Approved Feb. 3 '92
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader at
Chairperson

1:30 ~~a.m.~~/p.m. on January 23, 1992 in room 423-S of the Capitol.

All members were present except:

Representative Susan Wagle, excused

Committee staff present:

Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Robert Epps, Commissioner of Income Support and Medical Services, Department of SRS
Rita Wolf, Interim Director of Management Services/Dept. of SRS
Dona Booe, Income Maintenance Specialist, Department of SRS
Joseph F. Kroll, Director/Bureau of Adult and Child Care, Health/Environment
Monika Flask, representing Society for Hospital Social Work Directors, Kansas Sunflower Chapter.
John R. Grace, President, Kansas Association of Homes for the Aging
Walter H. Crockett, State Legislative Committee and Capital City Task Force of Kansas AARP.
Marilyn Bradt, Legislative Coordinator, Kansans for Improvement of Nursing Homes.
Irene Hart, Director of Central Plains Area Agency on Aging, Wichita,Ks.
Don Moses, Representative from Kansas Coalition on Aging
Chair called meeting to order, drawing attention to scheduled hearings today.

HEARINGS BEGAN ON HB 2566.

Commissioner Robert Epps, Department of Health/Environment offered hand-out. (Attachment No. 1) He detailed the hand-out, i.e., the first two pages reflect the position of support for Substitute HB 2566 by Secretary Whiteman.

Commissioner Epps outlined the remaining part of Attachment No. 1 noting fiscal impact with the implementation of PASR (Preadmission Assessment and Referral). (Option 1)- the Department projects the number of assessments would increase from 2,760 per year to 12,240 and the estimated cost per assessment is $120 each for a total of $1,468 with matching funds of 75% by the federal government. (Option 2)- a participation fee would be required of those doing the assessment procedure and this fee would offset the State General Fund matching requirement, therefore, there would be no fiscal impact. The Department of SRS sees no increase in staffing or operation expenditures since the assessment would be performed by outside providers.

Commissioner Epps, Dona Booe, and Rita Wolf all answered numerous questions. It was noted, the exclusions to be included in the regulations in Substitute HB 2566 offered by Secretary Whiteman included patients transferred from other certified adult care homes; patients, who having entered hospitals from adult care homes are returning to an adult care home; individuals whose length of stay is expected to be 30 days or less; persons entering a facility conducted by and for the adherents of a recognized church or religious denomination for the purpose of providing care/services for those who depend on prayer alone for healing.

Commissioner Epps drew attention to a review of the Preadmission Screening Report prepared pursuant to a 1990 Minnesota law. He then drew attention to the document used in the prescreening assessment in Attachment No. 1.

Further discussion and questions and answers continued.

Joseph Kroll, Director of Bureau of Adult/Child Care, Department of Health/Environment offered hand-out (Attachment No. 2) **HB 2566** if passed in the original form, will require all persons seeking admission to an adult care home participating in the Medicaid program to be pre-screened prior to admission. The Department of SRS has been prescreening persons eligible for the Medicaid program, desiring admission to a nursing facility for several years. The Department of Health and Environment feels individuals should have the right to determine where they will reside and what services they wish to purchase. Making information available concerning alternatives to nursing home placement could be provided to these individuals without the pre-screening requirement. Reports indicate most older Kansans would prefer to remain in their own homes or a less restrictive setting than a "nursing home". Until adequate alternative services are developed and are available to the potential residents of nursing homes, this prescreening will be a futile gesture. Mr. Kroll then noted the Department on Aging, SRS, and Health/Environment have recently completed a cooperative effort to address long-term care and as part of this effort all three of these agencies rejected the original form of **HB 2566,** and have offered a **Substitute HB 2566.** The Department of Health/Environment, which he represents today, urges support for that Substitute Bill.

Monika Flask, (Attachment NO.3) noted her printed testimony is directed to the original **HB 2566.** The Society for Hospital Social Work Directors that she represents today is opposed to the original **HB 2566.** The **Substitute HB 2566** is better, but they still have concerns with it. She isn't convinced the screening will be that helpful and is concerned that the cost may not be worth it if the resources are not available for those individuals, and in many rural areas resources for alternative services are just not available; concerned that the assessment can cause delays for the patient being discharged from the hospital; concerned with a lengthy 26 page assessment form; concerned with the affordability of resources for low income families who are not Medicaid eligible. She then answered questions.

John Grace, Kansas Association of Homes for the Aging offered hand-out (Attachment No. 4). He directed his testimony toward **Substitute HB 2566.** He proposed an amendment by adding language, "Notwithstanding the provision of sub-section (c) (ii), a person may be provisionally admitted to a nursing facility pending the providing of information of screening services." Mr. Grace believes in order to have an effective screening program, early intervention is vital. When they are knocking on the door of a nursing home these individuals are already at a traumatic
point. They need to be informed early on about the alternatives of services available to them. He directed attention to the assessment form and noted they would prefer not to have several different forms used for this procedure. He then noted it is wonderful to see the three state agencies work together cooperatively to recommend a much improved bill in the form of **Substitute HB 2566.** He answered questions.

Walter Crockett, representing the State Legislative Committee of AARP gave hand-out (Attachment No.5). Helping people to avoid institutionalization, to live in their own communities as long as they can greatly enhances the quality of their lives and can save the state money, as evidenced from recent evaluations of the Senior Care Act. Offering information in regard to alternatives to long-term care will benefit many seniors. The assessments should be conducted by trained individuals in SRS or other agencies specifically approved by SRS. He addressed concerns for a need for language in the bill to address necessary exemptions for certain persons. We all need to realize this assessment procedure will not, by itself, solve all the problems of premature institutionalization, but it should help. He urged favorable consider ation. He then congratulated Secretary Hurst, Secretary Whiteman and Secretary Young and their staffs who have worked cooperatively on this report.

Marilyn Bradt, Kansans for Improvement of Nursing Homes, Inc. (Attachment No.6), noted the Association has supported the concept defined in **Sub. HB 2566** since 1985. It has been the experience of those in the nursing home business that the decision to enter a nursing home or to urge nursing home care on a frail relative is too often made without knowledge of other alternatives. Mandatory screening is not only a tool to assess the care needs, but gives the opportunity to inform the people of available alternatives that could be less costly and perhaps allow them to stay longer in their own homes. She outlined some exemptions they feel are needed in the bill. It will not be enough simply to make information available to the consumer, there will be a need for counseling and assistance to private providers and nursing homes who cannot be expected to provide that service. However, hospital discharge planners could fulfill that function as long as they all are expected to use the same assessment instrument. KINH believes strongly that a uniform needs assessment instrument should be developed for use by all providers of this service in order to collect data statewide and to assure that all will be evaluated similarly. She urged support.

Irene Hart, Director of Central Plains Area Agency on Aging offered hand-out (Attachment No.7). She commended the Departments on Aging, SRS, and Health/Environment for working together to develop a coordinated approach to long-term care issues and **Sub. HB 2566.** Their Area Agency on Aging in Wichita feels this legislation will help reduce nursing home placements; help to make consumers more aware of services and options in their communitites; will help to develop data on inhome and community services needed to reduce institutionalization. She spoke of concerns. Will additional funds be appropriated to the Department on Aging for the information packets; whether or not the "other providers" of the assessment should exclude adult care homes from being providers for obvious conflict of interest reasons; add provisions to have to vaive the assessment process for those patients who would be admitted on a short-term basis because of perhaps recovery from a broken hip that would take just a few weeks to heal. She answered questions.

Don Moses, Chaplin at Brewster Place, and representing the Kansas Coalition on Aging, offered hand-out (Attachment No.8). He spoke of the importance of having a uniform assessment instrument; pre-admission screening program should include provision for information and referral at the time of dismissal from a hospital. A national survey of Medicaid directors indicates the pre-admission screening program can reduce the overall cost of long-term care. Community based programs are a vital part of alternatives for these individuals seeking advice or placement. He urged support.

HEARINGS CLOSED ON HB 2566.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on January 23, 1992

Chairperson Sader suggested to members if they have any further suggestions for amendments to Substitute HB 2566, they should confer with the Revisor's office before our next meeting scheduled for Monday, January 27th, in order that we can proceed with discussion and possible action on this legislation.

Chair then noted to the Department Secretaries and their staffs that the cooperative effort between these Departments is appreciated and she expressed thanks to all who have worked so hard.

Chair adjourned the meeting at 3:03 p.m.

The next meeting of House Public Health and Welfare Committee will meet Monday, January 27, 1992 at 1:30 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Jan. 23,

NAME	ORGANIZATION	ADDRESS
Jane Ford	Ks Hosp Assoc	Topeka
Kerry Townsend	KS Hosp Assoc.	Lawrence
Basil Covey	KRTA	Topeka
Sharon Hoffman	KCDC	Topeka
Linda Libensky	KS Home Care Assoc	Lawrence
Leslie Burkholder	Society for Hospital Social Work Directors Kansas Chapter	Abilene
Cindy Krehbiel	Society for Hospital Social Work Directors Ks Chapter	Hutchinson
Monica Flask	" "	Halstead
Nathan Burkholder	Student	Abilene
Larry Pitman	Ks Foundation For Medical Care	Topeka
Chad McDonald	Ks Assoc for Centers for IL	Topeka
DON MOSES	KCOA	TOPEKA
Katie Pyle	AARP (Capacity Task Force)	"
Allen Hixson	" "	KCILS
Irene Hart	CPAAA	Wichita
Carolyn Middendorf	KSNA	Topeka
Marilyn Bradt	KINH	Lawrence
Wendell Strohm	AARP	Topeka
W. H. Crockett	AARP	Lawrence
Lynda Dunn	KDOA	Topeka
Joseph Kucera	KDHE	Topeka
R Epps	SRS	Topeka
Dona Boe	income maintenance SRS	Topeka
Lola L. Wolf	SRS	Topeka
Jerry Ingalls	Memorial Hosp	Manhattan
Mike Brue	KAHA	Topeka
LISA GETZ	WICHITA Hospitals	WICHITA

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

Original set. complete!

House Public Health and Welfare Committee
Testimony on House Bill 2566

SRS, the Kansas Department of Health and Environment (KDHE) and the Kansas Department on Aging (KDOA) jointly recommend and request your consideration of our Substitute for House Bill 2566 when introduced to the 1992 legislature.

The substitute for House Bill 2566, presented today, more effectively achieves our goals of ensuring that all individuals seeking adult care home placement be provided an opportunity to be informed of and the right to choose from any available housing options, including adult care homes. By providing this service, individuals and families can delay and possibly prevent the depletion of their financial resources through expensive institutional care when cost effective community based services are available.

Should an individual assessed and found in need of adult care home placement decide not to take advantage of optional community based services, but instead choose institutionalization, Medicaid payment will not be denied if they qualify. Only in situations where no accessed medical need exists will medicaid payment be refused.

We continue to support the need for an assessment process, and we recognize the benefits of cooperation with KDHE and KDOA in achieving and coordinating long term care services for Kansans.

Robert L. Epps
Commissioner
Income Support/Medical Services
(913) 296-6750

1/23/92

P&W
1-23-92
Attm #1.

LTC Action Committee
Substitute
House Bill No. 2566

An act concerning social welfare; relating to providing Kansans information and assistance in obtaining appropriate long-term care services.

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

(a) The secretary of the department on aging shall assure that each area agency on aging shall compile comprehensive resource information for use by individuals and agencies related to long-term care resources including all SRS area offices and local health departments. This information shall include, but not be limited to, resources available to assist persons to choose alternatives to institutional care.

(b) Adult care homes as defined in K.S.A. 39-923 and medical care facilities as defined under K.S.A. 65-425 shall make available information referenced in section (a) to each person seeking admission or upon discharge as appropriate. Any licensed practitioner of the healing arts as defined in K.S.A. 65-2802 shall make these same resources available to any person identified as seeking and/or needing long-term care.

(c) (i) The secretary of the department of social and rehabilitation services shall develop a uniform needs assessment instrument to be used by all providers of assessment and referral services.

(ii) On and after the effective date of this act, no person shall be admitted to an adult care home providing care under Title XIX (Medicaid) unless the person has received assessment and referral services as defined in c(i). These services shall be provided under the Senior Care Act, under the Older Americans Act, by the secretary of the department of social and rehabilitation services, or by other providers as identified by the secretary.

(d) This act shall not be construed to prohibit the selection of any long-term care resource by any person. An individual's right to choose does not supersede the authority of the secretary of social and rehabilitation services to determine whether the placement is appropriate and to deny eligibility for long-term care payment if inappropriate placement is chosen.

DB:csl
01/02/92

PHHW
1-23-92
att #1
Pg 2 of 51

FISCAL IMPACT: PREADMISSION ASSESSMENT AND REFERRAL

Brief Analysis:

The substitution for HB 2566 requires that all persons seeking admission to an adult care home receive an assessment of need, treatment planning and referral to available resources prior to their admission.

Effect on Department of Social and Rehabilitation Services;

SRS would implement agreements with other agencies and providers to perform the assessments, treatment planning and referrals. The payment for these services could be accomplished through the Medicaid claims payment process.

Fiscal Impact:

Option 1 - $1,468,800 State $367,200 Federal $1,101,600
Option 2 - No Fiscal Impact

Premise of Cost Estimate:

Option 1 - The number of assessments would increase from 2,760 per year to 12, 240. The estimated cost per assessment is $120 for a total of $1,468,000 per year. The assessments would be considered to meet the federal requirement as Preadmission Screening and Annual Resident Review (PASARR) and as such would be matched at 75% by the federal government.

Option 2 - A participation fee would be required of the assessment providers, and this fee would offset the State General Fund matching requirement. There would be no fiscal impact.

Staffing and Operation Expenditure Requirements:

No significant increase would be expected as the service would be performed by outside providers.

Future Impact:

Costs would increase with inflation and caseload increases.

JCS:kaf

P. HHW
1-23-97
Attm #1.
Pg. 3.

STATE: KANSAS

TABLE 5.16E: PROJECTED NUMBER OF NURSING HOME RESIDENTS AND PERCENT CHANGE BY AGE AND SEX, 1980-2000

	NUMBER OF NURSING HOME RESIDENTS			PERCENT CHANGE		
TOTAL	1980	1990	2000	1980-1990	1990-2000	1980-2000
All ages	22366	25690	29039	14.86	13.04	29.84
Under 65	2562	2547	2977	-0.57	16.89	16.22
Under 45	585	614	586	5.08	-4.57	0.29
45-64	1977	1933	2391	-2.24	23.70	20.93
Age 65 & over	19804	23143	26062	16.86	12.61	31.60
65-74	3166	3287	3004	3.82	-8.63	-5.14
75-84	7882	8999	9487	14.17	5.43	20.36
85 & over	8756	10857	13571	24.00	25.00	55.00

MALES	1980	1990	2000	1980-1990	1990-2000	1980-2000
All ages	6504	6965	7569	7.07	8.68	16.36
Under 65	1069	1069	1264	0.05	18.20	18.25
Under 45	256	269	257	5.25	-4.57	0.44
45-64	813	800	1007	-1.59	25.85	23.85
Age 65 & over	5436	5895	6305	8.46	6.95	15.99
65-74	1214	1276	1169	5.03	-8.32	-3.71
75-84	2235	2517	2682	12.60	6.57	20.00
85 & over	1986	2102	2453	5.88	16.67	23.53

FEMALES	1980	1990	2000	1980-1990	1990-2000	1980-2000
All ages	15862	18726	21471	18.06	14.66	35.36
Under 65	1493	1478	1713	-1.01	15.94	14.76
Under 45	329	345	329	4.85	-4.56	0.17
45-64	1164	1133	1384	-2.70	22.18	18.89
Age 65 & over	14369	17248	19757	20.04	14.55	37.50
65-74	1952	2012	1834	3.06	-8.82	-6.03
75-84	5647	6482	6805	14.79	4.99	20.51
85 & over	6770	8754	11118	29.31	27.00	64.22

PHHW
1-23-92
Att. #1

Selected Sections Excerpted From:

IMPACT OF AN AGING POPULATION ON HEALTH CARE NEEDS

State Projections

Prepared for

The Administration on Aging
U.S. Department of Health and Human Services

By

Dorothy P. Rice
Arden L. K. Wick

1985

Institute for Health & Aging
University of California, San Francisco

PHHW
1-23-92

Payment Source for New Nursing Facility Admissions

Total Number of Admissions	Number / Percentage of Private Pay Admiss		Number / Percentage of Medicaid Admiss	
14,938	11,101	74.31%	3,837	25.69%

Source: MDS + data from Myers & Stauffer, Inc

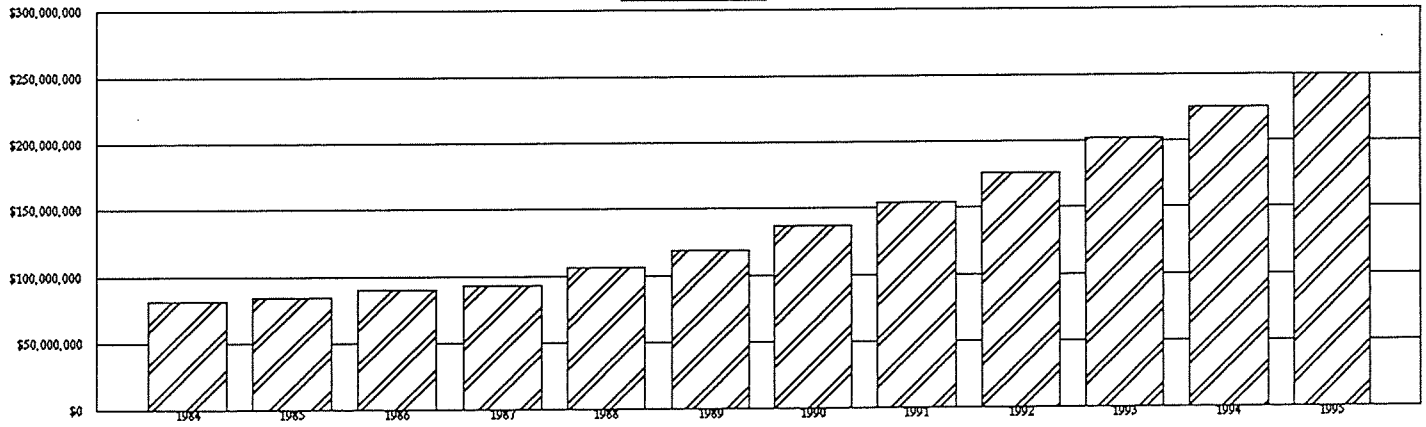
P Hall
1-23-92
attm #6

pg - 6/51

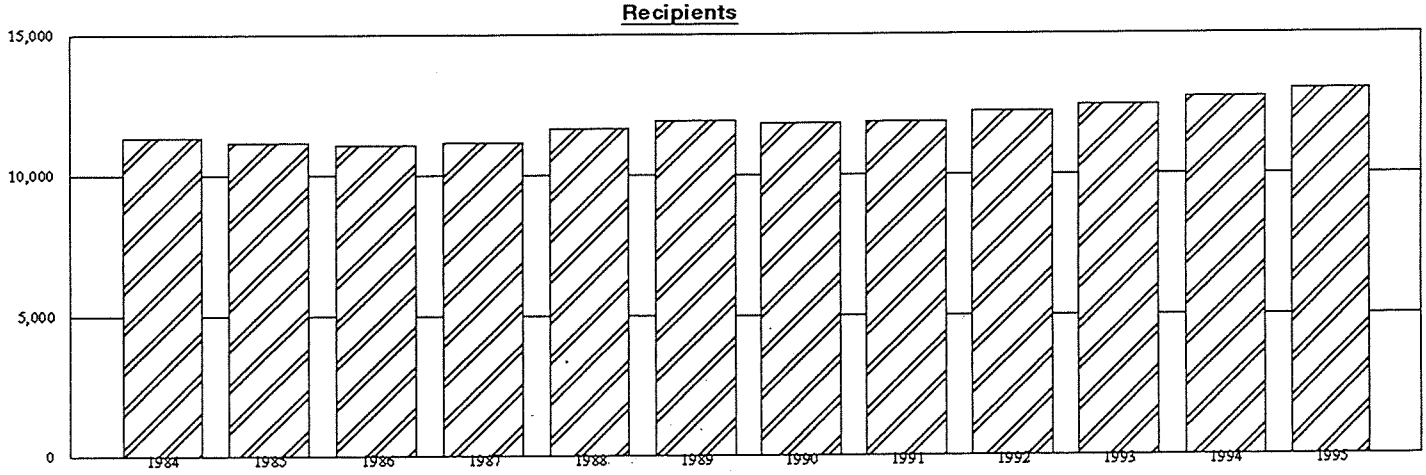
Nursing Facilities Expenditures, Recipients, and Cost per Recipient : FY 1984 – FY 1995

FY	Expenditures	% Chg	Persons	% Chg	Cost per Recipient	% Chg
1984	$81,747,994		11,361		$7,195	
1985	$84,426,922	3.3%	11,159	−1.8%	$7,566	5.2%
1986	$89,995,155	6.6%	11,080	−0.7%	$8,122	7.4%
1987	$92,374,023	2.6%	11,198	1.1%	$8,249	1.6%
1988	$106,115,459	14.9%	11,676	4.3%	$9,088	10.2%
1989	$118,200,451	11.4%	11,948	2.3%	$9,893	8.9%
1990	$136,955,269	15.9%	11,848	−0.8%	$11,559	16.8%
1991	$153,679,258	12.2%	11,904	0.5%	$12,910	11.7%
1992	$176,298,893	14.7%	12,250	2.9%	$14,392	11.5%
1993	$202,266,344	14.7%	12,500	2.0%	$16,181	12.4%
1994	$224,879,721	11.2%	12,750	2.0%	$17,638	9.0%
1995	$250,021,274	11.2%	13,005	2.0%	$19,225	9.0%

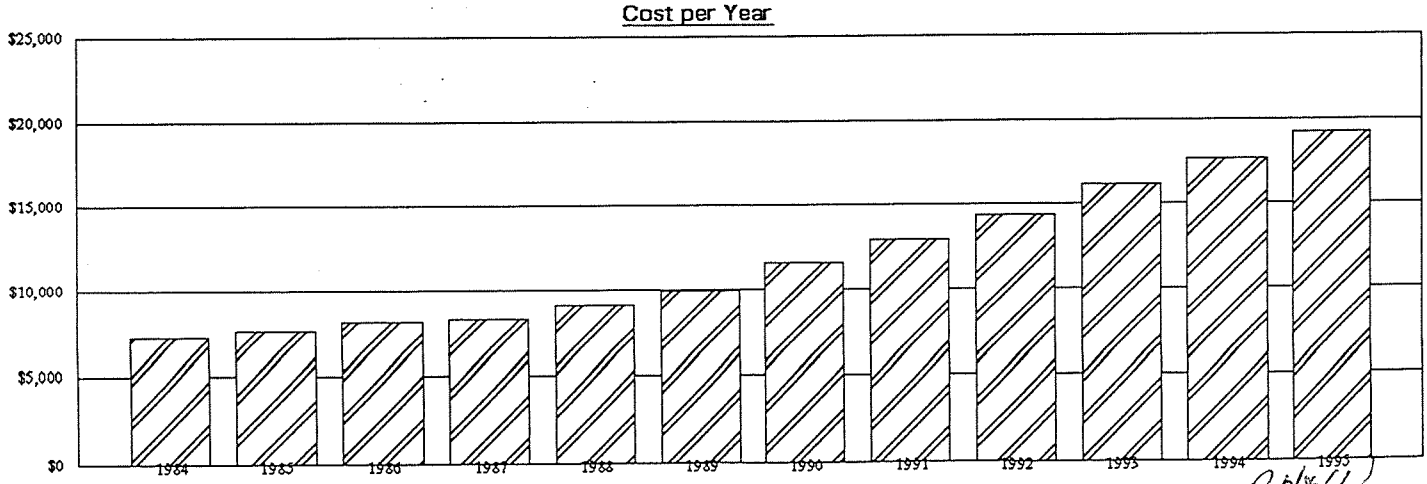
Expenditures



Recipients



Cost per Year



P&W
1-23-92
Attm #1.
Pg 7 of 51

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Donna L. Whiteman, Secretary

HB 2566
(Exclusions to be included in regulations)

Assessments shall be performed on all applicants except:

1) patients transferred from other certified adult care homes;

2) patients who, having entered hospitals from adult care homes are returning to an adult care home;

3) individuals whose length of stay is expected to be 30 days or less;

4) persons entering a facility conducted by and for the adherents of a recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing.

1/23/92

PHHCW
1-23-92
Att #1
39851

A REVIEW OF

THE

PREADMISSION SCREENING and

ALTERNATIVE CARE GRANT PROGRAMS

A Report from the Planning Team
To the Commissioner of the Department of Human Services

March 21, 1991

Prepared Pursuant to Minnesota Laws 1990
Ch. 568, Article 3, Section 56

JAN BUELOW
LONG TERM CARE MANAGEMENT DIVISION
POLICY ANALYSIS, RESEARCH AND CERTIFICATION UNIT

612/296-2862
612/296-6244 FAX

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
HUMAN SERVICES BUILDING
444 LAFAYETTE ROAD
ST. PAUL, MINNESOTA 55155-3844

Many of the recommendations in this report were incorporated into new state law.

PH&W 1-23-92 Attm # 1. Pg. 9251

ACKNOWLEDGMENTS

Much of the content of this report was based on the input and expertise of many people, including senior citizens and their representatives, county ACG administrators, county social workers and public health nurses, providers of long-term care services, representatives of the state agencies of Human Services, Health, Finance, and members of the Minnesota Senate and House of Representatives.

We wish to thank the people who served on this project's work groups for their invaluable assistance. The Planning Team was chaired by Sally Anderberg and Sue Zuidema. The work groups were chaired by Todd Monson, Becky Hooper, Sue Bulger, Charity Floen, Hal Freshley, Barbara Elkins, Carl Carlson, Mary Block, Lou Towner and Rob Super. Their firm commitment to the project and its ideals has helped to create a positive climate for the provision of alternative long term care services.

The Long Term Care Management Division of the Department of Human Services was responsible for the report. Brian Theine, graduate student intern, provided preliminary research, scheduled meetings, prepared summaries of committee work, formatted the report and assisted in the various re-writes of the report. Principal report authors were Jan Buelow and Barbara Colliander. Overall project direction was provided by Pam Parker, Director Long Term Care Management Division.

PHAW
1-23-92
Attm #1.
Pg. 10251

A REVIEW OF THE PREADMISSION SCREENING AND ALTERNATIVE CARE GRANTS PROGRAM

Section I. EXECUTIVE SUMMARY

Introduction

In 1990, the state legislature requested a review of both the Preadmission Screening (PAS) and the Alternative Care Grants (ACG) programs. The Commissioner of the Department of Human Services assigned the task to the Department's Long Term Care Management Division which, in turn, appointed work groups to assist in the review process. The meetings and deliberations of these groups took place during the summer and early fall of 1990.

This report presents the findings of the planning team and includes recommendations to the Commissioner for improving the PAS and ACG programs. The review process looked at all aspects of the programs. However, the key issues which sparked a need for a review were:

- Preadmission screening mission and purpose
- ACG program eligibility
- Copayments for ACG services
- Sufficient ACG funding and forecasting future needs for funds
- The formula for the allocation of ACG funds to counties

Overview of the PAS and ACG Programs

Preadmission screening began in 1981 as an assessment of applicants to nursing homes. The screening is conducted by a county team composed of a social worker and a public health nurse. The team determines if nursing home placement is necessary and offers cost effective alternatives to the client and family.

In 1982, the Alternative Care Grants program was initiated to support the efforts of the preadmission screening team. At the time of the preadmission screening, the client is told about the options available and makes the choice of nursing home placement or community placement. ACG funding is available to pay for home care services for people who choose to remain in the community and who are MA eligible or would be MA

PH+CW
1-23-92
attm #1.
pg 11.251

eligible within 180 days following admission to a nursing home. A case manager is assigned by the county to assure the health and safety of the client and to see that cost effective services are provided.

The ACG program has two parts:

1) The medicaid waiver portion is for persons who are MA recipients; the funding includes federal, state and county funding, and

2) The 180-day portion for persons who would be eligible for MA within 6 months if they entered a nursing home. The funding for this portion is only state and county dollars; for most of these clients, there is also a copayment based on a sliding fee schedule.

During the first one and one-half years of the PAS program, 2,323 persons were screened. The program has grown considerably since then: in fiscal year 1990, approximately 20,000 persons were screened. About 8,500 people are expected to receive ACG services in FY91. It is estimated that approximately 20,000 people have received ACG services since the beginning of the program.

Related Trends

The work groups reviewed demographic data and trends, in order to discuss the future needs for the PAS and ACG program. Some of the more significant findings were:

- Minnesota's elderly population is growing more rapidly than any other segment of the population. People over the age of 85 are most likely to need long term care services; this population will grow significantly within the next 10 years. The projected statewide average population increase for the 85+ age group is over 32 percent, and in some areas of the state, this population will increase by 50 percent.

- Minnesota has a high institutionalization rate relative to the rest of the country. While the national percentage of institutionalized elders is 5 percent, Minnesota's is 7.8 percent.

- There are a high number of elderly people in Minnesota who are in nursing homes, but who could benefit instead from community placements. Specifically, persons classified as "case mix A" are likely candidates for community placement. On a statewide basis, one quarter of nursing home residents are classified as "A's". In some areas of the state, the percentage of "A's" in nursing homes is over 30 percent.

PI&CO
1-23-92
attm #1.
pg 12.851

- In spite of a natural decline in demand for nursing home beds during the last ten years, there is a projected future need for greater nursing home bed capacity because of the growth in the elderly population. Unless there is an aggressive plan to develop alternative settings, over 5,000 additional beds would be needed by the year 2000, and a total of 8,439 additional beds would be needed by 2010.

- Costs for institutional placements will continue to be high. Assuming only a 5 percent increase in rates, and otherwise calculating the costs at constant 1990 dollars, the total state share cost of medicaid nursing home expenditures would grow from the present $224 million to over $713 million by 2010.

- There is a direct correlation between the ACG caseload and the medicaid nursing home caseload. As ACG utilization increases, the nursing home medicaid caseload drops. During a period early in 1990, when intake for the ACG caseload was frozen, the ACG caseload dropped, due to attrition. This was matched by a corresponding increase in the MA nursing home caseload. Data for the period from FY87 through the second quarter of FY91 indicates a ratio of 2 to 1, that is, for every two persons added to the ACG caseload, there is a reduction of one person from the nursing home medicaid caseload.

Conclusions and Recommendations

The various persons assigned to help with the review indicated that the PAS and ACG programs have many good features which have served well in the past ten years. However, there are areas where the complexity and the rules may now be stifling innovation and efficient administration of the program. The planning team proposed several significant changes in the program in order to address needs projected by demographic trends.

There were a considerable number of conclusions and recommendations for all of the aspects of the two programs. For this executive summary, the conclusions have been condensed into a few general areas of concern. While there are about 50 separate recommendations, only those related to major policy concerns will be listed here. A complete list of the recommendations may be found in the text of the report and the appendix.

PH+W.
1-23-92
Attn #1.
pg 13 of 51

PREADMISSION SCREENING

The conclusions reached regarding the Preadmission Screening program indicate that while the program has been functioning adequately in some areas, a major change is in order, especially if the state desires to expand the diversion of new admissions to nursing homes and to continue the moratorium on new construction of nursing home beds.

The current mission of PAS as a cost containment measure is still appropriate, but efforts at preventing or delaying nursing home admissions are often too late to effect a community placement. Earlier intervention in a person's long term care decision process is needed.

At the same time, all applicants to nursing homes still need an assessment and need to be offered cost effective alternatives, but they do not necessarily require a full comprehensive screening. Nursing home residents need to receive follow-up contacts to facilitate possible discharge back to a community setting.

A viable solution to the concerns about the current PAS process would be to allow counties more flexibility in administering the assessment and screening activities, allowing screeners to use professional judgment about the timing and complexity of the assessments.

Frail elderly persons and their families must know, prior to deciding about nursing home care, that options and choices are available. This knowledge must be easily accessible to them. Help in the long term care decision process should be provided through a variety of means such as information and referral, telephone triage, on-site screenings, home visits, and follow up contacts.

The county social worker and the public health nurse remain the most appropriate professionals to conduct such functions as telephone triage, assessments and comprehensive preadmission screenings. Other activities, such as information and referral, home visits and follow-up functions need not be done by a social worker or public health nurse, yet they should be done by a person skilled at helping people sort through the options and choices.

The planning team agreed that the current assessment form for a full preadmission screening is too long, has duplicative material and does not adequately allow for professional discretion. The form should be shortened to ensure an efficient use of the limited time available for screenings. There should continue to be professional expertise for developing the care plan based on the needs of the client and caregivers.

PH&W 1-23-92 attm #1. pg. 14 of 51

Finally, the team concluded that the current reimbursement system pays for tasks, i.e., a "screening", instead of functions or results. This has not been as cost efficient as desired. Paying for salaries for staff who are performing an outcome-based function, would ensure a greater sense of responsibility for results.

The recommendations of the planning team for PAS can be summarized as follows:

- The mission of the preadmission screening program should continue as an assessment of nursing home applicants, and an opportunity to offer cost effective alternatives. However, it should be broadened to include early intervention, increased information dispersal, and help in planning for independent living for as long as it is appropriate and desired. The preadmission screening program should continue to ensure state compliance with federal waiver and OBRA regulations.

  The new broadened screening concept should be available to all who request it; furthermore, all who enter a nursing home must receive some form of assessment, though in some situations this may not be a full face-to-face PAS.

- The new broadened screening concept should be promoted to the entire public, but especially to older adults, their family members, senior organizations, community agencies and organizations, and professionals typically involved in the long term care decision making process.

- The counties may continue to use a multi-disciplinary team (social worker and public health nurse) for preadmission screening and comprehensive assessments, but the county should have discretion to determine when only one of these professionals is needed to conduct a screening or assessment, assuring input from both disciplines.

- The counties should be authorized and funded to provide a well-functioning broadened screening concept which includes information and referral, telephone triage, in-home assessments, preadmission screening, follow-up contacts, and case management.

- The assessment for PAS should be less detailed and intrusive. Within federal and state mandates, the form should allow screeners to use professional judgment to adapt to the client's condition, situation and location.

P&C
1-23-92
Attm #1.
Pg 15.3 5 1

- The current system of reimbursing counties on a fee for service basis for each screening should be replaced with a mechanism where the state contracts with counties for staff to implement the broadened screening concept.

ACG PROGRAM ELIGIBILITY

There was considerable discussion on the current eligibility criteria for ACG. The planning team reached the conclusion that, given the current financial situation of the state and the funding available for the ACG program, and given the fact that the program is cost effective with its current eligibility standards, the eligibility criteria should not be expanded at this time. Therefore, the team recommended that the current criteria be retained. The current eligibility criteria for the ACG program are:

- The individual is age 65 or older;
- The individual is an MA recipient or is 180-day eligible;
- The PAS team would recommend nursing home placement for the individual, if home care services were not provided;
- The individual needs services which are not available through other funding; and
- The cost of ACG services provided to the individual must be less than the cost of nursing home care.

The team agreed that persons who would be eligible for MA without a spenddown should be required to apply, if they wish to receive home care services under the ACG program. Furthermore, to make MA eligibility more appealing to married couples, the team suggested that the spousal impoverishment rules for nursing home residents be applied to persons who are served under the medicaid waiver portion of the program.

COPAYMENTS FOR ACG SERVICES

The 180-day portion of the ACG program requires a copayment for those who have a monthly income over $800 and resources in excess of about $4,500.

Typically, counties have collected only about 30 percent of these fees. However, the planning team has concluded that a copayment is important for the ACG program. They believe that seniors generally want to contribute something to the cost of their services and that they value the services more if they have to pay for them.

The team determined that the state should expect the 180-day eligibles to pay according to a progressive sliding fee schedule based on income and assets and to expect those, whose income and assets exceed the 180-day eligibility criteria, to pay for their own care.

The planning team recommended that the ACG program operate on a revised copayment plan, open to all eligible older adults, as follows:

- MA recipients' home care services are covered 100 percent by medicaid funding;

- 180-day eligibles' home care services are covered by a combination of ACG funding and a copayment based on a progressive sliding fee schedule, and

- Persons who are neither MA nor 180-day eligible must pay 100 percent for their home care services which are not covered by another source, such as medicare or insurance.

This plan suggests that all persons meeting the non-financial ACG eligibility criteria are "eligible" to use ACG services, but the persons who are neither MA nor 180-day eligible are required to pay the full cost of their services. This is suggested as a promotional tool, to encourage all older Minnesotans to consider home care services.

The team suggested that, during the next year, the department review the purpose of collecting fees/copayments and the amount collected and recommend a mechanism for collecting the fees efficiently.

ACG SERVICES

The Alternative Care Grants program currently provides funding for: adult day care, adult foster care, respite care, homemakers, home health aides, personal care, case management, and care related supplies and equipment.

PH+W
1-23-92
Attm #1.
Pg 17 & 51.

There was pressure from counties, providers and consumers for the ACG program to cover additional services. No consensus was reached regarding which services should be added, however. The services which were desired varied from area to area and depended on the accessibility of a particular service and the availability of other funding sources.

The planning team's recommendations included a request that the ACG service package be flexible enough to meet clients' needs and that the program cover services that are not adequately funded through other sources. The team recommended that counties be permitted to use up to 10 percent of their ACG allocations for funding services not currently covered under ACG. Such services should include:

- Assisted living services;
- Chore services;
- Home-delivered meals;
- Transportation;
- Skilled nursing; and
- Nutrition services.

UTILIZATION OF THE ACG PROGRAM

The utilization of the ACG program has varied from county to county. Key factors in the number of ACG clients are: 1) enthusiasm of local staff and providers, 2) the knowledge of the older adults and their families and 3) the attitude of older adults about nursing homes. The team agreed that county staff need to be committed and enthusiastic, and that the older adults and their families need to be knowledgeable about home care options. There seems to be an attitude that eventually everyone will end up in a nursing home.

Minnesota needs to create a new mindset on the part of the general public, and in particular, older adults and their families. The new mindset is one which opts for community care. The team claimed that the state needs an outreach strategy and widespread public information and education about the program. This public awareness strategy should include the promotion recommended for the new

broadened screening concept, so that the public knows where to access services and get help in making decisions for long term care.

The major recommendation of the team was that a professional public awareness strategy be developed for the access and screening concept and the ACG program to promote the program as a holistic, comprehensive approach to lifestyle and health planning. The goal of the major statewide outreach and education effort is to change consumers' attitudes and behavior regarding long term care options.

MEASURING PROGRAM EFFECTIVENESS

While the planning team determined that the ACG program has been successful in keeping frail older adults in the community, the group recommended that long range goals and objectives for evaluating the program's effectiveness should be developed. Further, these goals and objectives must be translated into specific quantitative and performance indicators for the counties to determine if the goals and objectives are reached. This would improve the overall accountability for county efforts and support the argument for a stable funding base.

The group agreed that the state needs a mechanism for gathering and analyzing the various sources of data for the long term care system. Data sources are inconsistent or incomplete and are difficult to pull together for analysis.

The planning team recommended that:

- The ACG program be evaluated in terms of its primary goal to assist persons age 65 and older to remain as functionally independent as possible, in the most cost-effective and least restrictive setting;
- The department create outcome-based measurements with performance indicators for measuring effectiveness on local and statewide levels; and
- The department establish a long term care database which would combine extant date sources to that they are readily accessible to the state and other policy makers.

PHCW
1-23-92
attm #1.
pg. 19.351

FORECASTING AND FUNDING FOR THE ACG PROGRAM

While there has been overall a steady increase in ACG funds appropriated by the legislature, the planning team concluded that the funding of the program has not been stable. The ebb and flow of funding (i.e., appropriations one year, reductions the next) affects the ACG caseload and, as a result, the success of the program. When there was funding available, it took some time for the caseload to build up. During this time the money is not spent, and the appropriation for a future year has been reduced just as the caseload is reaching a peak. The reduced appropriation causes the increase in caseload to stop and the expenditures are reduced. However, the need and demand for services remains and forces the legislature to increase the funding for the next year. It was apparent to the planning team that the forecasting methodology and the funding should guarantee sufficient funds to provide for a stable, continuous program growth.

The two recommendations for forecasting and funding were:

- The department should use additional data gathered by the proposed long term care database to enhance its forecasting ability for the ACG program, and

- In its regular biennial budget process, the department should forecast the funds needed to allow an adequate stable growth of the program.

ALLOCATION FORMULA

The ACG appropriation is allocated to counties each year based on a formula in statute. It was the allocation formula for ACG funding which caused so many problems during fiscal year 1990 and led to the review of both programs. In fiscal year 1989 several counties were experiencing rapid growth in the ACG program. The growth required funding beyond the amount of the allocations that were available to them. The department was no longer able to reallocate funds from one county to another as it had in the past, because all counties asserted that they would spend their allocation during the fiscal year. In February 1990, the funding situation became so critical that the intake for new 180-day eligible ACG cases was frozen statewide.

The 1990 Legislature revised the allocation formula to more closely reflect the actual expenditures and caseloads of each county. This formula was reviewed by

P Hall 1-23-92 Attn #1. Ag. 20951

a work group and a modification of the statute was suggested. The planning team agreed that the overall goal of an allocation formula was to provide a stable funding base for each county. However, targeted funds should be available to counties most in need of additional funding. The important feature of targeted funds is that they become part of the county's base funding for the next year.

The planning team recommended the following allocation formula:

> If a county spends 95 percent or more of its FY91 allocation during FY91, the allocation for FY92 is 100 percent of the FY91 allocation, plus inflation.
>
> If a county spends less than 95 percent its FY91 allocation during FY91, it FY92 allocation is reduced by the amount of unspent funds below 95 percent of the FY91 allocation.

Unspent monies in the base would be pooled with any additional monies allocated by the legislature into a single pot for funding targeted projects. Recommended priorities for targeted funds are as follows:

- Counties which were cut in the FY91 allocation process and demonstrate that they will use the funds can receive priority until they have returned to the original FY90 allocation level.
- Counties which sustain general base reductions for failure to spend 95 percent of their allocation and can demonstrate to the department that their general base reduction should be restored.
- Counties which propose projects to divert community residents from nursing home placement or convert nursing home residents to community living.
- Counties which can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or otherwise unmet needs.

ADMINISTRATION OF THE ACG PROGRAM AND COORDINATION WITH OTHER WAIVER PROGRAMS

Various work groups discussed different aspects of the administration of the ACG program and expressed concerns about the complexity of the program and the

P. H-W.
1-23-92
Attn #1.
Pg 21. 2 51

inconsistencies with other waiver and MA home care programs. While it was agreed that there are some good reasons for differences, there was still a widespread belief that some of the complex processes and procedures, the myriad forms and the inconsistent policies could be eliminated or simplified to enable counties to administer the programs more efficiently.

The planning team requested that the department review the suggestions made by one of the work groups and to respond with appropriate changes or reasons why changes could not be made. This was done during the fall of 1990. Further, the planning team suggested that the alternative care and waiver programs should be as consistent with each other as possible. The team also requested the department to reduce paperwork and improve accuracy of data printouts.

These views are reflected in some of the ensuing recommendations:

- The department should make as many of the suggested changes in administrative procedures and forms as are feasible, with an aim towards making programs as congruent as possible.

- The department should develop one operating manual for the waiver programs (except MR/RC) and MA home care.

- The department should take a broader view of the programs by establishing a clear purpose and objectives for counties to meet; counties could then manage administrative detail, with technical assistance from the state.

RATES FOR ACG SERVICES

The rates for ACG and other waivered services are not completely consistent with each other nor with MA home care services. Attempts have been made to equalize rates; however, most rates are in statute or rule and must have appropriate amendments to make them consistent. In some cases, rates for one program would need to be increased to match another program. This would result in an added cost for the first program. The ACG program has an additional complexity in its rate structure: each county has its own rate for ACG services. Although the rates are all under a state limit, if all counties were allowed to use the state maximum limit, there would be an added cost.

The planning team concluded that, in spite of the added costs, there should be an attempt made to equalize rates over the different home care programs and that the

PH&W 1-23-92 attm #1. pg. 22 & 51.

same inflation index be used. Counties should be allowed to use the state limit for ACG rates and not have individual county limits.

The resulting recommendation was a request to the department to conduct a periodic review, at least every three years, of the actual costs for providing covered services, and, within available resources, adjust reimbursement levels as indicated by the review.

REIMBURSEMENT TO COUNTIES FOR ACG SERVICES

The last area discussed in the report is the billing and reimbursement system. This is the same MMIS used by all medicaid providers, but it has special features for reimbursement of ACG and waiver services. The system has proved complicated and difficult for counties and the department to utilize. The counties report continued problems with rejected and suspended billings. Attempts have been made to resolve these problems, but there are always a few invoices which do not make it "through the system".

The planning team determined that the solution to these problems would be a new reimbursement mechanism, where the department could contract with the counties for ACG funding and the county would be reimbursed in an aggregate fashion, rather than individual client fee for service invoices. It was noted that the billing and reimbursement problems still must be resolved for the waivers, since they must be maintained in the fee-for-service system under MMIS.

Consequently, the planning team recommended that the department replace the current billing system for the ACG program with a contracting system which eliminates the invoicing and fee-for-services reimbursement. They further suggested that the department review the current billing system for medicaid waivers and make revisions in order to reduce instances of bill suspensions and rejections.

PH&W
1-23-92
Attm #1.

0923g51

Implications of the Review

By making the changes in the PAS and ACG programs as suggested by the planning team, the department and counties expect considerable improvement in successfully reversing the trend for the long term care system. The features to be highlighted are:

- The flexible screening process is designed to reach more people as they make decisions about long term care, and to encourage greater use of cost effective alternatives;

- The outreach strategy for public awareness is designed to encourage people to choose the alternative settings;

- The copayment system is designed to require people to help pay for their home care services and to stretch the state dollar to more persons;

- The expanded services package is designed to better meet the individual needs of ACG clients and to allow more options for community settings;

- The consistency between program administrative procedures and service rates and a reduction of forms would ease the administrative problems;

- The establishment of a database would ensure improved forecasting for long term care needs, including a stable funding base for ACG, and would assist with measuring the achievement of goals through performance indicators;

- The amendments to the ACG allocation formula will support the stable funding base and target funds to areas where most needed.

- ACG reimbursement through a contract mechanism would encourage the state to look at broader program effectiveness criteria and allow the counties to be responsible for the micro-management concerns.

The achievement of these suggestions will depend on the continued cooperation between the department and county social service agencies, county public health nursing agencies, providers, and seniors themselves. These improvements have an added bonus in that they support the desire of older adults who wish to remain as independent as long as possible. The challenge for all concerned is to accomplish the goals and meet the needs within the available resources.

PH&W 1-23-92 Attm #1 Pg. 247 51.

RESULTS OF THE COMMUNITY-BASED SCREENING AND RECOMMENDATIONS

Name_____ Date of Screening_____

Address_____
(indicate name of adult care home, if applicable)

City/State/Zip_____

Social Security Number_____ Medicaid Number_____

Screeners_____

_____

On the basis of this screening:

1. ____client has a medical need requiring adult care home placement.

2. ____Client meets the criteria of medical need for adult care home placement but would be eligible for the Home and Community Based Services Program if client chooses.

3. ____client is determined to have no medical need requiring adult care home placement.

CARE PLAN

Service(s)	Specific Task(s)	Day(s)	Time(s)	Duration

PHHW
1-23-92
Att #1

3J 25751

IDN /__/__/__/-/__/__/-/__/__/__/__/
(SSN)

May, 1988

KanSAS ASSESSMENT INSTRUMENT

The Kansas Dept. of Social and Rehabilitation Services

Developed by
Linda J. Redford, R.N, Ph.D.
University of Kansas Medical Center
Center on Aging

*1. County of Residence _____ *2. Date of Screening _____
(mo/day/yr)

*3. Name (Last name first) _____

*4. Street, Apt. # _____

City _____ State _____ Zip _____

*5. Phone (with area code) _____

*6. Source of Referral _____

*7. Interviewers' Names and Titles (MSW, RN, etc.) _____
_____

*8. Indicate the location at which the assessment is being conducted?
1 Adult Care Home or Other Long-term Care Institutional Setting
2 Client's home
3 Hospital
4 Other _____
(specify)

*9. What is the client's present place of residence?
1 Adult Care Home or Other Long-term Care Institutional Setting
2 Own Residence (include apts. or other rented housing facility)
3 Home of relatives, friends, etc.
4 Other _____
(specify)

[ASK 10 and 11 ONLY IF CLIENT IS CURRENTLY IN AN ADULT CARE HOME]

*10. What was the client's residence prior to entering the Adult Care Home?
1 Adult Care Home or Other Long-term Care Institutional Setting
2 Own Residence (include apts. or other rented housing facility)
3 Home of relatives, friends, etc.
4 Other _____
(specify)

*11. What is the length of time (consecutive) the client has been in Adult Care Home(s)?
_____ Years _____ Months

**Complete on all clients unless otherwise indicated. In addition, questions not starred (*) should be asked of clients residing in non-institutional settings and those it appears could return to a non-institutional setting.*

Pltf'd
1-23-92
Att #1
26751

DEMOGRAPHIC DATA

*1. Sex of Individual Screened:
1 Male
2 Female

*2. Birthdate _____ Age _____
(month/day/year)
(Make certain to indicate the correct birthdate and age in the above spaces.)

*2a. Were the birthdate and age given by the client both correct?
1 Yes
2 No

*3. Ethnic Background:
1 Black
2 White (non-Hispanic)
3 American Indian
4 Hispanic
5 Asian/Pacific Islander
6 Other (specify) _____

*4. Is the client able to communicate well in the English language?
1 Yes
2 No

IF NO, indicate the client's primary language. _____

*5. Years of School Completed: _____

*6. What is/was your (the client's) primary occupation? _____

*7. Are you now married, divorced, separated or have you never been married?
1 Now Married
2 Widowed
3 Divorced
4 Separated
5 Never Married
9 Not answered

ASK 7a and 7b ONLY IF CLIENT IS CURRENTLY MARRIED

*7a. What is your spouse's current place of residence?
1 Adult Care Home or Other Institutional Setting
2 Own Residence (include apts. or other rented housing facility)
3 Home of relatives, friends, etc.
4 Other _____
(specify)

*7b. What is your spouse's condition?
1 Able to perform routine household tasks without assistance
2 Requires assistance with household tasks
3 Unable to perform routine household tasks

Phew 1-23-92 Attn #1 8927

HEALTH INFORMATION
(Questions 1-5 represent information which may be needed for referrals. This information is OPTIONAL).

*1. Name of Primary Physician _____

Name of Other Physicians _____

*2. What is your Medicare number? _____

*3. What is your Medicaid number? _____

*4. Other ID# needed for referrals _____

_____

_____

HEALTH STATUS

*1. List the health problems, sensory problems, or other health related conditions currently experienced by the client. Place a check mark (✓) in the column CURRENT TREATMENT if the client is currently receiving treatment for the condition. Make any additional comments under the section titled COMMENTS. Sources of information may be the client, the client's family and/or other persons familiar with the client, medical records, etc.

PROBLEMS OR CONDITIONS	CURRENT TREATMENT	COMMENTS (i.e. type problem, severity, etc.)

PHHW
1-23-92
Att #1.
28451

*2. How is the client's hearing (with hearing aid)? (USE PROFESSIONAL JUDGEMENT IN EVALUATING.)

0 Good
1 Fair
2 Poor
3 Totally Deaf
9 Not answered

*3. How is the client's eyesight (with glasses or contacts)? (USE PROFESSIONAL JUDGEMENT IN EVALUATING.)

0 Good
1 Fair
2 Poor
3 Totally blind
9 Not answered

*4. Have you (has client) fallen in the last month?

1 Yes
2 No

*4a. IF YES, how many times have you (has client) fallen in the last month?
Number of times _____

*5. What medications are you (is client) currently taking on a regular basis? Give (1) medication(s), (2) the dosage, and (3) how frequently do you (does client) take it?

Medications (including over-the-counter drugs such as vitamins, laxatives, etc.)	OTC	Rx	Dosage	Frequency Taken	Prescribed Frequency

*6. Do you (does client) require any of the following procedures or services? Place a check mark (✓) next to any procedures or services needed.

(a) _____ Dressing changes
(b) _____ Administration of oral, IM, or IV medications or fluids
(c) _____ Medication monitoring
(d) _____ Close Monitoring of health problem
(e) _____ Therapy (i.e. physical, occupational, speech, etc.)
(f) _____ Other (specify) _____

_____

*7. Does the client need any of the following equipment or assistive devices? IF YES, place a check mark (✓) in the NEED column next to the appropriate equipment or device. Complete the USE section for all items needed. Check N/A if not answered.

	NEED	USE			
		Uses	Has Does Not Use	Does Not Have	N/A
	(1)	(3)	(2)	(1)	(9)
Glasses or Contact Lenses...					
Magnifying Glass.....					
Dentures.....					
Cane.....					
Walker.....					
Crutches.....					
Wheelchair.....					
Hospital Bed.....					
Leg Brace.....					
Limb Prosthesis.....					
Back Brace.....					
Pacemaker.....					
Hearing Aid.....					
Portable Commode.....					
Indwelling Catheter.....					
External Urinary Device.....					
Ostomy Equipment.....					
Speech Aids (voice box, word box).....					
Other.....					

_____

_____

*8. How many <u>times</u> were you (was client) in the hospital in the past six months? Number of times _____

*9. When did you (client) last see a physician?

1 Within last month
2 1-6 months ago
3 7 months to 1 year ago
4 Longer than 1 year ago
5 Not sure
9 Not answered

PHRW
1-23-92
Att #1
99-30 ℄51

*10. When did you (client) last see a dentist?
1 Within last month
2 1-6 months ago
3 7 months to 1 year ago
4 Longer than 1 year ago
5 Not sure
9 Not answered

*11. How often do you drink alcoholic beverages?
0 Never
1 Less than once/mo.
2 Once a month
3 A few times a month
4 Once a week
5 A few times a week
6 Almost every day
7 Drank at one time, no longer drinks
9 Not answered

*11a. INTERVIEWER: Do you suspect the client has a greater alcohol intake than reported? 1 Yes 2 No
Comments _____

*12. Have you ever had a problem with your health because of drinking or has your physician advised you to cut down on drinking?
1 Yes
2 No
3 Not answered

*13. What is your smoking status; currently smoking, a former smoker, or never smoked? (smoking only a few cigarettes in lifetime is coded "NEVER SMOKED")
1 Never Smoked
2 Former Smoker
3 Currently Smoking
9 Unknown

*14. If currently smoking or a former smoker...
a) How long have (did you) smoke? _____
b) How many cigarettes per day? _____

15. During the past six months, how much time were you too sick to carry on your usual activities around the house?
0 None
1 A week or less
2 More than a week, but less than a month
3 1-3 months
4 4-6 months
5 Not sure
9 Not answered

P&W 1-23-92 Attm #1.
873/451

*16. How would you rate your health at the present time: good, fair, or poor?
0 Good
1 Fair
2 Poor
9 Not answered

*17. Do your health troubles keep you from doing the things you want to do?
0 Not at all
1 A little (some)
2 A great deal
9 Not answered

*18. Do you feel anyone is taking advantage of you physically, emotionally, or any other way?
3 Yes
2 Unsure
1 No
9 Not Answered

IF YES or UNSURE, what is the person's or persons' relationship to you?
1. _____

2. _____

COGNITIVE STATUS

INTERVIEWER: This section should be administered to all persons 60 years of age and older, persons with a history of severe head trauma, and persons with any indication of cognitive impairment, confusion, or disorientation. This section is optional for other persons.

INSTRUCTIONS FOR ADMINISTRATION:

1. Ask all questions exactly as stated.
2. If client is unable to answer a question as a result of obvious confusion or disorientation, mark the question incorrect.
3. If client refuses to answer a question and you are uncertain whether he/she is able to do so, mark "9 Refused to answer".
4. If client is unable to answer the questions because of a communication disorder or other physical condition, place a check mark (✓) in the box below, explain the problem, and go to the next section.

CLIENT UNABLE TO RESPOND |__|
REASON: _____

Go to Interviewer's Manual for additional instructions on administration.

*1. I am going to say three words that I'd like you to remember. They are PENCIL, CAR, and WATCH. Would you say them? (Any order is acceptable. Spontaneous correction is permissible. Place the number of correct words below. Also indicate below words other than the correct stimulus words. Use of correct response means all three words are correct.)
0 Correct
1 Incorrect
9 Refused to answer

Number of correct responses _____
Indicate any incorrect responses _____

PHHCW
1-23-92
Att #1.
pg. 32 of 51

I want you to remember the three words. It's very important. I'm going to ask you to say them to me in a few minutes. Remember, the words are: PENCIL, CAR, and WATCH. I am going to ask you some other questions now and we'll come back to the three words later.

*2. WHAT IS YOUR BIRTHDATE? (Check birthdate on front page. Month, day and year must be correct.) Record answer _____

0 Correct
1 Incorrect
9 Refused to answer

*3. WHAT DAY OF THE WEEK IS IT TODAY? (i.e. Monday, Tuesday, etc.)
Record answer _____

0 Correct
1 Incorrect
9 Refused to answer

*4. WHAT MONTH IS IT? Record answer _____

0 Correct
1 Incorrect
9 Refused to answer

*5. WHAT YEAR IS IT? Record answer _____

0 Correct
1 Incorrect
9 Refused to answer

*6. IF YOU HAVE $9 AND I GIVE YOU $6 MORE, HOW MUCH MONEY WOULD YOU HAVE? (Do not allow the client to write down the numbers to the problem. The question may be repeated at client's request. If repeated, the whole question should be repeated, not just parts of it. Check as incorrect any response other than 15 or $15.00.)

0 Correct
1 Incorrect
9 Refused to answer

*7. WHO IS THE PRESIDENT OF THE UNITED STATES? Record answer. _____

0 Correct
1 Incorrect
9 Refused to answer

*8. APPLES AND PEARS ARE FRUIT, CATS AND DOGS ARE ANIMALS, BLUE AND GREEN ARE _____? Record any incorrect response _____

0 Correct
1 Incorrect
9 Refused to answer

*9. SUBTRACT BY 3's STARTING WITH 20. (Check below as the client gives the numbers and record all errors. Spontaneous correction is allowed. Extending the sequence below the number 2 is not counted as an error but should be noted. No error is permitted.)

20 17 14 11 8 5 2

0 Correct
1 Incorrect
9 Refused to answer

pHrd 1-23-92 Patient #1, 933451

*10. CAN YOU TELL ME THE THREE WORDS I ASKED YOU TO REMEMBER? WHAT ARE THE THREE WORDS? (Any order is acceptable. Spontaneous correction is permissible. Place the number of correct words below. Also indicate below words other than the correct stimulus words. Use of correct response means all three words are correct.)

0 Correct
1 Incorrect
9 Refused to answer

Number of words given correctly _____
Indicate any incorrect responses _____

SCORING: To obtain cognitive status score, add the number of incorrect responses.

COGNITIVE STATUS SCORE: _____

NUMBER OF QUESTIONS NOT ANSWERED: _____

IF CLIENT SCORES 3 OR GREATER ON COGNITIVE STATUS SCORE, try to obtain the following information from FAMILY MEMBERS or OTHERS WHO KNOW CLIENT.

*1. Have you noticed whether (name) has difficulty remembering or becomes confused at times?

2 Yes
1 Unsure
0 No

*2. How long ago did the memory problem or confusion first become apparent?

1 Within the last month
2 Within the last six months but longer than a month ago
3 Within the last year but longer than six months ago
4 Over a year ago but less than 2 years ago
5 Over 2 years ago
6 Don't know
9 Not answered

*3. Did the onset of memory problem seem to begin and progress...

1 Very rapid (within days or weeks)
2 Very slow (became apparent over months or years)
3 Don't know

BEHAVIORAL ASSESSMENT

INTERVIEWER: This section is to be used if there is an indication of behavior disorders. These questions may be answered through interviewer observation or by a person or persons who know the client well.

IF QUESTIONS ON THIS SECTION ARE NOT ASKED, PLACE A CHECK (✓) IN THE BOX ___

PHaw
1-23-92
Att #1
pg. 34 of 51

*1. Does the client exhibit any of the behaviors listed below? If he/she does exhibit a specific behavior, indicate whether the behavior interferes with his/her functional capacity or requires special care and/or supervision.

	DOES NOT EXHIBIT (0)	EXHIBITS Does Not Interfere (1)	EXHIBITS Interferes (2)
Disoriented/Confused			
Withdrawn			
Hyperactive			
Emotionally labile.(i.e. cries easily, rapid mood swings, etc.)			
Paranoid			
Abusive to self			
Verbally abusive to others			
Physically abusive to others			
Hallucinates/Delusional			
Wanders			
Socially inappropriate behavior			

SCORE: _____

EMOTIONAL (AFFECTIVE) STATUS

INTERVIEWER: Ask these questions of the CLIENT ONLY. Ask the questions as they are worded on this form. Emphasize the words in bold print when asking the initial question.

If client is unable to answer the questions, place a check mark (✓) in the box below and explain the problem.

CLIENT UNABLE TO RESPOND ☐ REASON: _____

Go to Interviewer's Manual for additional instructions on administration.

*1. IN THE LAST MONTH, HAVE YOU FREQUENTLY:	Yes (1)	No (0)
a) Had difficulty concentrating on one thing?		
b) Had difficulty sleeping?		
c) Felt extremely tired?		
d) Felt nervous or restless?		
e) Felt useless, for example, felt like you were a burden on others?		
f) Felt irritable and impatient with yourself?		
g) Felt lonely even when you were with people?		
h) Felt life is no longer worth living?		
IF the answer to two or more of the above questions is YES, ASK:		
i) Seriously thought about taking your own life?		

SCORING: Add the number of YES responses to obtain the Emotional Status score. Also indicate the number of questions Not Answered in the box provided below.

SCORE: _____ NUMBER OF QUESTIONS NOT ANSWERED: _____

PH&W 1-23-92 Attn #1. 89351

*2. Have you (has client) ever been treated for a nervous breakdown, depression or other emotional problems?

1 Yes
2 No
9 Not Answered

ACTIVITIES OF DAILY LIVING

INTERVIEWER: The client should be the primary source of information for this section if he/she is able to respond appropriately and reliably to questioning. If you question a client's responses or the client is unable to respond appropriately to this section, seek information from other persons who know the client well and have had an opportunity to observe his/her performance in these areas. If no one is available to provide this information, performance testing and professional judgment should be used in evaluating the client's ability. Place a check mark (✓) in the appropriate column to indicate functional level.

		Level	(✓)	Score
*1. Drink/Feed	Independent. . .	0		0
		1		-2
	Helper.	2		-5
		3		-8
		4		-10
*2. Dress Upper Body	Independent. . .	0		0
		1		0
	Helper.	2		-1
		3		-2
		4		-4
*3. Dress Lower Body	Independent. . .	0		0
		1		0
	Helper.	2		-1
		3		-2
		4		-5
*4. Grooming	Independent. . .	0		0
		1		0
	Helper.	2		-1
		3		-3
		4		-4
*5. Wash or Bathe	Independent. . .	0		0
		1		0
	Helper.	2		-1
		3		-3
		4		-5

PHHW
1-23-92
Attm #1.
89-36451

*6. Care of Perineum/Clothing at Toilet

	Level	(✓)	Score
Independent. . .	0		0
	1		0
Helper.	2		-2
	3		-3
	4		-5

Personal Care Score 33 less ________ = ________

*7. Bladder Continence

	Level	(✓)	Score
Independent. . .	0		0
	1		-1
Helper.	2		-3
	3		-7
	4		-10

*8. Bowel Continence

	Level	(✓)	Score
Independent. . .	0		0
	1		-1
Helper.	2		-3
	3		-7
	4		-10

Continence Score 20 less ________ = ________

*9. Transfer, Chair

	Level	(✓)	Score
Independent. . .	0		0
	1		0
Helper.	2		-2
	3		-5
	4		-8

*10. Transfer, Toilet

	Level	(✓)	Score
Independent. . .	0		0
	1		-1
Helper.	2		-2
	3		-4
	4		-6

*11. Transfer, Tub or Shower

	Level	(✓)	Score
Independent. . .	0		0
	1		0
Helper.	2		-1
	3		-2
	4		-3

*12. Transfer, Automobile

	Level	(✓)	Score
Independent. . .	0		0
	1		0
Helper.	2		-1
	3		-3
	4		-5

*13. Walk up & down stairs/1 flight

	Level	(✓)	Score
Independent. . .	0		0
	1		0
Helper.	2		-2
	3		-5
	4		-8

PH&W
1-23-92
Attm #1.
09:37:451

ASK QUESTIONS 14 AND 15 ONLY OF PERSONS FOR WHOM WALKING IS THEIR PRIMARY FORM OF MOBILITY

		Level	(✓)	Score
*14. Walk on Level/50 Yards	Independent. . .	0		0
		1		0
	Helper.	2		-2
		3		-8
		4		-10
*15. Walk Outdoors/50 Yards	Independent. . .	0		0
		1		0
	Helper.	2		-2
		3		-5
		4		-7

ASK QUESTIONS 16 AND 17 ONLY OF PERSONS FOR WHOM WHEELCHAIR IS THEIR PRIMARY FORM OF MOBILITY

*16. Wheelchair for 50 Yards	Independent. . .	0		0
		1		0
	Helper.	2		-2
		3		-8
		4		-10
*17. Wheelchair outdoors/50 Yards	Independent. . .	0		0
		1		0
	Helper.	2		-2
		3		-5
		4		-7

Transfer/Mobility Score 47 less _____ = _____

TOTAL _____ + _____ + _____ = _____/100

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

INTERVIEWER: The client should be the primary source of information for this section if he/she is able to respond appropriately and reliably to questioning. If you question a client's responses or the client is unable to respond appropriately to this section, seek information from other persons who know the client well and have had an opportunity to observe his/her performance in these areas. If no one is available to provide this information, performance testing and professional judgment should be used in evaluating the client's ability. Place a check mark (✓) in the appropriate column to indicate functional level.

		Level/ Score	(✓)
1. USE OF TELEPHONE (i.e. locate and read phone numbers, dial numbers, and communicate effectively)	Independent. .	0	
		1	
	Helper. . . .	2	
		3	

Pitted 1-23-92 Attn. #1 Cg. 38751

		Level/ Score	(✓)
2. MEAL PREPARATION (i.e. plan, prepare, and/or cook a full meal)	Independent.	0	
		1	
	Helper. . . .	2	
		3	
		4	
3. LIGHT HOUSEKEEPING (i.e. straighten up, wash dishes, dusting, and sweeping, etc.)	Independent.	0	
		1	
	Helper. . . .	2	
		3	
		4	
4. LAUNDRY (i.e. sort clothes, carry laundry, measure detergent, operate washer and dryer, etc.)	Independent.	0	
		1	
	Helper. . . .	2	
		3	
		4	
5. ROUTINE HOME MAINTENANCE (i.e. fixing minor repairs such as tightening loose screws bolts, checking and lighting pilot lights, changing accessible light bulbs, carrying out trash, etc.)	Independent.	0	
		1	
	Helper. . . .	2	
		3	
		4	
6. MONEY MANAGEMENT (i.e. manage household budget, pay bills, balance checkbook, etc.)	Independent.	0	
		1	
	Helper. . . .	2	
		3	
		4	
7. COMMUNICATION (i.e. communicate verbally and in written form)	Independent.	0	
		1	
	Helper. . . .	2	
		3	
		4	
8. MEDICATION ADMINISTRATION (i.e. manage and administer own medication)	Independent.	0	
		1	
	Helper. . . .	2	
		3	

IADL SCORE: 30 - _____ = _____

PHow 1-23-92 Attn! 09.390.51

9. How often do you:	At Least 1x/week (4)	At Least 1x/mo (3)	Less Than 1x/mo (2)	Never (1)	Not Answered (9)
Go shopping					
Go to the doctor					
Visit friends or relative					
Go to church					
Go to social activities					

TRANSPORTATION

1. Do you own a car or have a car available to drive?
   1 Yes
   2 No

   IF YES, Do you drive the car?
   1 Yes
   2 No

2. Do you have transportation available when you need it?
   1 All of the time
   2 Most of the time
   3 Occasionally
   4 Rarely or never
   9 Not answered

3. Who do you rely on for transportation (check all appropriate categories)?
   (a) _____ Relatives
   (b) _____ Friends
   (c) _____ Neighbors
   (d) _____ Taxi services
   (e) _____ Public buses
   (f) _____ Senior or neighborhood buses
   (g) _____ Other (specify) _____
   _____

NUTRITION

*1. How is your appetite?
   0 Good
   1 Fair
   2 Poor
   9 Not answered

*2. Has your appetite increased or decreased in the last month?
   1 Increased
   2 Decreased
   3 Unchanged
   9 Not Answered

PSHRW
1-23-92
Att. # 1
Pg. 40 of 51

*3. What is your current: Weight _____ Height _____ (inches)

*4. As compared with your weight six months ago, have you (has client):
a) Gained weight 1 Yes 2 No IF YES, specify amount _____
b) Lost weight 1 Yes 2 No IF YES, specify amount _____

*5. Are you (is client) on a special diet? 1 Yes 2 No

IF YES, specify type of diet. _____
_____

6. How many meals do you (does client) generally eat a day? _____

7. Do you (does client) regularly eat between meals?
1 Yes
2 No

*8. How long has it been since you last ate? (ask only of client) _____
(Record as number of hours)

9. Do you (does client) eat more than 3 meals per week away from home?
1 Yes
2 No
9 Not answered

IF CLIENT EATS AWAY FROM HOME, ASK: Where do you usually eat (i.e., restaurant, nutrition site, home of relative, etc.)?
_____
_____
_____

SUPPORT INFORMATION

If client is unable to respond to the following questions, obtain the information from other persons familiar with client.

*1. How many adult children do you (does client) have? _____
(put "0" if client does not have adult children)

IF NO ADULT CHILDREN, SKIP TO QUESTION #4

*2. How many of your (client's) children live within a 30 minute drive?
_____

*3. How often do you (does client) have contact with one or more of your (his/her) children?
1 Daily
2 At least 1X/week
3 At least 1X/month
4 Less than 1x/month but at least 1x every 6 months
5 Less than 1x every 6 months
6 Never
9 Not answered

PNau 1-23-92 Attm #1 04/1451

4. How many persons regularly live with you (client)? _____

5. Who lives with you (client)? (Check all applicable categories.)
   1 _____ No one
   2 _____ Spouse
   3 _____ Other relative(s)
   4 _____ Friend(s)
   5 _____ Non-related paid helper
   6 _____ Not applicable, lives in institutional environment
   9 _____ Not answered

INTERVIEWER: Complete the charts on Household Support (p. 18), Informal Support (p. 19), and Formal Support (p. 20). Indicate those persons or agencies (formal support) who regularly provide the client assistance.

PHHW
1-23-92
Attm. #1
pg. 42 of 51

HOUSEHOLD SUPPORT

THIS CHART IS TO BE COMPLETED FOR HELPERS CURRENTLY LIVING IN HOUSEHOLD WITH CLIENT.

6. Please tell me who in your household regularly helps you with daily activities and/or assists you with personal care tasks. Give those persons who currently live with you. Begin with the person who helps you the most, then give the name of the person who would next provide the most help, etc. (If client is unable to answer, obtain information from family or other persons familiar with client).

	NAME 1 ____________	NAME 2 ____________	NAME 3 ____________
RELATIONSHIP (i.e., husband, wife, daughter, son, friend, etc.)	____________	____________	____________
PHONE NUMBER? (optional)	____________	____________	____________
Is (Name)	1 ____ Male 2 ____ Female	1 ____ Male 2 ____ Female	1 ____ Male 2 ____ Female
Is (Name) usually available to help	1 ____ Day 2 ____ Night 3 ____ Both	1 ____ Day 2 ____ Night 3 ____ Both	1 ____ Day 2 ____ Night 3 ____ Both
Does (Name) provide you assistance	1 ____ Daily 2 ____ 4-6 days/week 3 ____ 1-3 days/week 4 ____ < 1 day/wk	1 ____ Daily 2 ____ 4-6 days/week 3 ____ 1-3 days/week 4 ____ < 1 day/wk	1 ____ Daily 2 ____ 4-6 days/week 3 ____ 1-3 days/week 4 ____ < 1 day/wk
What does (Name) generally help you with? (Check all applicable categories)	1 ____ Personal care 2 ____ Preparing meals 3 ____ Housework, laundry, shopping, chores 4 ____ Taking medicines 5 ____ Medical treatments 6 ____ Transportation 7 ____ Managing money 8 ____ Supervision 9 ____ Other (specify) ____________ ____________ ____________	1 ____ Personal care 2 ____ Preparing meals 3 ____ Housework, laundry, shopping, chores 4 ____ Taking medicines 5 ____ Medical treatments 6 ____ Transportation 7 ____ Managing money 8 ____ Supervision 9 ____ Other (specify) ____________ ____________ ____________	1 ____ Personal care 2 ____ Preparing meals 3 ____ Housework, laundry, shopping, chores 4 ____ Taking medicines 5 ____ Medical treatments 6 ____ Transportation 7 ____ Managing money 8 ____ Supervision 9 ____ Other (specify) ____________ ____________ ____________

Placed 1-23-92
Attm 1.
43 of 51

INFORMAL SUPPORT SYSTEM

THIS CHART IS TO BE COMPLETED FOR HELPERS LIVING OUTSIDE THE CLIENT'S HOUSEHOLD

7. Please tell me the names of family members, friends, and neighbors who do not live with you but <u>regularly</u> help you. Begin with the person who helps you the most, then give the name of the person who would next provide the most help, etc. Please do not include persons who help you as part of their paid or volunteer work. (If client is unable to answer, obtain information from family or other persons familiar with client).

	NAME 1 ______	NAME 2 ______	NAME 3 ______
RELATIONSHIP (i.e., husband, wife, daughter, son, friend, etc.)	______	______	______
PHONE NUMBER? (optional)	______	______	______
Is <u>(Name)</u>	1 ___ Male 2 ___ Female	1 ___ Male 2 ___ Female	1 ___ Male 2 ___ Female
Is <u>(Name)</u> usually available to help	1 ___ Day 2 ___ Night 3 ___ Both	1 ___ Day 2 ___ Night 3 ___ Both	1 ___ Day 2 ___ Night 3 ___ Both
Does <u>(Name)</u> provide you assistance	1 ___ Daily 2 ___ 4-6 days/week 3 ___ 1-3 days/week 4 ___ < 1 day/wk	1 ___ Daily 2 ___ 4-6 days/week 3 ___ 1-3 days/week 4 ___ < 1 day/wk	1 ___ Daily 2 ___ 4-6 days/week 3 ___ 1-3 days/week 4 ___ < 1 day/wk
What does <u>(Name)</u> generally help you with? (Check all applicable categories)	1 ___ Personal care 2 ___ Preparing meals 3 ___ Housework, laundry, shopping, chores 4 ___ Taking medicines 5 ___ Medical treatments 6 ___ Transportation 7 ___ Managing money 8 ___ Supervision 9 ___ Other (specify) ______ ______ ______	1 ___ Personal care 2 ___ Preparing meals 3 ___ Housework, laundry, shopping, chores 4 ___ Taking medicines 5 ___ Medical treatments 6 ___ Transportation 7 ___ Managing money 8 ___ Supervision 9 ___ Other (specify) ______ ______ ______	1 ___ Personal care 2 ___ Preparing meals 3 ___ Housework, laundry, shopping, chores 4 ___ Taking medicines 5 ___ Medical treatments 6 ___ Transportation 7 ___ Managing money 8 ___ Supervision 9 ___ Other (specify) ______ ______ ______

Pg. 44851
Attm #1
1-23-92
(Pepper)

FORMAL SERVICES

8. Please tell me the services or assistance you are currently receiving or have received in the last year from any agency or organization, paid provider, or volunteer. (List the following services to the client then ask if he/she is receiving any additional services. List additional services under "Other" and give the agency or provider.)

	Currently receiving the service or assistance			Received service or assistance in the last year			If Used or Currently Using Service or Assistance, Give Name of Agency(ies) or Provider(s)
	Yes (1)	Not Sure (2)	No (3)	Yes (1)	Not Sure (2)	No (3)	
Meals or Assistance with Meal Preparation (i.e. Meals on Wheels, Nutrition Site, Paid helper, etc.)							
Housekeeping Services							
Routine home maintenance service (i.e., lawn care, minor repairs)							
Home Health Services (i.e. nurse, therapist, etc.)							
Personal Care							
Respite Care (i.e. Adult Day Care, Companion Sitter, etc.)							
Financial Assistance (e.g. food stamps, energy assistance, Medicaid, etc.) _____ (specify)							
Socialization and/or Recreational							
Transportation Services							
Legal Assistance (e.g. Legal aid, lawyer)							
Other							

PHaw 1-23-92 Attm.

*9. How many persons are you (is client) very close to that you (client) can talk with about feelings, problems, and concerns? _____

What is the relationship of this/these person(s) to you?

Relationship

1. _____
2. _____
3. _____
4. _____

10. Are there people you have not listed, who would be available on a regular basis to assist you with daily activities should you need it?
    1 Yes
    2 No

IF YES, who are these people and what is their relationship to you?

Name	Phone #	Relationship

PHYSICAL ENVIRONMENT

1. Is your home in an area which is.....
    1 rural area (population less than 2500)
    2 town (population 2500-30,000)
    3 city (population 30,000 plus)
    4 suburb (area adjoining city with no central city area)

2. What kind of home do you (does client) live in?
    1 Your own home
    2 A rented single family home
    3 A duplex
    4 An apartment in non-subsidized building
    5 A trailer
    6 Government subsidized housing (i.e., high-rise or other apt)
    7 An efficiency apartment or room
    8 Live with relatives or friends
    9 Other _____
    (specify)

PH+W
1-23-92
Att. #1
Pg. 46 of 51

3. Does the client have to climb two or more stairs to get to the following places?

	2 or More Stairs		Elevator or Ramp	
	Yes (1)	No (2)	Yes (1)	No (2)
Street into his/her dwelling				
First level to				
a) bedroom				
b) bathroom				
c) kitchen				
d) laundry facilities				

4. Does the client's dwelling have the following equipment and amenities and do they function adequately:

	Have		Function Adequately		
	Yes	No	Yes	Unsure	No
Flush toilet, tub or shower, (both)	1	2	1	2	3
Telephone.....	1	2	1	2	3
Refrigerator and stove.....	1	2	1	2	3
Television and/or Radio.....	1	2	1	2	3
Furnace.....	1	2	1	2	3
Fans or Air Conditioner.....	1	2	1	2	3
Piped Hot Water.....	1	2	1	2	3

5. Do you (does client) have pets in the home?
   1 Yes
   2 No

   IF YES, How many? _____

6. Is the client's dwelling accessible from the street for wheelchairs and other assistive devices?
   1 Yes
   2 No

7. Are the following rooms in the dwelling accessible for wheelchairs and other assistive devices?

	Yes (1)	No (2)
a. bathroom		
b. bedroom		
c. kitchen		

ASK QUESTIONS 8-12 OF CLIENT ONLY:

8. Do you feel safe inside your house at night?
   1 Very safe
   2 Somewhat safe
   3 Very unsafe
   9 Not answered

P. H&W 1-23-92

9. Do you feel safe outside of your house during the day?
   1 Very safe
   2 Somewhat safe
   3 Very unsafe
   9 Not answered

*10. Are you satisfied with your current living arrangement?
   1 Very satisfied
   2 Fairly satisfied
   3 Not very satisfied
   9 Not answered

IF NOT SATISFIED, explain why? _____

_____

*11. Do you wish to remain in your present place of residence?
   1 Yes
   2 No
   8 Don't Know

*12. If you would find you are unable or would no longer wish to remain in your present place of residence where would you choose to go?
   1 Own single family home
   2 Apartment in community (intergenerational)
   3 Apartments for elderly and disabled
   4 Home of relative or friend
   5 Sheltered housing facility
   6 Adult family home
   7 Nursing home or Adult care home
   8 Other _____
   (specify)

PHHW
1-23-92
Att #1
pg. 48 of 51

13. Indicate the condition of the following environmental structures and amenities. Put a check mark (✓) under the appropriate column. Use the comment section to further elaborate on problems.

	ADEQUATE (0)	PROBLEM (1)	NOT OBSERVED (8)	COMMENTS
EXTERIOR ENVIRONMENT				
SIDEWALKS-general condition, uneven cracks, raised slabs, etc.				
STAIRS-loose boards, inadequate width, slippery surface, etc.				
HANDRAILS-absent on stairs, loose, inadequate height, etc.				
PORCH-general condition, raised boards, uneven cracks, etc.				
EXTERIOR DWELLING CONDITION-general condition, peeling paint, improperly fitted windows, etc.				
OTHER EXTERIOR MAINTENANCE-piles of rubbish or junk, unkempt lawn, overgrown shrubbery, etc.				
INTERIOR ENVIRONMENT				
FLOORS-Slippery surfaces, rugs not tacked or lack non-skid backing, clutter, etc.				
STAIRS-Loose boards, inadequate width, slippery surface, etc.				
HANDRAILS-absent on stairs, loose, inadequate height, etc.				
TUB/SHOWER-slippery surfaces, no handrails or sturdy support structures, etc.				
TOILET AREA-No railing or support structure				
DOORS/WINDOWS-Inadequate locks, cracks or breaks in glass, inadequate fit, no curtains or shades, etc.				
ELECTRICAL EQUIPMENT-Bare wires, overloaded circuits, etc.				
HEATING/COOLING-Area heaters used, gas fumes present, no air conditioning or fans, inadequate ventilation, etc.				
GENERAL SAFETY-Barring or blockage of fire exits, excessive clutter, flammable chemicals, etc.				
CLEANLINESS-Unclean food preparation surfaces, soiled bedding, presence or odor of excrement, accumulation of trash or garbage, etc.				
OTHER HEALTH CONDITIONS-Evidence of rats or mice or their droppings, evidence of infestation with bugs or insects, etc.				

FINANCIAL SECTION

1. Do you (does client) have difficulty meeting your (his/her) expenses?
   1 All of the time
   2 Most of the time
   3 Sometimes
   4 Rarely
   5 Never

2. Who is responsible for paying bills and managing money in household?
   1 Self/Client
   2 Spouse
   3 Daughter/Son
   4 Other Relative
   5 Friend
   6 Guardian
   7 Bank
   8 Other _____
   (specify)

OVERALL INTERVIEWER ASSESSMENT

*1. a. Was the client able and willing to provide reliable and appropriate answers to the questions on the assessment?
   1 Yes
   2 Uncertain
   3 No

IF UNCERTAIN or NO, explain behavior _____
_____

b. If the answer to the above question is "UNCERTAIN" or "NO", indicate what other persons or sources you relied on for information?
   1 Client
   2 Family member (Relationship _____)
   3 Friend
   4 Written records (medical charts, etc.)
   5 Personal observation/performance testing
   6 Other (specify) _____

*2. Did client display any unusual behavior during the interview?
   3 Yes
   2 Uncertain
   1 No

IF YES or UNCERTAIN, explain behavior _____
_____
_____

PH4W
1-23-92
Att. #1
pg. 50 of 51

*3. Do you suspect the client is:

	Yes (3)	Unsure (2)	No (1)
1) Depressed			
2) Psychotic			
3) Confused or disoriented			
4) Physically abused			
5) Psychologically abused			
6) Abusing alcohol, medication &/or drugs			

IF YES to any of above, explain _____

*4. Do you suspect the client has impaired judgment?
3 Yes
2 Unsure
1 No

*5. Do you question the client's ability to function safely in his/her current environment due to poor orientation or judgment?
3 Yes
2 Unsure
1 No

*6. Do you question the client's ability to function safely in his/her current environment due to physical problems?
3 Yes
2 Unsure
1 No

*7. Based on this assessment and other information available to you, has there been a significant change in the client's physical, mental, social, or environmental status in the last 6 months?

	Yes (1)	No (0)
Physical health status		
Cognitive status		
Behavioral status		
Ability to perform ADLs & IADLs		
Social support		
Environmental conditions		

Describe what changes have occurred. _____

*8. In your opinion, does this client have the potential for significant improvement in his/her functional status if the following interventions were implemented:
a. rehabilitative or habilitative therapy
1 Yes 2 No
b. alterations in structure of the physical environment
1 Yes 2 No
c. caregiver education to enhance client's self-care capabilities
1 Yes 2 No

Pd+W 9-23-92 adm #1

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Azzie Young, Ph.D., *Secretary*

Reply to:

Testimony Presented to the

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2566

This bill would amend K.S.A. 39-778 to require all persons seeking admission to an adult care home participating in the Medicaid program to be pre-screened prior to admission.

The Nursing Home Reform Act (PL-100-203) passed by Congress on December 21, 1987 mandates the screening of all persons prior to admission to an adult care home which participates in the Medicare/Medicaid program. The purpose of this screening is to assure that persons with diagnoses of mental illness or mental retardation are admitted to facilities which can appropriately meet their needs.

The Kansas Department of Social and Rehabilitation Services has been pre-screening persons eligible for the Medicaid program and desiring admission to a nursing facility for several years. This pre-screening program was designed to assure that only those persons whose needs cannot be met in a less restrictive setting are admitted to the adult care home. Persons found not to need adult care home placement are referred to community programs for assistance. In addition, persons found eligible for admission to an adult care home could be provided the option of community based services instead of placement in an adult care home. House Bill 2566 expands this program to all persons, regardless of payment source, and goes beyond screening for mental health reasons.

We are not aware of any research indicating that persons seeking admission to adult care homes in Kansas cannot benefit from these services. Federal and state regulation requires a physician order for admission and prescribed medical plans. It would appear that the premise to this bill is that persons are admitted to the nursing home "too soon" as private pay residents; and when their funds deplete, they seek financial assistance through the Medicaid program. Therefore, if the initial admission was delayed, there would be a lower cost to the Medicaid program. This is an unproven premise. In fact,

Landon State Office Building • 900 SW Jackson • Topeka, Kansas 66612-1290 • (913) 296-1500

it could be argued that a person already in a nursing home on a private pay basis, converting to Medicaid, is in better health than one who stayed at home, uncared for and malnourished. This is certainly true in the absence of sufficient community resources to provide in-home care and services.

This issue raises basic philosophical questions, in that historically our country has allowed persons to purchase the care of their choice if they have the means. Although those who advocate pre-screening assure that it is promoted only to assure that the prospective resident knows of all options available and/or to provide the state with the means to project future need, others see such consideration as the prelude to rationed health care.

What will happen when the pre-screening process indicates an individual does not meet the "criteria" for admission to an adult care home? Can the Department of Social and Rehabilitation Services prevent that individual from adult care home placement when the individual is willing to pay for the service? Granted, people need to make informed decisions. However, requiring that every person seeking admission to an adult care home be pre-screened for approval could be an infringement on the right of self determination.

Persons should have the right to determine where they will reside and what services they wish to purchase. Making information available concerning alternatives to nursing home placement could be provided without the requirement of a pre-screening.

The emphasis in the past few years has been on development of alternate community resources for the frail elderly. Reports developed by the Department on Aging have indicated in the past that most older Kansans would prefer to remain in their own home or a less restrictive setting than a "nursing home". Until these alternative services are developed and available to the potential residents of nursing homes, pre-screening will be a futile gesture.

The Department on Aging, Department of SRS, and Department of H&E recently completed a cooperative effort to address long term care. As part of this effort, all three agencies rejected this bill and drafted a substitute. This substitute focuses on providing information on alternatives to those seeking nursing home admission, provides a means for such information to be distributed, specifies development of a uniform assessment tool and assures the person not under Medicaid retains freedom of choice.

The Department respectfully requests the Committee not report favorably House Bill 2566.

Testimony
Presented by: Joseph F. Kroll, Director
Bureau of Adult and Child Care
Kansas Department of Health and Environment
January 23, 1992

PNWL
1-23-92
Attm #2
92

TESTIMONY REGARDING HB 2566

MONICA FLASK, LMSW
DIRECTOR OF SOCIAL WORK
HALSTEAD HOSPITAL
HALSTEAD, KANSAS

representing the

SOCIETY FOR HOSPITAL SOCIAL WORK DIRECTORS,
KANSAS SUNFLOWER CHAPTER

JANUARY 23, 1992

We have reviewed HB 2566 as it now stands, and wish to present our opposition to the bill based on the following facts:

1) We do not believe this bill will decrease the amount of funding currently being spent on nursing home care. We believe very few people are entering nursing homes needlessly (at the point at which screenings would be done) and that the cost of screening as defined by HB 2566 would outweigh the savings realized by a decrease in nursing home admissions.

2) We believe that mandatory screening would cause a significant delay in dismissals from the hospital, thereby increasing cost overall, although this cost may not be directly billable to Medicaid in many instances. It currently takes an estimated average of 1 - 2 weeks to initiate screening for SRS Home and Community-Based Services and Homemaker Services. It would seem unlikely that an increase in screening requirements will be accomplished in a timely manner without a significant increase in staff.

3) Hospital social workers and discharge planners are already screening patients in hospitals. It is our job to be aware of community resources and to try to implement plans of care which meet the patients' needs. The vast majority of patients prefer to remain in their own homes and we often are involved in setting up extensive care plans for services to maintain people at home. Therefore, mandatory screening for hospital patients is a duplication of services.

4) Mandatory screening is not going to be helpful if community resources are not available. While there are a reasonable amount of services available in some urban areas, the rural areas often have minimal or no home health services and may not even be able to offer Meals on Wheels to many people.

In areas where home health is available, there is still a tremendous lack of <u>maintenance</u> home care available at an affordable cost. Patients often receive

PHCC
1-23-92
Attach #3
p 1.

home health care for 2 - 3 weeks and then have services terminated due to lack of funding. Private pay care is quite expensive, with RN visits costing $60/visit or more. In Harvey County, a single person with an income of $750 per month must pay (according to the sliding fee schedule) $31.50 per RN visit (up to 2 hours) and $20.25 per home health aide visit.

5) We do not believe mandatory screening is necessary to determine need for services. There are many less expensive ways to determine the need, including surveying hospital social workers, SRS social workers, home health agencies, etc.

We believe there are more efficient and cost-effective ways to prevent nursing home admissions. We would recommend consideration of the following:

1) Mandatory screening at time of nursing home admission is too late. It would be more effective to provide screenings at an earlier time, so that preventive services could be initiated prior to a crisis occurring.

2) Screening should be voluntary, available to all persons needing care (rather than just Medicaid recipients), and well-marketed, so people are aware the service exists.

3) Increasing visibility of services already available. For example, many people have much difficulty even locating the phone number for SRS, even if they know the correct title of the agency. Simple means can be found to make information available. (For example, the Feist mid-Kansas telephone directory has a section devoted to community resources which is quite readable and readily accessible to most persons.)

4) Increasing efforts to make discharge planning available to nursing home residents. Many people need not stay in a nursing home permanently if services are available.

5) Increasing the availability and decreasing the cost of home support services, especially to include home health care on a maintenance basis.

In summary, we oppose HB 2566 as it now stands. We believe there are more effective, more cost-efficient ways to achieve the goal HB 2566 is intended to achieve. Thank you for this opportunity to express our opinion on this matter.

PHHW
1-23-92
Attach 3
Pg. 2-2

Kansas Association
of Homes for the Aging

Enhancing the quality of life of those we serve since 1953.

Memorandum

Date: January 23, 1992

To: Representative Carol Sader, Chairman and members of the House and Public Health and Welfare Committee

From: John R. Grace, President/CEO

Re: HB2566

==========

Madam Chairman, thank you for the opportunity to testify today.

If I may, I would like to direct my testimony to the substitute bill for HB2566 that is being proposed by the Kansas Department on Aging, Department of Health and Environment, and Department of Social and Rehabilitation Services.

As the committee is aware, these three agencies have been meeting cooperatively during the past three months to develop specific recommendations relating to long term care issues. In their report they are recommending that the current HB2566 be withdrawn and a substitute bill which I have attached to my testimony be presented and recommended for passage.

We feel that House Bill substitute 2566 is a better program of providing information about the choices available to seniors regarding long term care services. We are pleased to see that the area agencies on aging will have a role in the development of comprehensive information for use by individuals and agencies relating to long term care resources.

We have two specific comments relating to this proposed substitute bill:

1) Under sub-section (c)(i), the Secretary of SRS would be required to develop a uniform needs assessment

634 SW Harrison
Topeka, Kansas 66603
913-233-7443
Fax: 913-233-9471

PHHW
1-23-92
att #4
1-3

instrument to be used by all providers of assessment and referral services. Currently all nursing homes are required to utilize the Minimum Data Set assessment instrument for all incoming admissions to their facility. We believe that this document is a valid tool for measuring the needs of the resident and would prefer not to have another separate assessment tool that would be utilized.

2) We do feel that there should be some exceptions available for the admission of persons to nursing facilities. Many of the admissions to nursing homes occur when a traumatic incident has triggered the admission. For instance, an individual has broken their hip; they have been admitted to the hospital; family member comes to town; now they are ready to be admitted to the nursing home. We would not want an individual's ability to receive the appropriate care needed to be in jeopardy by mandating that some pre-admission process occur. Therefore, we would propose that the additional amendment be added:

"Notwithstanding the provision of sub-section (c)(ii), a person may be provisionally admitted to a nursing facility pending the providing of information or screening services."

We believe that older people should be informed about those services that are available to the community and that they should have the right to choose those services that best meet their needs.

Thank you Madam Chairman and members of the committee.

PHHW
1-23-92
Att #4
2-3

LTC Action Committee
Substitute
House Bill No. 2566

An act concerning social welfare; relating to providing Kansans information and assistance in obtaining appropriate long-term care services.

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

(a) The secretary of the department on aging shall assure that each area agency on aging shall compile comprehensive resource information for use by individuals and agencies related to long-term care resources including all SRS area offices and local health departments. This information shall include, but not be limited to, resources available to assist persons to choose alternatives to institutional care.

(b) Adult care homes as defined in K.S.A. 39-923 and medical care facilities as defined under K.S.A. 65-425 shall make available information referenced in section (a) to each person seeking admission or upon discharge as appropriate. Any licensed practitioner of the healing arts as defined in K.S.A. 65-2802 shall make these same resources available to any person identified as seeking and/or needing long-term care.

(c) (i) The secretary of the department of social and rehabilitation services shall develop a uniform needs assessment instrument to be used by all providers of assessment and referral services.

(ii) On and after the effective date of this act, no person shall be admitted to an adult care home providing care under Title XIX (Medicaid) unless the person has received assessment and referral services as defined in c(i). These services shall be provided under the Senior Care Act, under the Older Americans Act, by the secretary of the department of social and rehabilitation services, or by other providers as identified by the secretary.

(d) This act shall not be construed to prohibit the selection of any long-term care resource by any person. An individual's right to choose does not supersede the authority of the secretary of social and rehabilitation services to determine whether the placement is appropriate and to deny eligibility for long-term care payment if inappropriate placement is chosen.

DB:csl
01/02/92

PH HW
1-23-92
Att #4
3-3

TESTIMONY ON THE PROPOSED MODIFICATIONS TO HB 2566: PRE-ADMISSION ASSESSMENT FOR LONG-TERM CARE INSTITUTIONS

January 23, 1992

I am Walter H. Crockett. I represent the State Legislative Committee and the Capital City Task Force of Kansas AARP. For many years Kansas AARP has urged, as one of our highest priorities, that the state institute a continuum of care for handicapped and frail citizens, ranging from community-based services to long-term care. We have noted that Kansas consistently ranks near the top of the states in the number of elderly citizens who are institutionalized and near the bottom in devoting funds to community-based services. We believe this situation ought to be remedied just as soon as possible. Helping people to avoid institutionalization, to live in their communities as long as they can, greatly enhances the quality of their lives. Recent evidence from evaluations of the Senior Care Act shows that it also saves money.

No doubt lack of information among individuals and their families about the alternatives to long-term care is one reason we place so many of our citizens in institutions. Assessing the health status of people before they are admitted to long-term care, and advising those who are relatively healthy of services other than institutionalization that are available to them, is one way to move toward greater use of community-based programs by those who need help to in carry out their daily activities.

These assessments should be conducted by trained individuals in SRS or in agencies specifically approved by SRS. Recommendations based on the assessments ought to be advisory, not obligatory: people who choose to spend their own money on an institution, instead of on community-based services, ought to be free to do so. And exemptions from the required pre-admission assessment should be made for individuals whose stay in an institution will clearly be a short one. There may be other reasonable changes that would improve the draft bill proposed by the three-department committee. Nevertheless, we agree strongly with the intent of this bill and we support it with enthusiasm.

We note, however, that this bill, by itself, will not solve our problems of premature institutionalization. We also need to expand the range of alternative services that are available to our citizens. Kansas AARP expects to offer strong support to extending the Senior Care Act to additional primary service areas when such a bill is introduced in this session. The report of this inter-departmental committee also recommends a range of additional programs, or the augmenting of existing programs, that will make a true continuum of care available to Kansans who need help to remain in their homes. We urge the adoption of those recommendations just as soon as it is feasible.

Beyond this, we congratulate Secretaries Hurst, Whiteman, and Young and their associates on the quality of this inter-departmental report. It identifies major problems with the long-term-care services that are available in this state and points the way to solving those problems. We applaud productive inter-departmental projects like this one and trust that they will continue far into the future.

PHouse
1-23-92
Att #5

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

TESTIMONY PRESENTED TO
THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING HB 2566

January 23, 1992

Madam Chairperson and Members of the House Public Health and Welfare Committee:

According to a 1986 study of state pre-admission programs there is considerable agreement among the 31 states having such a program that some such mechanism is essential for assessing the needs of persons applying for nursing home admission to assure that such care is appropriate to their needs, both as a means of containing the cost of long-term care and to provide that care in the manner least restrictive of personal choice. It is a concept that KINH has supported strongly for some years in several legislative incarnations.

The proposed revision of HB 2566 contains several provisions that we believe make for a stronger bill.

In referring to "assessment and referral services" the revision more accurately reflects the intent of the assessment to determine the individual's needs so that those needs can be most appropriately met, rather than "screening" which implies that some persons will be winnowed out in the process and will be denied any choice in the kind of care they receive. In the matter of freedom of choice, Sec.(d) will be reassuring to those who have not previously understood that it has never been the intent of the pre-admission screening concept to prohibit persons able to pay for nursing home service from receiving that service if it is their considered choice over other alternatives.

It has been our experience that the decision to enter a nursing home or to urge nursing home care on a frail relative is too often made without full knowledge of the alternatives. Mandatory screening of all persons applying for nursing home placement is not only a tool to assess the care needs of the person applying for entry, but also presents an opportunity for advising that person of community options that they might wish to consider as an alternative to nursing home care if the screening indicated that they could function with a lesser (and less costly) level of assistance and remain in their own homes.

The question sometimes arises as to whether some exceptions to the mandatory assessment should be permitted. There are variations among the states in their requirements. Some states screen all persons who are Medicaid eligible or will become so within a specified period of time, usually 90 or 180 days. Some states exempt persons having Long Term Care Insurance, persons admitted from a hospital, or entering with an expectation of a short-term stay. Though in the short run exemptions of this kind may serve to hold the cost of the program down, and you may wish to consider them for that purpose, it should be with the understanding that such exceptions deny the potential consumer the opportunity offered by the assessment to learn about the various alternatives to nursing home care that may be available and appropriate. That seems to us to lose much of the value of an all-inclusive requirement.

PH+W
1-23-92
Attm # 6
1-2

Sec. (b) of the proposed revision implies that adult care homes, medical facilities and all licensed practitioners of the healing arts will, themselves, provide the information and referral services. We would prefer that adult care homes and healing arts practitioners be expected to refer persons to one of the designated agencies such as Area Agencies on Aging, SRS local offices, or Local Health Departments for assistance rather than to expect them to provide the information themselves. Adult Care Homes have a primary interest in providing nursing home care, not in guiding potential residents away from their doors. And not all physicians have the time or extensive knowledge of local programs and services to assist in assembling an appropriate package of services tailored to individual need.

It will not be enough simply to make the information available to the consumer. For those persons for whom alternatives to nursing homes are appropriate, there will need to be counselling and assistance to locate providers of local services as followup to the assessment that identifies the consumer's needs. Nursing homes cannot be expected to provide that service. On the other hand, hospital discharge planners could very well fulfill that function as long as they are expected to use the same assessment instrument.

KINH strongly believes that a uniform needs assessment instrument should be developed for the use of all providers of assessment and referral services in order to collect useable date statewide, and to assure that everyone is evaluated similarly.

There is no particular professional expertise identified with regard to who does the assessment. Most states have required a team of a registered nurse and a social worker. That is the makeup of the current Medicaid assessment teams in Kansas, and we believe such a team, properly trained in the procedure, provides an appropriate core of knowledge to carry out the assessment.

Assessment of all nursing home admissions offers a tool to advise and counsel older persons and their families at a critical decision point in their lives. In offering the possibility to private-pay individuals to avail themselves of the less costly in-home services, they can in some cases be helped to stretch their resources and to delay the time when they may need Medicaid assistance. It offers the potential to save state Medicaid dollars and sets the state on the path toward an emphasis on community alternatives to nursing home care. KINH urges you to support this legislation.

Marilyn Bradt
Legislative Coordinator
Kansans for Improvement of Nursing Homes

PH&W
1-23-92
Attm #6
pg. 2-2

Testimony in support of Substitute House Bill 2566

Presented to the House Public Health and Welfare Committee
Rep. Carol Sader, Chairperson

Presented by Ms. Irene Hart, Director
Central Plains Area Agency on Aging
525 North Main
Wichita, Kansas 67202

Rep. Sader and Committee Members,

I'm pleased to be testify today in support of the language of SHB 2566 as developed by KDOA, KDHE, and SRS. These departments are to be commended for working together on this issue as well as developing a coordinated approach to various long term care issues we face in Kansas.

Briefly I feel the bill will;

1. Help eliminate inappropriate nursing home placements;

2. Help make consumers (seniors in Kansas and their families) more aware of services and options in their communities; and

3. Help develop data on in-home and community services needed to reduce institutionalization.

Some issues you might consider as you consider this bill include;

1. whether we can add provisions to have the assessment process waived for short term (perhaps 60 days or less) convalesce adult care home stays. An example of this might be the recovery period after a broken hip;

2. whether the "other providers" of the assessment (c), (ii), should exclude adult care homes from being providers for obvious conflict of interest reasons; and

3. if additional funds are to be appropriated to KDOA for the "comprehensive resource" information packets that are to be developed by the area agencies on aging or whether these are to be prepared with existing resources.

Irene Hart
P&W
1-23-92
Attm # 7

KANSAS COALITION ON AGING
1195 S.W. Buchanan, Topeka, KS 66604
Telephone: (913) 235-1367

Testimony Presented to
The House Public Health and Welfare Committee
Concerning HB No. 2566
January 22, 1992

Mr. Chairman and Members of the Committee:

The Kansas Coalition On Aging supports the concept of pre-admission screening as expressed in HB No. 2566. The 1992 KCOA Public Policy Priorities include the following: "PRE-ADMISSION SCREENING - Access to appropriate long term care services can be assured through the support of effective information and referral services and the establishment of a pre-admission screening program for applicants for nursing home care. KCOA supports the development of mechanisms to assure access to community-based long term care services."

A pre-admission screening program should include provision for information and referral at the time of dismissal from a hospital. Referral for screening should be made to an appropriate community agency providing such service, i.e. health departments, Area Agencies on Aging or SRS.

A uniform assessment instrument is particularly important to replace the three being used currently. All people being assessed for care should have the same criteria applied and receive the same information on long term care alternatives as appropriate to their condition.

Studies which have been done nationally indicate that pre-admission screening in combination with referral and information services can reduce the over-all cost of long term care. A national survey of Medicaid directors and preadmission screening program administrators in all the states in 1986, early in the program development, showed that 43% of the responsents indicated preadmission screening decreased overall cost of long-term care, 25% saw no impact, 10% reported an increase in cost and 24% didn't know.

PH&W
1-23-92
Att #8
1-2

coordination

Other early studies showed that pre-admission screening must be supported by community programs that are available to nursing home applicants. Having both information and referral services and community services for in-home care in indispensible to the success of pre-admission screening.

Because of the experience of our members which resulted in the Public Policy statement quoted above, KCOA urges the consideration and passage of legislation that provides for pre-admission screening including the program elements necessary to make it successful.

Thank you.

Don Moses, KCOA Representative

PHHW
1-23-92
Att #8
2-2