1-89 to 6-30-90 for **private rooms**.

$86,367.47 was spent above and beyond the per diem rate for adult care homes in the period 7-1-89 to 6-30-90 for **extra nursing care and supplies**.

$655,418.70 was spent above and beyond the per diem rate for adult care homes/swing beds in the period 7-1-89 to 6-30-90 for **head injury care**.

Conclusion

Most of the expenditures for private rooms, extra nursing care and supplies, and head-injured care were unnecessary (not medically indicated) and should be avoided in the future. Medicaid necessity should be determined by the facility director of nursing and physician, and care provided as appropriate.

Recommendations

In rare instances when a **private room** is medically necessary, the facility can provide this and reflect the expense in the cost report.

In the infrequent event that a resident requires **extra nursing care and supplies** clearly beyond the range of normal experience in adult care homes, the facility can provide these and reflect the expense in the cost report.

Appropriately credentialed facilities such as specialty hospitals, which can provide rehabilitation for six months and require weekly reviews for appropriateness of stay, should be utilized when inpatient stays are needed for **head injury care.** Otherwise, and most commonly, community-based services should be utilized (physical, occupational and speech therapies through outpatient hospitals or home health agencies). A head injury waiver will soon be available to identify individuals eligible for a variety of services (in a variety of settings) the waiver will cover. A Medicaid recipient can access these services through referral by a physician, discharge planner or other appropriate professional.

Nursing facilities will gain the advantages of control over decisions regarding best patient care practices, control over the delivery of cost-effective care, and the ability to build a per diem rate more reflective of the true cost of care through the cost report process.

1/23/91
JWA

..S HEAVY CARE EXPENDI..RES

ITEM	FY 1990 ACTUAL	FY 1991 BUDGETED	FY 1991 YEAR TO DATE *
Private Room	$496,333	$500,000	$470,000
Therapeutic Beds	$684,313	$675,000	$850,000
Head Injury Rehabilitation	$655,419	$650,000	$600,000
Crisis Stabilization	$48,803	$50,000	$25,000
Extra Nursing Care	$86,367	$90,000	$40,000
Dental: ICR–MR	$34,195	$35,000	$20,000
TOTAL COSTS	$2,005,430	$2,000,000	$2,005,000

* Fiscal Agent uses only one code for "Heavy Care" : therefore, individual item costs for FY 1991 are estimates only.

SOURCE: MEDICAL FISCAL UNIT CSS 1–23–91

A PREPARED STATEMENT TO THE PUBLIC HEALTH AND WELFARE COMMITTEE OF THE KANSAS SENATE DELIVERED BY DEBRA J. WARD OF SUPPORT SYSTEMS INTERNATIONAL, INC. THURSDAY, JANUARY 24, 1991.

GOOD MORNING. MY NAME IS DEBRA WARD. I AM A REGISTERED NURSE WITH 26 YEARS OF NURSING EXPERIENCE AND FOR 7 YEARS I PRACTICED IN THE NURSING FACILITY SETTING. I AM ALSO A FIELD MANAGER FOR SUPPORT SYSTEMS INTERNATIONAL, INC.

LADIES AND GENTLEMEN: TODAY THE UNITED STATES HEALTH CARE DELIVERY SYSTEM IS FACING THE DIFFICULT CHALLENGE OF CARING FOR PATIENTS INFLICTED WITH PRESSURE SORES. AND, NOWHERE IS THIS PROBLEM MORE EVIDENT THAN IN OUR NATION'S NURSING FACILITIES.

NURSING FACILITY RESIDENTS COMPRISE THE LARGEST GROUP OF PATIENTS WHO ARE AT-RISK OF DEVELOPING SEVERE PRESSURE SORES[1,2]. IN RECOGNITION OF THIS PROBLEM, THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA '87) AND ITS IMPLEMENTING REGULATIONS PLACE A SIGNIFICANT EMPHASIS ON THE NEED FOR MEDICARE AND MEDICAID FACILITIES TO ENSURE THAT NECESSARY DECUBITUS CARE TREATMENT AND SERVICES ARE AVAILABLE FOR THEIR RESIDENTS (42 C. F. R. S.483.25 (C)).

THIS SIGNIFICANT PATIENT CARE ISSUE WILL ONLY CONTINUE TO GROW AS LEFE EXPECTANCY INCREASES AND THE POPULATION AGES. KANSAS CLEARLY SHOULD HAVE CONCERN FOR THIS ISSUE. ACCORDING TO THE U.S.

CENSUS BUREAU (1986), WE RANKED #12 IN THE COUNTRY IN PERCENTAGE OF POPULATION AGE 65 AND OVER, AND FOUR OTHER STATES IN THE TOP 12 CAME FROM THE MIDWEST REGION. IN A 1986 NATIONAL HOSPITAL DISCHARGE SURVEY, THE MIDWEST REGION RANKED SECOND ONLY TO THE SOUTHERN REGION FOR CASES WITH THE FIRST-LISTED, ALL-LISTED DIAGNOSIS AND TOTAL DAYS OF CARE OF PRESSURE SORE PATIENTS.

FOR AN INDIVIDUAL, THE DEVELOPMENT OF A PRESSURE SORE MEANS A FOURFOLD INCREASE IN THE RISK OF DEATH AND FAILURE OF THAT SORE TO HEAL INCREASES THE DEATH RATE TO SIX TIMES HIGHER. SOME OF THE MORE COMMON COMPLICATIONS OF PRESSURE SORES CAN LEAD TO SEPSIS WITH A MORTALITY RATE APPROACHING 50%[IBID]. AS POLICY MAKERS AND HEALTH CARE PROVIDERS, WE CANNOT IGNORE THE IMPACT THESE STATISTICS HAVE ON QUALITY OF LIFE AND HUMAN SUFFERING FOR KANSAS RESIDENTS.

TODAY, I HAVE SOME DATA WITH ME THAT INDICATES THAT PRIOR TO THE OCTOBER 1ST REORGANIZATION WITHIN SRS THAT ELIMINATED THE LONG TERM CARE DEPARTMENT, THE STATE OF KANSAS WAS MOVING IN THE CORRECT DIRECTION TO ADDRESS THE PRESSURE SORE PROBLEM. PRESSURE SORES ARE USUALLY STAGED ACCORDING TO THE CLASSIFICATION SYSTEM ESTABLISHED BY THE INTERNATIONAL ASSOCIATION OF ENTERSTOMAL THERAPISTS (THE IAET) WITH STAGE 1 REPRESENTING THE LEAST DAMAGE TO THE TISSUES THROUGH STAGE 4 INVOLVING DAMAGE TO MUSCLE AND POSSIBLY BONE. STAGES I AND II ARE THE MOST COST- AND TIME-EFFECTIVE POINTS AT WHICH TO INTERVENE, YET OUR FEDERAL AND MOST

STATE PROGRAMS DO NOT REIMBURSE FOR CLINICALLY EFFECTIVE INTERVENTION UNTIL THE SORE REACHES STAGE III. THEREFORE, OUR HEALTH CARE PROVIDERS ARE FORCED TO USE INEFFECTIVE METHODS, SUCH AS TURNING SCHEDULES AND EGGCRATE, IN AN EFFORT TO MINIMIZE THE DAMAGE TO ALREADY COMPROMISED TISSUES.

AS A COMPANY, SUPPORT SYSTEMS INTERNATIONAL, INC., (SSI) COLLECTS DATA ON ALL NURSING FACILITY PATIENTS PLACED ON OUR THERAPY UNITS.

FOR THE PERIOD OF MARCH '90 THROUGH DECEMBER '90, OUR NATIONAL DATA BASE OF 3,093 PATIENTS SHOWS 5% OF ALL PATIENTS WHO WENT ON THERAPY UNITS HAD A STAGE I, 16% HAD A STAGE II, 36% HAD A STAGE III; AND 42% HAD A STAGE IV PRESSURE SORE[3].

WHEN WE COMPARE THIS TO THE KANSAS DATE BASE OF 46 PATIENTS, WE FIND A PICTURE THAT SHOWS MORE EFFECTIVE PLACEMENTS WITH EARLIER INTERVENTION THAT PREVENTS FURTHER SKIN BREAKDOWN AND THUS COSTS THE SYSTEM LESS MONEY. IN KANSAS WE FIND 1% OF THE PATIENTS GOING ON THERAPY UNITS FOR STAGE I; 14% FOR STAGE II; 53% FOR STAGE III; AND 30% FOR STAGE IV. KEEPING IN MIND THAT OUR CURRENT REIMBURSEMENT SYSTEMS PAY ONLY FOR STAGE III'S AND IV'S, IT IS IMPORTANT TO NOTE THAT YOUR PREVIOUS METHODS WERE WORKING. 53% OF KANSAS PLACEMENTS WERE MADE FOR STAGE III'S, SIGNIFICANTLY

HIGHER EARLY INTERVENTION THAN THE NATIONAL NORM OF 36%. THE POSITIVE IMPACT OF THIS EARLIER PLACEMENT CAN ALSO BE SEEN IN THE LOWER THAN NATIONAL PLACEMENTS OF STAGE IV'S. THESE NUMBERS ARE A CLEAR INDICATION THAT KANSAS HEALTH CARE PERSONNEL AND POLICY MAKERS HAD THE RIGHT IDEA--IT COSTS LESS IN DOLLARS, RESOURCE CONSUMPTION AND HUMAN SUFFERING TO TREAT QUICKLY AND AGGRESSIVELY.

LET'S CREATE A PICTURE OF WHAT KANSAS IS FACING IN 1991. OF THE PROJECTED 13,000 LTC MEDICAID PATIENTS THIS YEAR[4], 7.8% WILL HAVE PRESSURE SORES[5]. THIS TRANSLATES TO 1014 KANSAS RESIDENTS WHO YOU AS POLICY MAKERS HAVE DIRECT RESPONSIBILITY FOR, WHO WILL FACE A FOURFOLD INCREASED RISK OF DEATH. OF THESE, APPROXIMATELY 21% TO 30% (OR 213 TO 304 PATIENTS) WILL HAVE A STAGE III OR IV ULCER[6].

OBVIOUSLY, WITH THE DAILY RENTAL OF SPECIALTY BEDS HIGHER THAN THE PER DIEM RATE IN SOME OF YOUR FACILITIES, THIS IS NOT A COST THAT THE NURSING FACILITY PROVIDERS CAN ABSORB, NOR ONE THAT WE CAN IGNORE AT THE STATE LEVEL.

I THINK IT IS IMPORTANT, THEN, TO LOOK AT WHAT THE STATE AND ITS RESIDENTS ARE GETTING FOR THEIR MONEY. AGAIN, FOR THE PERIOD OF MARCH '90 TO DECEMBER '90, 63% OF KANSAS PATIENTS ON SSI SPECIALTY BEDS WERE CONSIDERED IMPROVED AT THE TIME OF THEIR OFF DATE, AND 20% WERE HEALED. THIS COMPARES TO THE NATIONAL FIGURES OF 56%

IMPROVED AND ONLY 9% HEALED. THE HIGHER HEALED RATE COULD BE ATTRIBUTED TO YOUR PREVIOUS SYSTEM OF EARLY INTERVENTION, THEREFORE IT TOOK FEWER DAYS TO REACH A "HEALED" STATUS.

IT IS MY UNDERSTANDING FROM A PREVIOUS CONVERSATION WITH SRS, THAT A SUGGESTED ALTERNATIVE TO THE HEAVY CARE REIMBURSEMENT PROGRAM CURRENTLY UNDER CONSIDERATION IS ROLLING THE COSTS OF HEAVY CARE (INCLUDING SPECIALTY BEDS) INTO THE PER DIEM RATE THAT FACILITIES RECEIVE. THERE ARE TWO CONCERNS WITH THIS APPROACH:

#1) THE FACILITIES WOULD BE FINANCIALLY PENALIZED FOR A PROBLEM THAT DOES NOT ORIGINATE WITH THEM OR THEIR CARE. GREATER THAN 80% OF THE PRESSURE SORE PATIENTS IN KANSAS ARE ADMITTED TO THE LTC SETTING WITH A SORE[IBID]. THE FACILITIES THAT ACCEPT THESE PATIENTS ARE NOT ONLY BEING CHARGED WITH DEFICIENCIES THROUGH THE SURVEY PROCESS, BUT WOULD BE FINANCIALLY IMPACTED FROM A REIMBURSEMENT PERSPECTIVE FOR PROVIDING A TREATMENT THAT THEY KNOW TO BE CLINICALLY EFFECTIVE.

#2) UNDER THE CURRENT METHOD OF DETERMININGTHE PER DIEM RATE, IT CAN TAKE AS LONG AS 18 MONTHS FOR A COST INCURRED BY A FACILITY TO BE REFLECTED AS AN INCREASE IN THEIR PER DIEM. FOR EXAMPLE, IF A PARTICULAR FACILITY USES AN AVERAGE OF FOUR THERAPY UNITS PER MONTH AT A RATE OF $65/DAY, THEY WILL INCUR UNREIMBURSEABLE EXPENSES OF $140,400 OVER A TWO YEAR PERIOD. IT IS OBVIOUS THAT A NURSING FACILITY WOULD NOT BE ABLE TO INCUR THIS AMOUNT OF LOSS

AND SURVIVE. THEREFORE, THEY WOULD NOT BE ABLE TO PROVIDE THE MOST CLINICALLY-EFFECTIVE THERAPY FOR THEIR RESIDENTS.

WITH SOME SOURCES CITING AS MUCH AS $30-40,000 TO TREAT A SINGLE STAGE III OR IV PRESSURE SORE[6] AND AN ANNUAL NATIONAL COST APPROACHING $6.5 BILLION DOLLARS TO CARE FOR THESE PATIENTS[7], THE FOLLOWING RECOMMENDATIONS ARE SUBMITTTED FOR YOUR CONSIDERATION:

1) CONTINUE THE HEAVY CARE REIMBURSEMENT PROGRAM AS IT WAS PRIOR TO THE OCTOBER 1, 1990 REORGANIZATION TO ALLOW YOUR LONG TERM CARE PROVIDERS TO CONTINUE ACCEPTING THESE PATIENTS FROM THE HIGHER COST ACUTE CARE SETTING.

2) ADJUST THE PREVIOUSLY ESTABLISHED CLINICAL CRITERIA (PRIOR TO THE OCTOBER 1ST REORGANIZATION) TO INCLUDE REIMBURSEMENT FOR EARLY INTERVENTION PRODUCTS SUCH AS MATTRESS OVERLAYS. STAGE III AND IV PRESSURE SORES ARE PREVENTABLE THROUGH AN AGGRESSIVE PROGRAM OF EDUCATION AND EARLY INTERVENTION.

WE RECOGNIZE THAT THIS IS A FINANCIAL CONCERN THAT MUST BE ADDRESSED. HOWEVER, THERE HAVE BEEN STUDIES DONE BY MEDICAID PROGRAMS SUCH AS YOURS THAT HAVE SHOWN AS MUCH AS A $100,000 ANNUAL SAVINGS[8] THROUGH THE USE OF SPECIALTY BEDS. OVER THE PAST 4 MONTHS, WE HAVE RECEIVED ABOUT 40 DENIALS OF SUBMITTED PRIOR

AUTHORIZATIONS--ALL OF THESE ON PATIENTS THAT WOULD HAVE PREVIOUSLY BEEN APPROVED, ALL OF THESE ON PATIENTS WHO HAVE WORSENING SORES TODAY AS A RESULT OF PROVIDERS HAVING NO OTHER ALTERNATIVE TO OFFER THEM AND THUS REMOVING THEM FROM PRODUCTS THAT ARE PROVEN TO HEAL PRESSURE SORES.

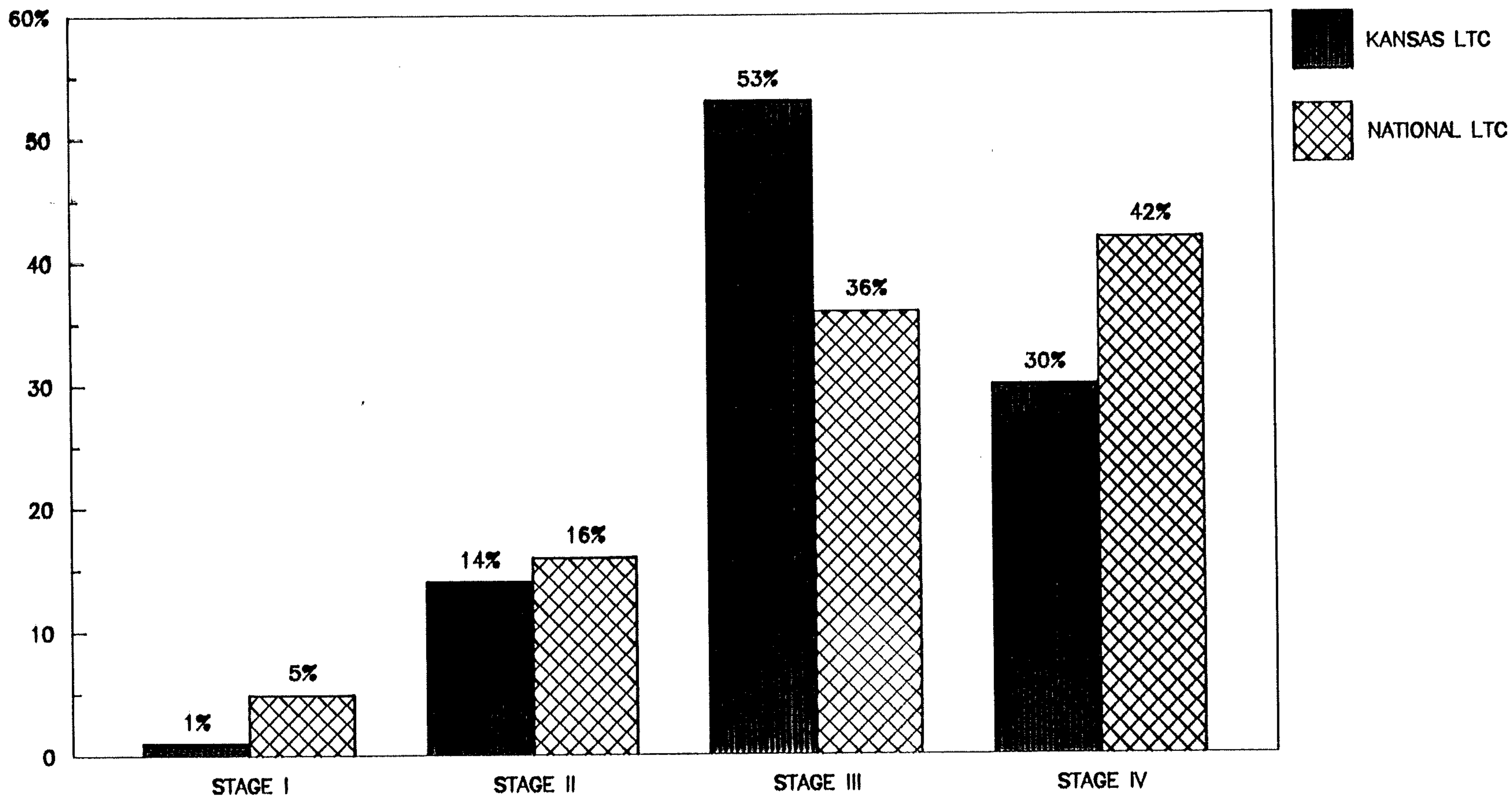
AS A COMPANY, SUPPORT SYSTEMS INTERNATIONAL "DONATED" OVER $100,000 DOLLARS WORTH OF TREATMENT TO THE PATIENTS CAUGHT IN THE TRANSITION PERIOD SINCE OCTOBER 1ST. OUR NURSES CONTINUE TO MONITOR AND OFFER CLINICAL ADVICE ON THOSE PATIENTS WHO HAVE SINCE BEEN REMOVED FROM THERAPIES.

THIS MATTER DESERVES IMMEDIATE ATTENTION. EVERY DAY THAT WE DELAY, RESULTS IN NEW SORES DEVELOPING AND CURRENT SORES WORSENING.

PLEASE DO NOT TURN A DEAF EAR TO THESE STATISTICS. KANSAS NURSING FACILITY PATIENTS DESERVE TO BE TREATED WITH DIGNITY AND RESPECT. THEY ARE ALREADY CAUGHT IN THE WEB OF MISUNDERSTANDING AND MISINFORMATION.

THANK YOU FOR YOUR TIME AND ATTENTION TO THIS MATTER.

PRESSURE ULCER STAGES
KANSAS LTC VS. NATIONAL LTC
MARCH 1990 THRU DECEMBER 1990



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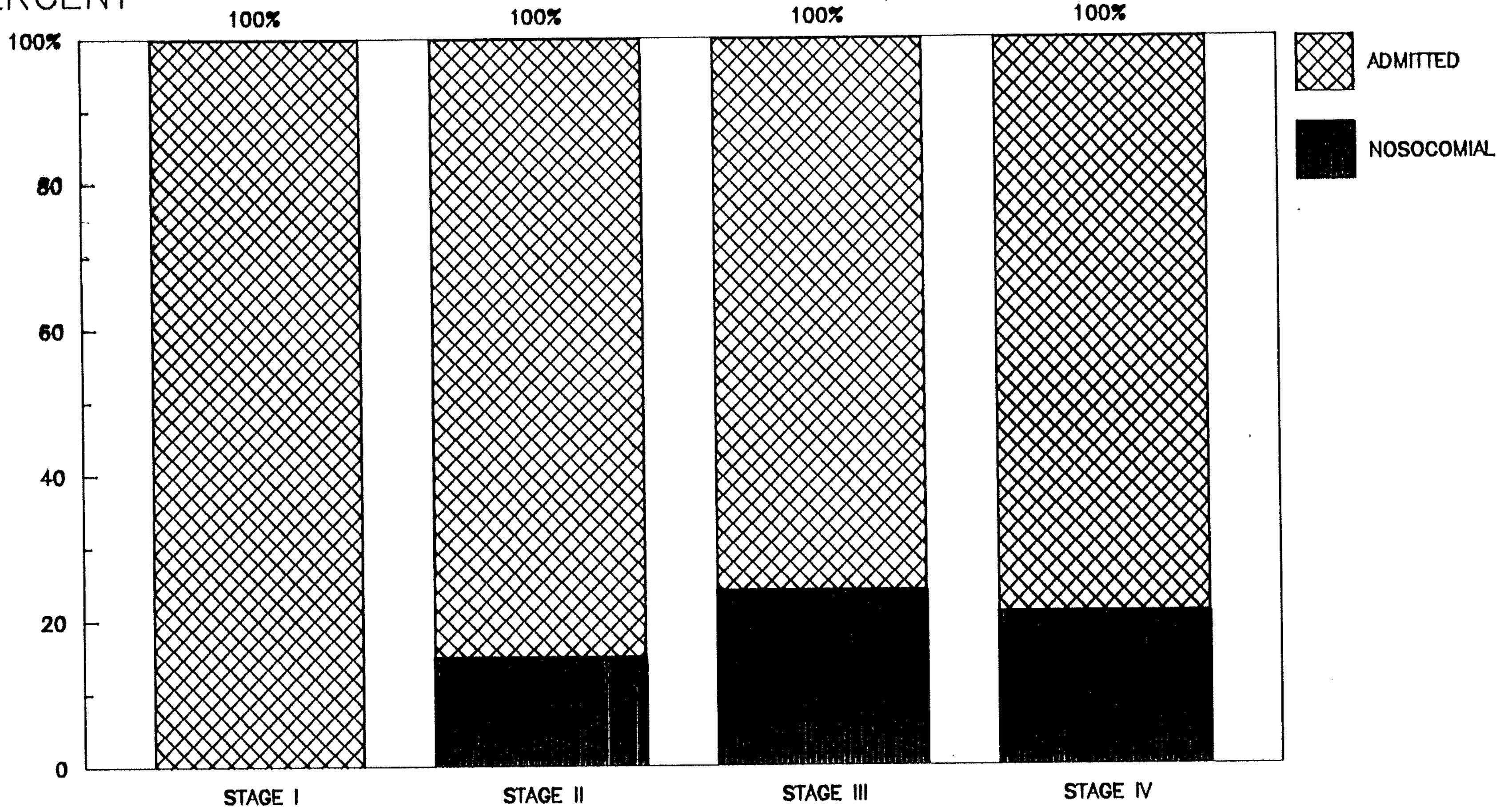
PRESSURE ULCER ACQUIRED LOCATION
KANSAS LTC
MARCH 1990 THRU DECEMBER 1990



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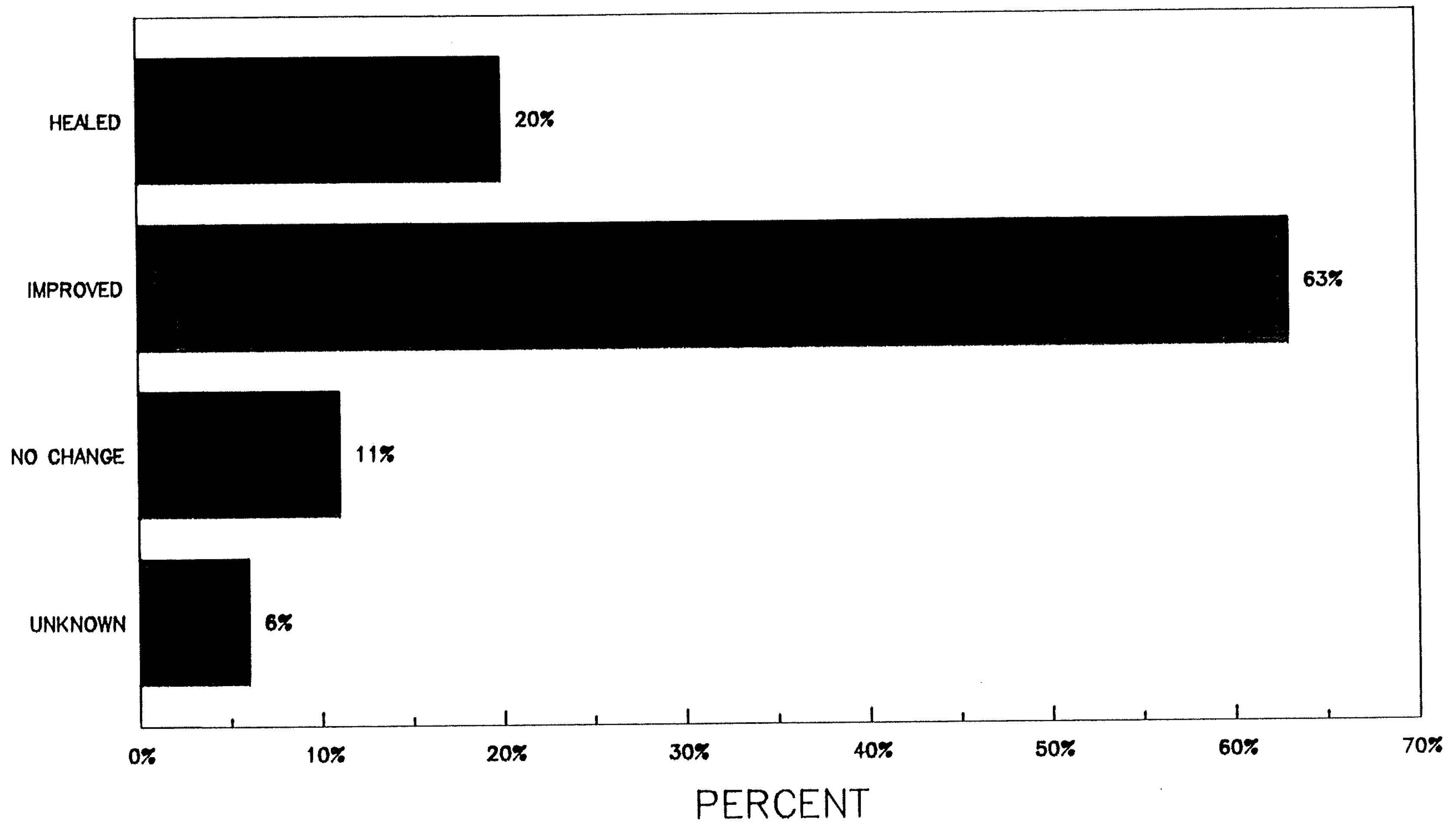
CONDITION OF WOUND AT OFF DATE
KANSAS LTC
MARCH 1990 THRU DECEMBER 1990



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The University of Kansas Medical Center

Department of Nursing Services

TESTIMONY

BY

VICKIE WEAVER RN, CETN
ET NURSE CLINICIAN-KUMC
PRESIDENT- MIDWEST REGION IAET
(INTERNATIONAL ASSOCIATION FOR ENTEROSTOMAL THERAPY NURSING)

TO

KANSAS SENATE SUBCOMMITTEE:HEALTH & WELFARE

Introduction

As the years progress, and the life expectancy curve changes the Health Care Industry has seen marked changes in the type of Health Care Delivery Systems necessary to provide quality of life to the increasing aged population. Over the past 20 years, life expectancy has changed from 72 years to 75 years, and the death rate for those 74 and younger has decreased from 509 to 392 per 100,000 population. One problem identified as a major deterrant to quality of life by the Joint Commission on Accreditation for Health Care Organizations (JCAHO), which is also identified as a Quality Indicator for future use during the review process of a Health Care Agency, is the development of a pressure sore. In this brief testimony, I plan to familiarize you with the national scope of the problem, relate my role in providing care for this type of patient population, and discuss with you the efficacy and usage of specialty care beds for certain identified patients with active wounds.

Pressure Sores as a National Health Concern

In March, 1989, the problem of pressure sores was identified as a Nationwide health care issue, due to the amount of expenditures annually utilized for treatment. To that point, there was no identified effort on a multidisciplinary focus in prevention or treatment, screening, and statistical analyses. Multiple independent reports were being published regarding seperate patient populations, protocols and procedures. A National Pressure Advisory Panel was created, to address these issues. The Panel consisted of 9 MD's, 8 PhD's and 14 RN's (6 of which were ET Nurses), all identified as having expertise in the field of wound care. At that time, the conclusions pertinent to report in this testimony are as follows:

*Pressure sores are a significant and increasing source of

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Department of Nursing Services

human suffering.

*There is a need for major investigative initiatives to determine actual costs of prevention and treatment measures on the national scope.

*Expert opinion suggests the lack of reimbursement for prevention adversely affects the performance of risk assessment and early intervention strategies.

*A unified reporting and surveillance strategy should be developed

*A nationwide educational focus is needed

Pressure Sores Defined

A pressure sore is a localized area of tissue destruction which tends to occur (develop) when soft tissue is compressed between a bony prominence and an external surface. This pressure can be high pressure exerted over a short period of time, or constant low pressures exerted over a prolonged period of time. These wounds have been commonly called by many other terms you may be familiar with (decubitus ulcers, bedsores, pressure ulcers), and have been attributed in the past to poor nursing care. Through research, it is now well documented that the development of pressure sores is a multifocal process involving not just "Good Nursing Care" (ie: regular turning and repositioning of the patient) but the patient's general health status, nutritional values, and other aspects of their medical care combined. There are validated assessment tools utilized currently to establish if a patient is at risk for development of a pressure sore (Braden and Norton), of which most Health Care Agencies are developing workable ones within their own facility. A copy of the form utilized at KU is attached for your reference. It is estimated that 3-14% of all acute care admissions will develop skin breakdown to some degree, and 15-25% of all skilled care admissions will also develop pressure sores. Incidence of hospital acquired was estimated at 1-5%, which concludes that a majority of these are acquired elsewhere, and are actually present upon hospital admission. Therefore, major educational effort is being placed into prevention and treatment strategies in Skilled Facilities, Intermediate Care Facilities and Home Care Agencies. We (Ms. Jester and myself) travel throughout the State, providing educational programs to these areas, and would be happy to offer any additional supportive information you may need to assist with cost containment yet continuity of quality care to our Kansas residents.

Specialty Care Bed Usage as an adjunct therapy for Pressure Sores

Treatment measures for patients who have established pressure sores is as varied sometimes as much as the diversity of the number of stores in the local mall! Many products have recently arrived on the market that claim to be better than the next, all of which

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The University of Kansas Medical Center

Department of Nursing Services

prior to the development of standards for usage, must have clinical research to support their efficacy. One established fact is that no product will allow a pressure sore to heal if the source of pressure to that wound is not removed. To quote Dr. Mani, our expert physician on burn care "you can put anything on the pressure sore but the patient themselves!" In this statement, he is educating the audience to the fact that products do not heal pressure sores, patients heal themselves with the aid of products and technology. The standard number used in establishing if there is pressure great enough against the skin to cause damage (capillary closure pressure or interface pressures referred to in many articles) is 32mm of mercury. When Ms. Jester and I published the clinical investigation of pressure relief/reduction devices, we evaluated 37 types of products to determine ones which may be effective and warrant further investigation. Not every patient who develops a pressure sore requires the use of a specialty care bed. There are many other "low end" devices available to Health Care Agencies to provide adequate pressure relief/reduction. The use of specialty care beds is advantagous,however, in the event that the patient has been adequately assessed for other alternatives, and the total patient is being taken into consideration. As I see the problem, there needs to be some sort of standardized screening tool established, so that proper placement of these devices is afforded, and that overuse can be controlled. We have established such a mechanism at KU, through educational efforts, development of an assessment tool, and establishment of a multidisciplinary skin care quality assurance committee. The expenditures for specialty care beds has decreased from an estimated annual usage of over $200,000 to under $90,000 since that time.

Conclusions

I would like to refer you to an article by Dr. David Bearman of the Santa Barbara Health Initiative (in "Today's Nursing Home) attached. I had a conversation with Dr. Bearman to determine if any follow up publications have been submitted since the program is in place. Dr. Bearman welcomes calls and inquiries regarding the sucess of the program in their area. California has added the use of these beds to their benifits because they have found that there is "substantial risk of the pressure sores not healing if the beds were not utilized", and that in some cases the patient was actually kept in the nursing home to be cared for on a bed, avoiding hospital readmission. They have also documented the fact that acute care stays have lessened through the use of these beds with proper assessment of the patients prior to placement.

Dr. Dsvid Bearman
135 E. Ortega St. (805) 963-9261
Santa Barbara, CA 93101

I support the use of specialty care beds for patients within the program of the Home Care division for usage in Skilled Care Facilities

utilizing my clinical experience and literature review as a basis for my opinion. Should you require copies of any article clinically discussing the usage and efficacy of these high tech beds, I would be glad to submit them to you. Thank you for your time this morning.

VICKIE WEAVER, R.N., CET
Enterostomal Therapy Nurse Clinician

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BETHANY · MEDICAL · CENTER
The Hospital of Choice

1-24-91

Senate Sub-Committee Meeting
Topeka, Kansas

To Whom It May Concern,

My name is Jan Jester RN,CETN, I work at Bethany Medical Center in Kansas City, Kansas. My primary position is working with patients with skin integrity problems such as pressure ulcers, patients who have or will have ostomy surgery, and a Breast Cancer Screening Clinic.

I have been very concerned with some changes that are taking place in our state Medicaid program currently, that are affecting a large part of my practice. As of October 1990, patients in long term care facilities on Medicaid are not being allowed to be on Speciality Beds specifically the Low Air Loss Beds and Air Fluidized Therapy Beds for pressure relief, Moisture control, and reduced shear and friction as they move about in bed. I would like to explain my interest in this problem in behalf of many elderly and disabled patients in our state. I see a minimum of 20-25 patients a week that fall into the category of skin integrity problems. Some of them have what we term Stage I problems, and others have Stage IV problems which involve bone and muscle and are very serious. In the past we were able to dismiss these patients faster from acute hospitals because we could send them to the long term care facility on a speciality bed which would help relieve the pressure and allow them to continue to heal in that facility. Now we don't have that option and many of these patients will suffer because of it.

People that have worked with Skin Integrity problems for many years as I have, have tried very hard to work with the available limitations. We have been able for quite a long time to expedite post-hospitalization referral, and therefore decrease acute care hospitalization. My experience has been that we can safely and also appropriately discharge these patients quite early in their healing process if low air loss or air-fluidized therapy beds are to be used. This is a big health care saving. For example, approximately $230 a day can be saved in the room rates alone. The average hospital room rate is around $310, and the average SNF rate is about $80, and that saves a lot.

In addition to the dollar savings, we must look at the fact that it relieves suffering and lowers the risk of many of these patients becoming worse and having to be re-hospitalized, or in some cases dying as a result of infection in these ulcers from continued pressure.

Senate P H&W
Attachment #5
~~01-24-91~~

51 North 12th Street Kansas City, Kansas 66102 (913) 281-8400
VHA.

As a Skin Care Specialist I am really concerned that while cuts must be made, we must also consider the entire problem, and the liability that goes with denying treatment. Some points that I would like to raise that may affect the outcome of future decisions are:

1. Ability of nursing homes to get the patients to a state of healing with the speciality beds---and what will happen without the beds.
2. Cost to hospitals to maintain Medicaid patients after Medicare benefits expire.
3. Inability to discharge patients without the use of speciality beds.
4. Inability of nursing homes to accept heavy wound and skin patients without the use of the speciality bed.
5. The program which we have had in effect for the past years has now become a standard of care in Kansas, as well as other states.
6. The welfare of Wound Care Patients, and terminal patients is at stake.

When I have talked with persons at the state level, I have been assured that Speciality Beds are still allowed, but as of today 1-23-91, Neither of the major bed suppliers have received approval of even one bed since this started in October. If the ruling has not changed, then why are patient requests being denied, and patients being deprived of this type of care.

Recently I saw a patient that was released from Bethany to the Nursing Home after improving greatly on a speciality bed. She was denied the bed for the Nursing Home. She was readmitted because of multiple ulcers. She was again denied a bed in Long Term care as recently as 1-4-91. It is my concern that this patient will die if she continues to be denied any type of pressure relief, and the pain to her is great. She has Parkinsons Disease, Diabetes, Renal Failure and multiple pressure ulcers in addition to being very elderly and frail.

When I speak of pressure relief, this is much different than pressure reduction which is what most of the overlay mattresses provide. Pressure relief, relieves pressure to capillary shutdown when the blood no longer gets to the involved area. I have provided you with a page describing Pressure Relief vs. Pressure Reduction.

I feel that if we could talk out this problem we who work daily with large numbers of Wound Care Patients could make some suggestions about different items that could be helpful with some of the patients, without having to always use beds. To date we have not been able to have in-put into decisions.

Thanks for allowing me to share with you my concerns. I classify myself as a "Patient Advocate", in that I really care about the patients I care for. I hope that we in the state of Kansas can look at this problem and allow our patients the dignity they deserve in their later years, or times of illness.

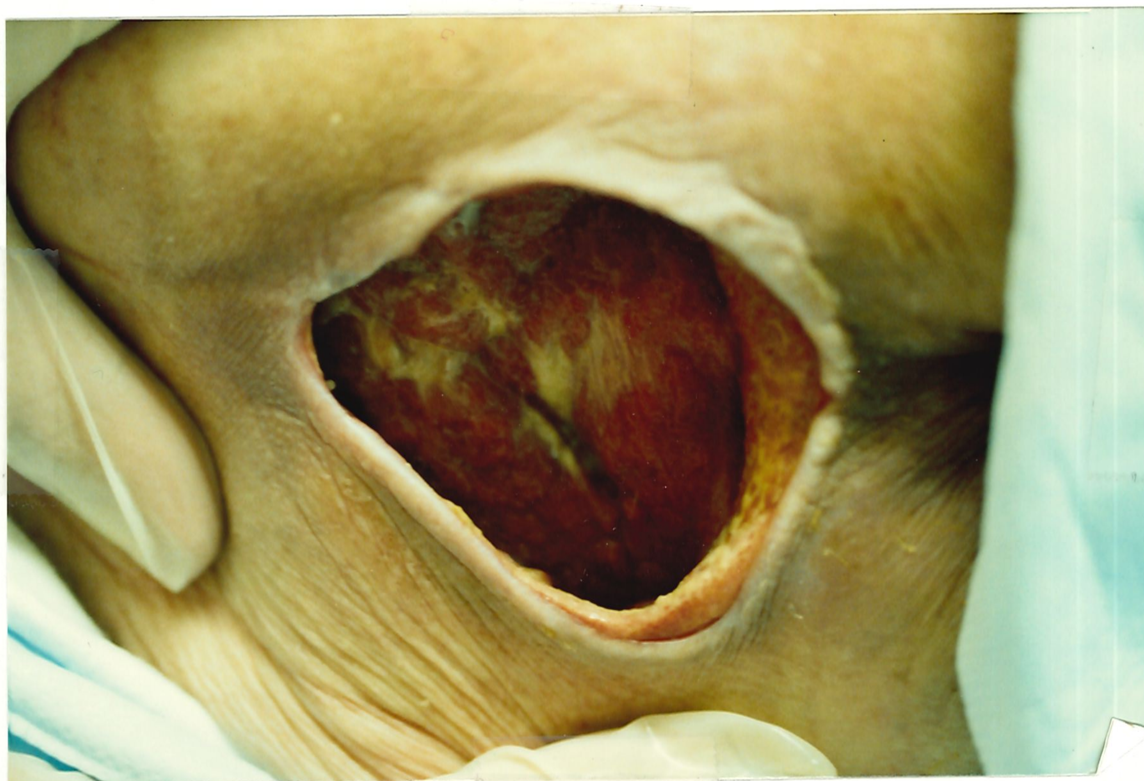
I do not come here to cause a problem, but to offer my help in solving a very desperat problem in our state Medicaid program.

I am enclosing some articles, and a picture for you to explain further what I am concerned about. If you would be interested in making rounds with me to see some of these patients, this could be arranged.

Sincerely,

Jan Jester RN, CETN

Jan Jester RN,CETN
E.T. Nurse Specialist
Bethany Medical Center



THE WOUND CARE CENTER OF KANSAS CITY℠

January 23, 1991

To Whom It May Concern:

RE: The use of air fluidized therapy and low air loss beds.

There are at least two types of patients who require either low air loss beds or air fluidized therapy in the home or nursing home setting: first, those patients who have undergone surgical reconstruction of pressure ulcers and second, those patients who are in the process of secondary healing of their open pressure ulcers using various topical agents.

Those patients who have undergone surgical reconstruction of their pressure ulcers require three to six weeks of bed rest post reconstruction during which pressure must be avoided. The only way to prevent excessive pressure in the area of reconstruction is through the use of air fluidized therapy or the low air loss beds.

Those patients who are undergoing the process of secondary healing of their pressure ulcers will not heal unless pressure is completely relieved at the ulcer site. This again requires the use of the air fluidized therapy or low air loss bed. These patients, of course, would require the use of beds for longer periods of time, ranging from three to six months.

When air fluidized therapy and low air loss beds are not available in the nursing home setting or in the home, the patients will require prolonged hospitalizations so that this therapy can be done. It would certainly be more economical to provide these services in the home than to keep the patient in the hospital for extended periods.

Thank you for your consideration.

Sincerely,

James D. Leahy, M.D.
Medical Director
Wound Care Center of Kansas City

155 South 18th Street, Suite 105, Kansas City, Kansas 66102, (913)281-8821
A service of Bethany Medical Center
Affiliated with Curative Technologies, Inc.