Approved 3-16-92
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader, Chairperson, at 1:30 a.m./p.m. on February 26, 1992 in room 423-S of the Capitol.

All members were present except:

Rep. Grant, excused

Committee staff present:

Emalene Correll, Researach
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Rep. John Solbach
Mary M. Stutterheim, B.S.R.N.
Joseph Kroll, Director/Bureau of Adult/Child Care, Department of Health and Environment
Marilyn Bradt, Kansans for Improvement of Nursing Homes
Commissioner Robert Epps, Department of SRS
Representative Hackler
Lila McKee, Chair of Educational Audiologist's Writing Committee
Mike Hughes, Atchinson Schools
Eileen Meyer, Ks. School Nurse Organization
School Nurses, U.S.D. 253, Emporia Unified School District, (Written testimony only)
Mary Ann Luby, Principal, Sacret Heart, Elementary School (Written testimony only).

Chair called meeting to order drawing attention to committee minutes. After members read minutes, Rep. Neufeld moved to adopt minutes of February 12, 1992 as presented, seconded by Rep. White. No Discussion. Motion carried.

Chair drew attention to **HB 3045.**

BRIEFING ON HB 3045.

Ms. Correll gave an explanation of **HB 3045**, noting technical changes. She noted Committee members may desire to update current language in regard to the term "nursing facility" which is used more frequently. The other terms, "intermediate care home", or "skilled home" are not used as frequently. She noted the term "nursing facility" is the term used for reimbursement purposes.

HEARINGS BEGAN ON HB 3045.

Rep. Solbach stated he did not have written comments, as he meant only to introduce Ms. Marie Studderheim. Recently, he and she discussed the economics of a 1-5 bed nursing home rather than a 1-2 bed home. They discussed the options of introducing new legislation that might address this situation. He introduced Ms. Studderheim.

Marie Studderheim offered hand-out (Attachment No. 1). She noted objectives related to **HB 3045:** To provide an adult care alternative that is economically feasible for special populations; to relieve the burden of the caregiver population; to provide services that meet the needs of the rural elderly and the urban elderly by addressing concerns of cost, flexible hours, location convenience, minimization of transportation.

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

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 a.m./p.m. on February 26, 1992

HEARINGS CONTINUED ON HB 3045.

Ms. Studderheim continued, to confront some of the psychological barriers, providing a transitional program between in home services and the institutional setting that is mutually beneficial to the recipient and caregiver by offering care in a 1-5 bed facility. She outlined services available; objectives of the proposal; services not available; budget considerations; most common questions asked regarding this type of facility and care; staffing; quality of care. She answered numerous questins.

Joseph Kroll, Department of Health/Environment offered hand-out (Attachment No. 2). He noted he now better understands what precipitated the introduction of this legislation and he invited Ms. Stutterheim to visit with the people in his Department as they would be happy to discuss this project with her. The statement of the Department of Health/Environment is not opposed to the family care model proposed, as long as it is limited in size and scope. Extending the concept from one to five beds should probably have no negative impact on the residents, however the feeling of the Department is that over five beds would not be appropriate for this type of facility. As long as the provision of care is limited to no more than five persons, other laws remain intact which require appropriate qualified staff. As proposed, the Department could support **HB 3045.** He answered questions.

Marilyn Bradt, (Attachment No.3), noted that Kansans for Improvement of Nursing Houmes would not wish to over-regulate, but they do believe the Department of Health/Environment should draft more explicit regulations giving direction for care plans, standards of care, minimum environmental standards that would cover the various levels of nursing care these homes are authorized to provide. KINH wants assurance that there are adequate safeguards for the needs of the elderly or disabled Kansans. There could be a potential for neglectful, slipshod, or even abusive care of the sick, vulnerable elderly who may seldom be seen by anyone but the caregiver except for perhaps one inspection per year by the Department of Health/Environment. Our first consideration should be to monitor the quality of care given in these homes and would like to see monitoring done quarterly. She answered questions.

Commissioner Robert Epps, Department of SRS, offered hand-out (Attachment No. 4). He noted support for passage of **HB 3045,** however the Department would want those individuals being cared for in these facilities to be assured quality care. He noted in discussions with the Department of Health/Environment that they support only up to a five bed capacity. He and Mr. Kroll answered questions. The Department of Health and Environment and Department of SRS agreed to followup on a request with respect to physical standards requirements for these private homes to meeting requirements of Medicaid adult care homes.

HEARINGS CLOSED ON HB 3045.

Chair drew attention to **HB 2881** and requested a briefing on the bill.

STAFF BRIEFING ON HB 2881.

Ms. Correll gave a detailed explanation of **HB 2881.**

HEARINGS BEGAN ON HB 2881.

Rep. Hackler, the bill's sponsor, offered hand-out (Attachment No. 5). She noted **HB 2881** is a simple concept. Under present statute, notice of screening results must be given to parents/guardian of each child given basic hearing/visual screening in a school setting. She detailed proposed language, drew attention to a balloon provided, (see Attachment No. 6). She explained these additional amendments were requested by school nurses who know the savings in costs will be significant to many school districts. Additional amendments proposed in balloon were indicated on page 2, line 2, and page 2 at the end of line 13. She urged support. Rep. Hackler then answered questions.

Commissioner Epps offered hand-out (Attachment No. 7) and stated support for **HB 2881** by the Department of SRS. He further noted that the Omnibus Budget Reconciliation Act of 1989 mandates all medically necessary services be provided to KAN BE HEALTHY participants. Medical Services within the Department of SRS has developed interagency agreements with 12 local school districts to reimburse for KAN BE HEALTHY screenings in the school setting. The local district provides the state match (41.24%) which is matched with federal medicaid dollars. He answered questions.

Lila McKee, Educational Audiologist, offered hand-out (Attachment No.8) and voiced opposition to **HB 2881** as it pertains to the school-age hearing screening law. She agreed that the present hearing screening law needs revision, but the revisions offered in **HB 2881** are not satisfactory. Proposed guidelines are being worked on and reviewed by school nurses, audiologists, educators, administrators, and nurses to bring a bill offering numerous revisions to the current hearing/screening law to the 1993 Legislature. She cited concerns with the current screening law, i.e., notification of screening results, whether pass or fail, to parents. She urged Committee not to adopt the revisions proposed in **HB 2881**, but rather to allow the educational audiologists, school nurses, Ks. Board of Education, Ks. Department of Health/Environment to work together to find a more acceptable solution to this issue of parental notification on screening results. She answered questions, noting she does support the need to eliminate notifying parents of the screening process. Guidelines could be set out for parental notification, but not through a legislative mandate.

Discussion was held in regard to "approximate date" in respect to notification.

Rep. Hackler stated she was unaware that the audiologists opposed **HB 2881.**

At this point Chair asked if any conferees scheduled to testify were from out-of-town and could not return tomorrow.

Mike Hughes, Atchinson Public Schools, offered testimony, noting the school nurses in his district would applaud his appearance today, giving the view that notification to parents after the screening process is completed is a waste of time and money. He would support **HB 2881** without the notification notice. (He had no written testimony).

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 ~~a.m.~~/p.m. on February 26, 1992

HEARINGS CONTINUED ON HB 2881.

Eileen Meyer, Kansas School Nurse Organization, offered hand-out (Attachment No. 9), stated their Organization of School Nurses does support hearing/vision screening of school children in Kansas. The language in **HB 2881**, as it appears today, is very restrictive. She cited specifics, i.e., a child says he or she cannot hear, but she would be unable to test that child because prior notice had not been sent to the parent. The proposed bill shows some disparity in regard to vision testing being required every 2 years and hearing testing required every 3 years. These screenings are equally important and both should be completed no less than every two years. She called attention to suggested amendments in her attachment. Ms. Meyer also called attention to an error in the balloon that deleted "board of education", and this was unintentional.

There was no time for questions of Ms. Meyer, and she stated she would be happy to answer questions next week of the Committee wishes her to do so.

Emporia Unified School District, (Attachment No. 10), recorded as written testimony only this date.

Written testimony also provided by Sacred Heart Elementary School, Emporia, Kansas is recorded as (Attachment No. 11).

Chair thanked all members and conferees for their patience.

Chair adjourned the meeting at 3:09 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-26-92

NAME	ORGANIZATION	ADDRESS
Eleen Meyer	Kansas School Nurse Organization	RR #2 - Box 130 Emporia, Ks
Martha Skeet	Kansas School Nurse Organization	Rt 3 Box 40 Lawrence KS 66044
Melvin J. Bruntzel	KSBE	1852 NW Carlson Rd Topeka, Ks 66615
Sue Dame	USD 418	514 N. Main McPherson, Ks 67460
Sue Bowden	USD 265	201 S. Main Goddard, Ks. 67052
Lila McKee	Educational Audiologists	2008 S. Halstead Hutchinson, KS 67502
Tom Gray	KS Speech Lang Hrg Assoc.	2913 James Ave Manhattan, KS 66502
Rosie Gay	Board of Cosmetology	Hays
Eva Dieme	Board of Cosmetology	Wichita
Alberta Klaus	Ellis Co. Clk's Office	Hays
DeAnn Schmidt	Ellis Co Clk office	Hays
Peggy J. McCullick	Ellis County Clerk	Hays
Jim Snyder	KFDA	Topeka
Gary Robbins	KS Opt Assn	Topeka
Mack Smith	KS Mortuary Arts Board	Topeka
Joyce Markendorf	KDHE	Topeka
Janet Neff	KDHE	Topeka
Alice Hamilton Nicholas	KDOA	Topeka
Ally Liemeyer	437 Houston	Manhattan
Don Fast	KASEA - Ks Ass of Spec Ed. Adm, Topeka	
Bob Geers	ARC/Ks	Topeka
Ken Bahr	Ks. Hospital Assn.	Topeka
Norm Reynolds	KASB	Topeka
Pete McGill	Ks Funeral Directors	Topeka
Jim Young	AARP/CCTF	Topeka
Keith R Landis	Christian Science Committee on Publication for Kansas	Topeka
Mike Hughes	USD 409	605 Ks Ave Atchison 66002

TESTIMONY GIVEN BY:

Legal Name - Mary M. Stutterheim
Organizational Unit - Independent

Residential Addresses:

1. Praire View, Kansas 67664
2. 133375 Running Horse Road, Platte City, Missouri 64079

Professional Background:

BSRN (Kansas/Missouri licenses).

To the best of my knowledge and belief, all data in this presentation is true and correct.

Mary M. Stutterheim
Mary M. Stutterheim

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IN REFERENCE TO HOUSE BILL 3045

OBJECTIVES OF THIS PROPOSAL:

I. To provide an adult care alternative that is economically feasible for a special population (AD and Related Dementias), who are often non medicaid/non medicare qualifying.
[See figure 1 - AD Disease Statistics].

II. To relieve the burden of the caregiver population, specifically the "adult children" primarily women between the ages of 40-60 years of age. Women are often "sandwiched" between the parent(s) needing help, the husband, the job, and the children (Study by Elaine Brody MSW gerontology researcher).

III. To provide services that meet the needs of the rural elderly as well as the urban elderly, by addressing:
   a. cost factors
   b. flexibility of hours
   c. location convenience
   d. minimization of transport difficulties.

IV. It will hopefully confront some of the psychological barriers:
   a. of caregivers' ability "to let go" and their "guilt feelings," by providing a transitional program between "in home" services and the formal institutional setting.
   b. of caregiver lack of confidence in a mutually beneficial situation to recipient and to self.

For a broad overview of "a service inventory" please refer to figure 2.

It will be necessary to first examine **PRESENT SERVICES** available to AD (Alzheimers) and Related Dementias, and the drawbacks.

A) Church/Community affiliated "Caregiver day out" programs - usually 4 hours respite care, not expensive, activity emphasis with a volunteer staff. Drawbacks - lack of flexibility of hours, limited program time,

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limited services, and daily transport demands.

B) <u>Adult Day Care Programs</u> - cost vary greatly; as low as $10-30.00 daily to as high as $8.00 per hour. Drawbacks - non flexible hours, daily transport demands, often too expensive. A study completed by Linda Wright with UMKC, Center on Aging, had examined several other factors that specifically pertain to non success of <u>RURAL</u> Day Care, including location inconvenience, lack of understanding of program and services offered, as well a psychological barrier's. A study finished by Susan Kordish, Planning Director of Pennsylvania AAA also clarifies underuse and/or failure rates of Rural Adult Day Care. Jerry Cooper, with Brookdale Adult Services in St. Joseph, Mo., has struggled 2 years to start a city (urban model) Day Care Program with no present success. There are numerous operating Day Care Programs in Kansas City - some successful, and other attempted non successful ones.

C) <u>Private Pay Respite Care</u> - the most "in demand" care is for <u>home</u> services (usually provided by personal service agencies). It definitely solves transport difficulties; it allows the person to stay in his/her own familiar surroundings, and offers varied services. The main drawback is cost - $18,000 yearly or $1500 per month.

D) <u>Nursing Homes and Special Care Units</u> are expensive with costs varying from $2000 to $3000 plus per month. Respite beds in nursing homes are very expensive and one must usually contract for 2 weeks or more.

E) <u>One and Two Bed Adult Care Homes</u> - are economically <u>not</u> feasible: at the cost of $5.00 per hour, it would equal $3600.00 monthly per 1 person, for 24 hour care; for 2 residents, the monthly cost would be $1800.00. (This provides <u>simple</u> nursing care with no guarantee of

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professional nursing services.)

F) Boarding Care Homes and/or Adult Family Care Homes - custodial or supervisory care applicable to early stage dementia. More economical due to group situation, but impractical due to progressive degeneration of disease; therefore, resulting in eventual non-qualifying status of resident.

G) Various Community Fragmented Services like "Telephone Reassurance", "Friendly Visitor", "Hospice", "Meals on Wheels", Transport Programs, etc. Important, but not comprehensive, programs allow persons to stay in home, gives limited respite, offers limited supportive services. Not always available to the isolated rural areas, and small town communities.

It is now necessary to examine **Services Not Available** to AD and Related Dementias:

A) Boarding Care Homes and/or Adult Family Homes - licensed for supervisory, custodial care, do not meet needs of Stage II and Stage III of Alzheimers.

B) Medicare Services - usually non qualifying home health aide supportive services; it rarely provides for long term care of chronic conditions inn the home.

C) Medicaid Services - strict eligibility requirement for needy and low income families. The emphasis is on Medical needs, not supportive services.

D) Mental Health Transitional Homes - AD is not a "mental illness"; non qualifying. [It is a progressive degenerative disease that attacks the brain.]

What programs are presently not allowed due to laws and regulation? Looking at an example:

HOUSE BILL 3045 would allow the possibility of a 5 Bed Adult Care Home, operating a 5 day week "live in" situation, operating on a $1200 monthly cost (averages approximately $3.00 per hour) per individual. This allows a 1 to 5 caregiver to resident ratio for 18 hours of the day, plus having additional professional

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nurse/caregiver service for 6 hours of the day. This "quality assurance" compares to figure 3, 14 SCU of SNF's, which is an excellent staffing ratio (better ratio, as covers 24 hour care). In "direct service" nursing hours per resident, it is above the 2.6 to 3.0 range of SCU of SNF's. This satisfies Objective I of Page 1. Objective II is best clarified by asking "Who is the caregiver" [see fact sheet, figure 4].

Note: 75 percent Female.

46 years is the average age (with 28 percent under 35 years of age). 55 percent are employed with 33 percent full time workers reporting lost time from job/employment.

"In generally, 1.8 million women care for an elderly member of the family and raise children at the same time. The quality of care given, is affected by stress burnout and the caregivers personal wellbeing." (Reference Nick Gallo - "A Helping Hand for Home Caregivers") [See figure 5 for the stress demands], "What do caregivers do?"

These family caregivers may need a comprehensive program that offers weekday respite care during the middle of the week, while at their jobs; they need shift job hour flexibility which day care alone does not offer. The program promotes family ties (loved ones go home on weekends). It cost less than SNF respite, less than private home support services. It relieves management problems of utilizing fragmented community services, or finding and retaining help for "in home" services. It promotes full time employment with reduced "lost time" from work. These above points, also partially satisfy Objective III (page 1) of proposal. Logically it then addresses daily transport problems, reduced to 2 x weekly (to and from trips). Being a single resident house structure, it allows great choice in location convenience.

In general, for Objective IV, further research need to be done. But, concerning this last objective (page 1) how could the caregiver have confidence of a mutually beneficial situation? (From Linda Wrights study - the rural families felt guilty or

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were not accepting of "benefits to caregiver" without proven "benefit to care recipient.")

By looking at figure 6, Sundown Syndrome, plus addressing wandering behavior, day and night confusion - need for familiar family and friend interaction, any program outside the home may seem detrimental to the care recipient. My personal professional experience, has shown the ability of AD and related Dementia persons to have TWO familiar "homes", as long as there is regular contact between the two locations. (Its difficult and stressful to get the person TO day care, not to take them home.) Once at the day care setting or 5 day respite setting, there is adjustment; the 5 day program reduces the anxiety/stress of caregiver and care recipient in making daily trips.

BUDGET CONSIDERATIONS

A basic 5 day week - 5 "live in" residents would cost $1500 per resident each month. [Same cost as average "in home services"]. By adding up to 5 person "in house" day care, 5 hour program, the cost is reduced to $1200 per "live in" resident. [This is less than cost of average in home service].

Another cost effective idea - allows for a "live in" part time housekeeper in exchange for room and board - also guarantees an extra "staff" person "on call" for premises at night in case of emergencies.

CLARIFICATION OF BUDGET: (example)

Expenses: (Monthly)

- Salaries - $4500.00
- Vacation Benefit Fund (savings) $200.00
- Payroll Tax - $315.00
- Professional Fees: (consultations)
  - Physician - $150.00
  - Dietician/PT - $100.00
- Licensing Fee - ?
- Rent/Mortgage (with insurance) $600.00
- City Tax, Trash Service, etc. - $100.00
- Utilities/Telephone - $300.00

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Yardwork/Maintenance - $100.00

Home Maintenance - $100.00

Office Supplies/Activity Supplies - $100.00

Food/Household - $400.00

Miscellaneous - $100.00

TOTAL: $7065.00

Income:

$1200 (monthly)		* $440 (monthly)		
x 5 Resident's		x 5 Resident's		
$6000	+	$2200	=	$8200.00

*5 hour "in house" day care for (up to) 5 persons (while "extra staff" person, professional nurse is on duty.)

$8,200 - 7,065 = $1,135; this difference allows for day care fluctuations.

Most Common Asked Questions:

1. Would there be any way to further the cost? Yes, if the state allowed "spouse help" or "family caregiver help" (for non-working or part time employed caregiver) to subsitute for 4-6 hours of CNA staffing-families would receive cost reductions, as well as create an environment of "mutual participation and increased pride of personal involvement."
2. Would this legislative change increase situations for the type of elder abuse found in "certain boarding home situations"? A 1 to 5 Bed program and/or facility is not a "boarding home." Regulations, quality staff, and qualifications of the licensee and/or provider could be very specific. Boarders of boarding homes receive basic supervision, but the boarders are responsible for their own independent medical/dental care. A 1 to 5 Bed Home is similar to a Special Care Unit of a Skilled Nursing Home; residents are only "admitted" under daily 6 hour supervision, assessment, coordination nursing services of a professional health provider.
3. What would be the suggested qualification's of the licensee/operator?

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a. Minimum BSRN licensure, plus minimum of 6 months work experience and/or educational experience with a SCU of a SNF, plus a minimum of 6 months of PH nursing and/or home health nursing (to increase family service skills)

b. Minimum of a BS in social work/social services, plus a minimum of 6 months work/educational experience in a SCU of a SNF, plus a minimum of LPN or equivalent health related licensure (to increase nursing skills).

4. Can the staffing "quality assurance," and services available, be clarified? In a therapeutic mileuu of a "family hone" environment, smallness of resident group program similarity to a SCU, it could address needs of stages I & II & beginning III. Services available: consulting dietician, consulting physical therapist, direct nursing services of an RN (or equivalent health care coordinator), 1 CMT, 3 CNA's with 24 hour staffing. All of "nursing employees" work 3/4 time, 6 hr/5 day week to avoid "burnout syndrome"; it would also offer a monthly family support group program.

5. Isn't "in home" supportive health services best for everyone, with needed emphasis in legislative support for these services? There is great demand for in home affordable services for the working middle class families. But with societal trends toward a "two-member" working family, we need alternatives in the health care delivery system. I think this legislative change with realistic restrictions, supports an important need for working "two member families" or working women, who still want to keep their loved parent intimately part of the family home base, with stress limiting factors. For rural America the situation is complex as the caregiver sets often high self standards for independently managing "the situation", with resulting high stress. Home service delivery is complicated by the hired outside caregiver making daily trips on rough roads and facing difficult weather conditions, to bring the service to the

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family; this is not always so dependable. The spouse, daughter (or other) of care recipient will often not trust their home to the outside caregiver (they stay to "watch over things") and thus do not get physical breaks away from the home stress situation. This is exemplified by the statistics on domestic elderly abuse.

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ALZHEIMER'S ASSOCIATION
Someone to Stand By You.

Fig '

ALZHEIMER'S DISEASE STATISTICS

Definition '

Alzheimer's disease (AD) is a progressive, degenerative disease that attacks the brain and results in impaired memory, thinking and behavior. It is the most common form of dementing illness. The person with AD may experience confusion, personality and behavior changes, impaired judgement, and difficulty finding words, finishing thoughts or following directions.

The following statistics are estimates used by the Alzheimer's Association:

- Approximately 4 million Americans are afflicted with Alzheimer's disease.
- Alzheimer's disease is the fourth leading cause of death among adults, taking more than 100,000 lives annually.
- Unless a cure or means of prevention are found for Alzheimer's disease, an estimated 12 to 14 million Americans will be affected by the year 2040.
- Approximately 10% of the population over 65 years of age is afflicted with Alzheimer's disease. This percentage rises to 47.2% in those over the age of 85, which is the fastest growing segment of the United States population. This is significant because the nation's entire aged population is increasing rapidly and it is estimated that by the year 2050, the U.S. will have 67.5 million people over the age 65 compared with 25.5 million today.
- From onset of symptoms, the life span of an Alzheimer victim can range anywhere from three to 20 or more years.
- More than 50% of all nursing home patients are victims of Alzheimer's disease or a related disorder. The annual cost of nursing home care ranges between $24,000 and $36,000. *2000 to 3600 monthly
- Approximately 70% of the care given Alzheimer victims is provided by families. The cost to a family caring for the AD patient at home averages $18,000 per year.
- The financing of care for Alzheimer's disease -- including costs of diagnosis, treatment, nursing home care, informal care, and lost wages -- is estimated to be more than $80 billion each year. The federal government covers $4.4 billion and the states, another $4.1 billion. Much of the remaining costs are borne by patients and their families.
- Congress has appropriated $138 million for Alzheimer's disease research in fiscal year 1990. This figure represents a 12% increase over 1989 levels, amounting to just over $35 per patient. By comparison, the National Institute of Health invests ten times that amount for research on cancer, cardiovascular disease and AIDS.

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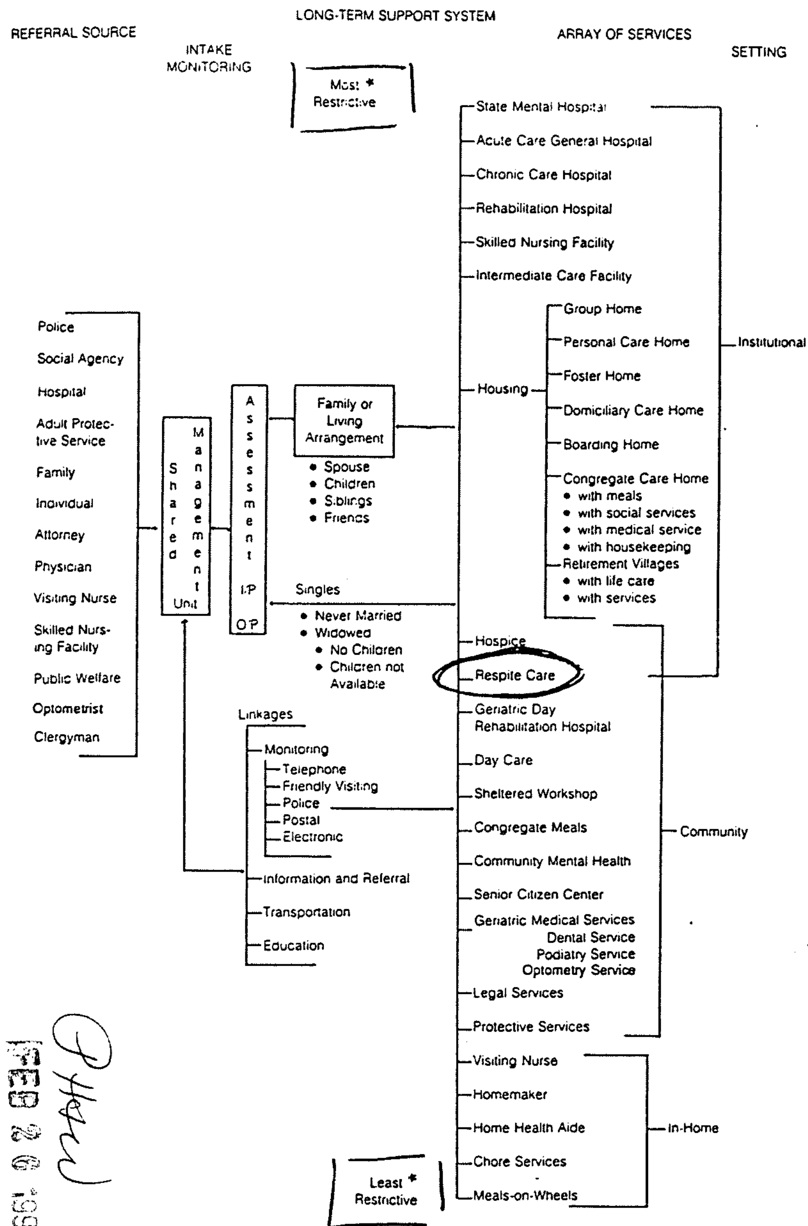

* The classification of from most to least restrictive is a general view of services and may vary within each service.

Figure 1. Inventory of Recommended Available Services, Appropriate to a Long-Term Care/Support System. Reprinted by permission of American Journal of Public Health 70(11) from S.J. Brody and C. Masciocchi. 1980. Data for long-term care planning by health systems agencies.

Comprehensive Care

Elderly patients are likely to have multiple problems. A thorough diagnostic evaluation will usually reveal a combination of physical, psychological, and social problems that contribute to their impairment. The interaction of these stresses is almost a prototype for the development of psychosomatic disorders. A few of the stresses and strains are indeed related to chronological age, but, as is true for persons of any age, successful treatment depends on resolving emotional as well as physical problems.

For a patient with dementia, a comprehensive treatment plan will take into account the full range of the patient's problems including the assets and liabilities of the patient's home or other living environment, the characteristics of patient and family, and the family's financial situation (Miller and Cohen 1981).

Ideally, care providers should consider the implications and interactions of all these factors and organize the delivery of services to meet all needs of all patients. The goal is rarely achieved in practice. Those responsible for care and treatment make choices according to the relative importance of various factors in the lives of the patients and in the available resources of a particular service system.

Since there is no single continuum of care, care providers go through a process in which, for example, the decision about where a patient is to live depends on his or her health status, mobility, family support, and preference. Financial considerations may take precedence: a person might be able to remain at home but not be able to afford supervisory help, necessitating institutionalization. The almost endless variations of individual circumstances and needs are met in the complex matrix of health care delivery (Brody and Masciocchi 1980).

Interdisciplinary Team Care

Another system of care delivery is the interdisciplinary team approach. In a typical community, an interdisciplinary team may be

Staffing

As indicated earlier, AAHA's membership identified staffing issues as serious concerns and priorities, especially given current regulatory constraints, the focus on cost containment, and the experience of other early research and demonstration projects wherein staffing ratios were impractical for the long-term care industry (Parker and Sommers 1983). In our survey, 14 skilled nursing facilities provided adequate information for staffing comparisons. Within these, facility size ranged from 120 to 784 beds, the number of dementia unit beds from 8 to 200. It should be noted that existing staff patterns were calculated and adjusted to a 40-bed SNF unit for ease of comparison. All facilities had at least one RN during the day and 13 had at least one RN during the evening.

Comparison of Special Care Unit Staffing at 14 SNF Facilities

	Nurses (RN + LPN)			Aides		
	Day	Evening	Night	Day	Evening	Night
Skilled Nursing Facilities (SNF)	3.9	1.3	1.3	5.2	5.2	2.6
	3.0	1.5	.75	4.5	3.0	3.0
	2.75	?	?	7.7	?	?
	2.6	1.9	1.3	5.7	4.3	2.6
	2.7	1.8	.9	5.4	4.5	2.7
	2.4	1.6	1.6	5.7	3.2	1.6
	2.4	2.4	1.6	6.4	4.8	4.8
	2.4	1.6	.8	6.6	3.3	1.6
	2.1	1.4	.7	4.2	4.0	3.0
	2.0	1.0	1.0	5.5	3.5	1.0
	2.0	1.0	1.0	6.5	4.5	2.5
	1.6	1.6	.8	7.0	5.2	3.5
	1.4	1.4	.3	5.2	5.3	1.3
	1.25	1.0	—	5.0	5.0	5.0
Health-Related Facilities (HRF) (Intermediate Care)	1.2	1.2	.9	3.5	3.5	2.7
Average by Category (SNF)	2.3	1.5	1.0	6.2	4.28	2.7
Median by Category (HRF)	2.4	1.5	.8	5.5	4.5	2.6

Indications of social work or recreational staff allocations not consistent. Where these were included, however, there range from .4 full-time employees to 1, again based on that illustrative 40-bed unit example.

Several approaches to staffing merit note:

1. assigning activity workers to a 10 a.m. to 6 p.m. shift, which was more reflective of available program hours
2. locating social work and activity workers' offices on the special care units
3. using part-time feeders, assistants, or nurse's aides on the evening shift for feeding and assistance at bedtime
4. modifying traditional specific discipline or departmental responsibilities for tasks and activities.
   For example:
   - In three facilities, nurse's aides conduct reality orientation, remotivation, grooming, and activity programs. Two other facilities have plans to utilize this approach.
   - In three facilities, nurse's aide assignments are based on patient functional levels, allowing staff to conduct small group programs for persons at similar levels.
5. In four facilities, volunteers were sought from among staff, prior to the development of the special care unit, to work on this unit.
6. In five facilities (three nonprofit and two proprietary), there are coordinators for the special care unit whose time commitments range from half- to full-time with no relationship between either their existence, time allocation, or the number of designated special care beds. These individuals usually have the title of Clinical Coordinator with responsibility for program innovation, staff education, problem solving, and, within the proprietary facilities, program marketing. In one case, the coordinator is also responsible for actual programming on the unit.

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Caregivers Fair, Conclusion

others present at the Caregivers Fair were positive. Many expressed the hope that another will be planned for 1991. Though no formal evaluation of this year's event had been held as of early December, Harold Bezona, AARP President, and one of the planners of this year's event was optimistic and enthusiastic about prospects for a similar event in the coming year. "Be assured we'll have another next year, an even better one."

AARP's 30th Anniversary Celebration

Following the Caregivers Fair, AARP, one of its co-sponsors and planners, held a celebration of its 30th anniversary. The St. Joseph chapter of AARP was the sixth to be organized in the United States, and one of ten to have celebrated thirty years, according to Harold Bezona, St. Joseph AARP President. At the celebration a letter from the national AARP President congratulating the St. Joseph chapter was read and presented. Nine past President of the local chapter were recognized. A highlight of the celebration was recognition of two charter members, Edra Meeks and Gladys Brooks. Entertainment was provided by the Joyce Ray Patterson Center's Kitchen Band, directed by Mildred Huffman.

The St. Joseph AARP has about 200 members. It meets each third Tuesday at 1 p.m. at the Joyce Ray Patterson Senior Center.

A Child's View of Alzheimer's Disease

An eight-year-old boy writes of his experiences with his aunt, a victim of Alzheimer's disease. Aunt Dodie Has Alzheimer's provides a good starting point for discussing family illness. It also is a way to encourage youngsters to write. Order from Paraclete Press, P. O. Box 624, Pentwater, MI 49449. 12 pages. $5, prepaid.

Fact Sheet on Caregivers

In 1987, a national survey of caregivers was conducted for the American Associ[ation] of Retired Persons, (AARP), and The Travelers Companies Foundation. For pu[r]poses of this research, a caregiver was defined as someone who provides unpaid a[ssis]tance to a second person, aged 50 or older, needing help with one activity of daily living (ADL-dressing, bathing, feeding, toileting and transferring) or two instrume[ntal] activities of daily living IADL-grocery shopping, managing finances, housework, m[eal] preparation, transportation, administering medications, etc.)

Based on this definition, approximately 7.8 percent of all households contained a [car]egiver between December 1986 and December 1987. Consequently, there were alm[ost] 7 million U. S. households containing caregivers (6,979,000).

The AARP and The Travelers Companies Foundation research reports on persor[ns] currently providing care (65%) as well as persons who had been caregivers within t[he] 12 months prior to the survey (35%). In addition, 63% of respondents reported bei[ng] primary caregivers.

Following is a profile of caregivers and care receivers based on the survey:

WHO ARE THE CAREGIVERS?

- Seventy-five percent of caregivers are female.
- The average age is 46 with 28% under 35 and 15% over 65.
- Sixty-six percent are married.
- Only 37% share a household with the care recipient.
- Approximately one-third of caregivers "became caregivers" because they live close proximity to the older person; eighteen percent because they have a clos[e] relationship with the older persons and 16% "because no one else would do it.
- While the majority of caregivers (47%) reported their household income to b[e] $25,000 or more, 20% reported household incomes of less than $15,000 and 10[%] reported incomes of $50,000 or more.
- Caregivers reported the additional responsibility of caring for children; 31[%] reported children in the household under 12 years of age and 23% reported livin[g] with children 12 through 17.
- Fifty-five percent of caregivers are employed; 42% are employed full-time an[d] 13% are employed part-time.
- 33% of full-time employees and 37% of part-time workers have lost time from work due to caregiving responsibilities.
- 15% of those previously employed choose early retirement and 12% reported giving up work entirely while they were helping their older relative.
- Nine percent reported taking a leave of absence; four percent reported problems with supervisors and three percent turn down promotions.
- Of those who lost time from work, had to go from full-time to part-time or had to take a leave of absence (198), only 20% lost work benefits.

WHOM DO THEY CARE FOR?

- Care recipients are generally relatives of the caregiver (85%), most likely a mother.
- Fifty percent live in their own home or apartment.
- Fifty-eight percent are housebound and 28% of the housebound older persons are also bedridden while 24% are wheelchair-bound.
- The average age is 77 with 13% between 50-64 years of age and 24%, 85 years old and older.
- Care receivers are most likely to suffer from chronic illness (70%); 16% suffer from acute illness an 5% suffer with both.

Continued on the next page

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WHAT DO CAREGIVERS DO?

- The majority of caregivers provide personal services. While approximately one-third do not provide assistance with ADLs, about one-third provide help with three or more ADLs.
- Almost all caregivers assist with IADLs. Three-fourths help with grocery shopping, transportation and housework, and about two-thirds prepare meals or manage finances. Only one-in-two help administer medications.
- One average, caregivers have been providing assistance for about two years and expect to continue providing care indefinitely.
- One-half of those surveyed spend at least 12 hours per week on caregiving. Eleven percent give constant care and 28% give care eight hours or less per week.
- About three-fourths of caregivers have used at least one social service with community organizations and governmental agencies most likely being the provider.
- Resources used most often were newsletters, home health aids, homemaker/chore services and educational seminars.
- Caregivers devoting more than 20 hours per week to the needs of the older persons and those providing assistance with three or more ADLs are among the heaviest users of services.
- Caregivers who do not sue [handwritten: use] a particular service do not perceive a need for the service or they are not aware of it.
- Paid services are used moderately. The most frequently used paid services are home health aides, homemaker/chore services and respite care.
- Six in ten caregivers have incurred additional expenses as a result of caregiving. The most frequently mentioned expenses were travel, telephone bills and special diets/medicines.
- The total caregiving expenditure in a typical month is $117 for those incurring additional expenses.
- For those incurring additional expenses as a result of caregiving, these expenditures represent about 7% of their income, on average.
- Fifty-one percent of caregivers reported spending less time on leisure activities; 34% spent less time with their families and 33% have paid less attention to their own health needs.

Life with an Alzheimer's Victim

Art Danforth, author of Living with Alzheimer's: Ruth's Story, was the caregiver and his wife, Ruth, the patient afflicted with the dreaded dementia. Both were victims of the disease. Danforth tells, candidly and compassionately, of his wife's struggles and of his own fears and worry about her as well as of his moments of anger and his sense of guilt as he spent hour after hour, day after day meeting his wife's needs. You may order the book from Prestige Press, P. O. Box 2608, Falls Church, VA 22042-0608. $15.95 (cloth), $9.95 (pb), prepaid.

A Caregiver's Bill of Rights

I have the right

- ☐ to take care of myself. This is not an act of selfishness. It will give me the capability of taking better care of my relative.
- ☐ to seek help from others even though my relative may object. I recognize the limits of my own endurance and strength.
- ☐ to maintain facets of my own life that do not include the person I care for, just as I would if he or she were healthy. I know that I do everything that I reasonably can for this person, and I have the right to do some things just for myself.
- ☐ to get angry, be depressed, and express other difficult feelings occasionally.
- ☐ to reject any attempt by my relative (either conscious or unconscious) to manipulate me through guilt, anger, or depression.
- ☐ to receive consideration, affection, forgiveness, and acceptance for what I do from my loved one for as long as I offer these qualities in return.
- ☐ to take pride in what I am accomplishing and to applaud the courage it has sometimes taken to meet the needs of my relative.
- ☐ to protect my individuality and my right to make a life for myself that will sustain me in the time when my relatives no longer needs my full-time help.
- ☐ to expect and demand that as new strides are made in finding resources to aid physically and mentally impaired older persons in our country, similar strides will be made toward aiding and supporting caregivers.
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Add your own statement of rights to this list. Read the list to yourself every day.

Reprinted from Caregiving: Helping An Aging Loved One, an AARP book by Jo Homes.

PH&W
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14-15

THE SUNDOWNER'S SYNDROME

Fig

****

TREATMENT OF BEHAVIORAL SYMPTOMS IN ALZHEIMER'S DISEASE
MISSOURI ALZHEIMER'S DISEASE AND RELATED DISORDERS TASK FORCE

****

A relatively common symptom in patients with cognitive impairment is a tendency for greater confusion toward evening time. Evening time, toward sundown is usually quieter, darker, with decreased sensory input from the environment. Acute confusional episodes occurring toward evening time are usually called "sundowner's syndrome". This is most often seen if the collectivity impaired individual is in an institutional setting such as a hospital or nursing home and especially in intensive care units where there may be additional sensory deprivation. The patient with Alzheimer's Disease may become more disoriented, agitated and frightened as night time approaches. Sundowning can often be prevented or treated by increasing sensory input into the environment toward late afternoon/early evening, e.g., familiar faces (family, friends), more light, some music or other reassuring auditory stimuli. Occasionally small doses of an anti-anxiety agent given 30-60 minutes prior to onset of symptoms can help to temper their intensity.

Another common and frustrating behavioral problem in patients with Alzheimer's disease is day/night confusion. The typical scenario is that of an Alzheimer's patient who awakens at 3:00 a.m., gets dressed and makes ready to "go to work", believing it is day. The Alzheimer's disease patient who sleeps during the day and is up at night places great strains on family and other caregivers. The most helpful interventions with this behavior are non-chemical. To make a concerted effort not to let the patient sleep during the day so that when bedtime comes the patient is tired and will sleep. At times, even when this is done, Alzheimer's disease patients may have night time awakenings to use the bathroom or because their sleep is fragmented. Avoiding diuretics, caffeine, nicotine, and excess fluids after dinner may cut down on the need to void during sleep. At times, a rapid-acting, short half-life sedative may be helpful, either prior to sleep or even when night time awakenings occur. Alzheimer's disease patients function better after a good night's rest and so do caregivers.

In future publications we will discuss wandering behavior, impulse control problems and other behavioral symptoms seen in Alzheimer's disease. A psychiatrist experienced in working with geriatric patients can be a valuable consultant to patients, family and nursing staff dealing with behavioral manifestations of Alzheimer's disease.

****

LOSING A MILLION MINDS:
ALZHEIMER'S DISEASE INSIGHT INTO THE MEDICAL MYSTERY

****

The Missouri State Conference on Alzheimer's disease will be held April 21 and 22, 1988 at Tan-Tar-A Resort, Osage Beach, Missouri. Anyone interest in additional information regarding this conference can contact Sandy Gifford, Division of Aging, 2701 West Main Street, Post Office Box 1337, Jefferson City, Missouri 65102 (314) 751-3082.

PH&W
FEB 26 1992
Att #1
15-15

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 3045

The Kansas Department of Health and Environment appears before the Committee as a cautious proponent of House Bill 3045.

We understand that this bill has been requested for the purpose of allowing an individual to operate a five-bed skilled nursing facility because operating a two-bed skilled nursing facility is not economically feasible.

The one- and two-bed adult care home can provide whatever level of care they are deemed capable of providing. The provision of skilled nursing care under other statutory law does require twenty-four hour licensed nurse coverage. Currently, 16 one- and two-bed adult care homes are licensed, all limited to the provision of personal care.

The two-bed nursing home in a private residence has been provided for in Kansas law in recognition that such a facility can provide care and services required, with a minimum of regulation, based on the premise that such care was being provided within a "family model." Our Department is not opposed to the family care model, as long as it is limited in size and scope. Extending this concept from two to five residents probably has no negative impact on the residents of such facilities.

Modern nursing home law, both national and state, is largely in response to negative issues identified by the provision of nursing home care in private residences. Existing regulations governing such facilities are brief, and geared toward the provision of care limited to two persons. These regulations probably are applicable and appropriate up to a limit of five, but not appropriate for any facility caring for more than five.

As mentioned in our opening statement, we appear as a cautious proponent of this bill. However, as long as the provision of such care is limited to no more than five, and other laws remain intact which require appropriate qualified staff, we do support expanding the one- and two-bed classification to five beds.

Presented by: Joseph F. Kroll, Director
Bureau of Adult and Child Care
February 26, 1992

P.H&W
2-26-92
attm. # 2

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 3045

February 26, 1992

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

KINH has consistently supported the concept of alternatives to nursing home care. HB 3045 changes the present category of one and two-bed adult care homes to one to five beds, thus increasing the number of people who may be cared for in these homes at levels of care ranging from personal care to skilled nursing care. This care setting is, by its size and nature, less "institutional" than the usual nursing facility.

The potential for giving good care in homelike surroundings by skilled, compassionate caregivers is certainly there. At the same time, the possibility exists for neglectful, slipshod or even abusive care of sick, vulnerable elderly persons who may seldom be seen by anyone but the caregiver, except for an annual inspection by the Department of Health and Environment. Health and Environment, of course, makes additional inspections upon complaint or if a problem is suspected.

Our first consideration should be to assure frequent monitoring of the quality of care and quality of life of individuals cared for in the proposed one to five bed homes. We would like to see some kind of limited local monitoring that would check the progress of the residents at least quarterly.

KINH had much the same kind of concern when the adult family home was established in SRS some years ago. There, a limited case management system at least assures that individuals in the program will be seen and their needs evaluated periodically. A similar system, perhaps using local health department nurses and social workers might provide that kind of oversight in the proposed category of homes.

We understand that there is a careful balance to be maintained between the need for flexibility in order to provide a homelike atmosphere, and the need to assure the safety, health care and psychosocial needs of persons who, by categorical definition, may require skilled nursing.

Current regulations for the present one and two bed homes are minimal. We do not want to overregulate but we believe that Health and Environment should draft more explicit regulations giving direction for care plans, standards of care, and minimum environmental standards that will cover the various levels of nursing care these homes are authorized to provide.

In short, KINH wants assurance that there are adequate safeguards for the needs of these elderly or disabled Kansans.

Marilyn Bradt
Legislative Coordinator

PH&W
2-26-92
attm #3

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

House Committee on Public Health and Welfare
Testimony on House Bill 3045

February 26, 1992

The Kansas Department of Social and Rehabilitation Services supports the passage of House Bill 3045. This bill would increase the number of persons able to be served in a one and two bed adult care home to not more than five individuals. The bill also amends the number of persons who could be cared for in an "intermediate and skilled nursing care home" and an "intermediate personal care home" to six or more individuals. Presently there is no fiscal impact of this change to the nursing facility program for Medicaid recipients.

We also note there is the potential for additional services available to individuals who exceed the 300% SSI level and are finding it difficult to locate affordable care in a nursing facility. Depending on the individual's needs, they may find the expansion of the one to five bed adult care homes more affordable and able to meet their needs.

Although we support the passage of House Bill 3045, we would want individuals being care for in these facilities to be assured quality care. Also, in our discussion with Health and Environment, we understand they support the passage of this bill, but not for more than five persons. SRS concurs with this position of limiting the bed capacity to five.

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

PH&W
2-26-92
att #4.

RUTH ANN HACKLER
REPRESENTATIVE, FIFTEENTH DISTRICT
JOHNSON COUNTY
685 WEST CEDAR
OLATHE, KANSAS 66061
913-782-0445

STATE CAPITOL BUILDING
ROOM 112-S
TOPEKA, KANSAS 66612

STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

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Cut down expense & time.

TESTIMONY
before
PUBLIC HEALTH & WELFARE
by Conferree:
Representative Ruth Ann Hackler

Dear Colleagues,

HB 2881 is very simple in concept.

Under present statute, notice of results must be given to the parent or guardian of every child given basic hearing and visual screening in a school setting.

The amendments contained in HB 2881 provide:

> If the test results indicate that examination by a qualified physician may be desirable, such information shall be reported to the parents or guardian of the pupil, otherwise no report to the parents or guardian is required. All test results shall be kept on file.
>
> If the test results fail to indicate that examination by a qualified physician or specialist may be desirable, no report to the parents or guardian is required.

Parents would be notified of the approximate date such tests will be given during the school year and how the notification will be given.

I have been asked to bring these amendments by school nurses who know that the savings in costs will be significant to many school districts and that savings in time can be better spent serving children's needs.

PH&W

FEB 26 1992
Attm #5

I want to propose the following additions which are shown on the attached balloon:

p.2 line 2, add "or ~~certified~~ licensed audiologist"

p.2 at the end of line 13, board, add "following the guidelines of school visual screens established by the Department of Health & Environment".

Presently most schools use the Snellen test (the BIG E). The guidelines of the Department of Health & Environment should be followed for a more comprehensive visual screening.

I appreciate your favorable support to this bill.

Ruth Ann Hackler

PH&W

FEB 26 1992

attm #5
pg 2 of 2

Session of 1992

HOUSE BILL No. 2881

By Representatives Hackler, Amos, Brown, Gilbert, Jones, Lahti, Love, Lynch, Macy, Parkinson, Praeger, Scott, Thompson and Webb

2-6

AN ACT relating to schools and school districts; concerning the provision of vision screening and hearing screening to certain pupils; amending K.S.A. 72-1205 and 72-5205 and repealing the existing sections.

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

Section 1. K.S.A. 72-1205 is hereby amended to read as follows: 72-1205. (a) Every pupil enrolled in a school district or an accredited nonpublic school shall be provided basic hearing screening without charge during the first year of admission and not less than once every three years thereafter.

(b) Every pupil enrolled in a school district shall be provided basic hearing screening by the board of education of the school district in which the pupil resides and is enrolled.

(c) Every pupil in an accredited nonpublic school shall be provided basic hearing screening either (1) by the board of education of the accredited nonpublic school in which the pupil is enrolled, or (2) upon request therefor by the pupil's parent or guardian, by the board of education of the school district in which the pupil resides. No board of education of a school district shall be required to provide basic hearing screening outside the school district. If the accredited nonpublic school in which the pupil is enrolled is located within the school district, basic hearing screening shall be provided in the nonpublic school. If the accredited nonpublic school in which the pupil is enrolled is located outside the school district, basic hearing screening shall be provided in a school of the school district.

(d) *The parents or guardian of the pupil, when possible in conjunction with other information provided by the school to the parents or guardian, shall be notified by the school of the approximate date such tests will be given.* All tests shall be performed by a person competent in the use of a calibrated audiometer and who has been designated by the board of education which provides the basic hearing screening. ~~The results of the test and, if necessary, the desirability of examinations by a qualified physician shall be~~

PH&W FEB 26 1992 Attmt 6 1-2

1 ~~reported to the parents or guardians of such pupils.~~ *If the test*
2 *results indicate that examination by a qualified physician* [or certified audiologist] *may be*
3 *desirable, such information shall be reported to the parents or guard-*
4 *ian of the pupil, otherwise no report to the parents or guardian is*
5 *required. All test results shall be kept on file.*
6 Sec. 2. K.S.A. 72-5205 is hereby amended to read as follows:
7 72-5205. Each school board shall provide basic vision screening with-
8 out charge to every pupil in its school not less than once every two
9 ~~(2)~~ years. *The parents or guardian of the pupil, when possible in*
10 *conjunction with other information provided by the school to the*
11 *parents or guardian, shall be notified by the school of the approx-*
12 *imate date such tests will be given.* All such tests shall be performed
13 by a teacher or some other person designated by the school board [following the guidelines of school visual screens established by the department of health and environment].
14 ~~The results of the test and, if necessary, the desirability of~~
15 ~~examination by a qualified physician or optometrist shall be~~
16 ~~reported to the parents or guardians of such pupils: Provided,~~
17 ~~That the information so reported shall not show preference in~~
18 ~~favor of any such professional person.~~ *If the test results indicate*
19 *that examination by a qualified physician or optometrist may be*
20 *desirable, such information shall be reported to the parents or guard-*
21 *ian of the pupil. The information so reported shall not show a*
22 *preference in favor of any such professional person. If the test results*
23 *fail to indicate that examination by a qualified physician or optom-*
24 *etrist may be desirable, no report to the parents or guardian is*
25 *required. All test results shall be kept on file.*
26 Sec. 3. K.S.A. 72-1205 and 72-5205 are hereby repealed.
27 Sec. 4. This act shall take effect and be in force from and after
28 its publication in the statute book.

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attm #6
2-2

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

House Committee on Public Health and Welfare
Testimony on House Bill 2881

February 26, 1992

House Bill 2881 proposes that every pupil enrolled in a school district or an accredited nonpublic school shall be provided basic hearing and vision screening without charge. The hearing screening shall occur not less than every three years, and the vision screening shall occur not less than every two years. The Department of Social and Rehabilitation Services supports this bill.

This bill supports the screening protocols put forth in the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program under Medicaid, known as KAN Be Healthy in Kansas. According to the KAN Be Healthy Program, hearing screens are recommended beginning at age 3 and every three years thereafter. Vision screens are recommended beginning at age 3 and every two years thereafter.

The Omnibus Budget Reconciliation Act of 1989 (OBRA) mandates that all medically necessary services be provided to KAN Be Healthy participants. The mandated participation rate by 1995 is 80%. Medical Services within the Department of Social and Rehabilitation Services has developed interagency agreements with 12 local school districts in Kansas to reimburse KAN Be Healthy screenings in the school setting. The local school district provides the state match (41.24%) which is matched with federal Medicaid dollars. This cooperation helps to increase KAN Be Healthy participation and also assists the school district budget by providing federally matched Medicaid money.

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

PH&W
2-26-92
Attm #7.

February 26, 1992

Testimony before Public Health and Welfare Committee
House of Representatives

Pertinent to House Bill 2881

Submitted by:
Lila McKee, Chairperson,
Educational Audiologist's Writing Committee

As an educational audiologist, and as Chairperson of the Educational Audiologist's Guidelines Writing Committee, I am here to voice opposition to H.B. 2881, as it pertains to K.S.A. 72-1205, the school-age hearing screening law. I certainly agree that the present hearing screening law needs revision, but that the revisions offered by this bill are not satisfactory.

In 1985, a guidelines writing committee of educational audiologists was formed. The committee members were asked by their peers to write new Kansas State Board of Education guidelines for educational audiology and school hearing screening. In the Spring of 1986, proposed guidelines were reviewed by school nurses and audiologists and adopted. Since then the writing committee has written two addendums to the "Guidelines for Audiology and Hearing Screening". They are "Hearing Conservation in Industrial and Vocational Education" and "Infant/Toddler Hearing Screening". Both addendums were reviewed by educators, administrators, nurses and audiologists before being approved. A third addendum, "Tympanometry Screening", is currently being drafted.

It is the plan of the educational audiologists and KSBE that following the conclusion of the activities of the writing committee, and in light of already existing requirements in the KSBE screening and evaluation regulation, K.A.R. 91,12-40, we will bring to the 1993 legislature, in the KSBE legislative package, a bill offering numerous revisions to the current hearing screening law. Technological advances, and a wealth of research in the area of identification audiometry, clearly point out major weaknesses and omissions in the present hearing screening law. For these reasons, we have been encouraged by the Kansas Department of Health and Environment, Kansas Speech and Hearing Association, and Kansas School Nurses Association to proceed towards that goal.

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One of our concerns with the current hearing screening law has been the requirement that the results of the screening be reported to parents, whether pass or fail. Therefore, we have proposed, in the initial draft of our legislative proposal, slated to be brought to the legislature next year, a revision of the sentence which begins on page 1, line 42 to read, "For pupils who failed the screening, the results and, if appropriate, the need for further evaluation by a qualified audiologist or physician shall be reported to the parents or guardians of such pupils". Suggestions to hearing screeners on ways to notify parents that screening has recently been completed and, to use a familiar colloquialism, "No news, is good news!", indicating their child has passed the screening, will be covered in the "Guidelines for Audiology and Hearing Screening". We do not feel this notification needs to be legislated, and are particularly concerned that hearing screeners not be required to notify parents of the approximate date of hearing screening, before it can be conducted.

On Thursday of last week, the Kansas Board of Education, Special Education Office, notified the State's special education administrators that they were opposed to House Bill 2881. Since KSBE is the primary agency for monitoring school compliance to the hearing and vision screening laws, it would become the responsibility of their compliance monitor to determine if there had been parental notification prior to screening.

Therefore, I would urge you to not adopt the revisions to K.S.A. 72-1205 proposed in H.B. 2881, but rather to allow the educational audiologists, school nurses, Kansas Board of Education, and Kansas Department of Health and Environment to work together to find a more acceptable solution to this issue of parental notification for passed hearing screenings.

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FEB 26 1992
att #8
2-2

Kansas School Nurses Organization
K-NEA

Testimony presented to

House Public Health and Welfare Committee

by

The Kansas School Nurse Organization

House Bill 2881.

The Kansas School Nurse Organization supports HB 2881.

For a child to grow and develop normally and benefit from school experiences, the child must be able to communicate effectively with others. Vision and hearing are essential communication senses for interaction within a traditional classroom setting. Screenings for detection of deficits and more importantly, the intervention and remediation of the identified defects is of paramount importance to the educational outcome of the student.

The Kansas School Nurse Organization represents nearly over 30% of the 500 registered professional nurses and approximate 125 public health nurses serving schools in the state of Kansas. School nurses have been active in Kansas for 75 years. The mission of the organization is to promote the delivery of quality health programs for the school community, to advance school nurse practice, to strengthen professional growth of school nurses and afford school nurses the opportunity to address their mutual concerns.

The provision for vision and hearing screening within the schools has been in practice for some time. The proposed language of this bill provides coordination and correlation for both screening programs and procedures. It is most important that there not only be identification of vision and hearing deficits, but accountability for follow up of remediation for the student as well. Simply identifying a problem without creating responsibility for referral and folow up is ineffective. The proposed language should more accurately reflect the reality of practice within schools today in which students who are referred are followed to determine if the problem identified is evaluated by the appropriate professional.

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1-5

When enacted, hearing screening and vision screening will be mandated both by the State and Federally. There should be no necessity to notify parents of the approximate date such tests will be given. School nurses and other testing professionals within the schools may schedule students throughout the entire school year. Compliance to testing only on specific dates is impractical and simply not efficient within current professional practices as most nurses provide service to one or more schools and may be called to another building to provide service.

Language with regard to who shall do the testing should reflect actual practice. There are some 625 registered professional nurses employed by school districts to fulfill the requirements for mandated health screenings and provide health services to students. Currently the language used with regard to the vision screening reflects it to be the responsibility of the classroom teacher. The word "teacher" was indeed used in the original draft of this mandate which may have been written when teachers carried in wood, stoked the fires, swept the floors, provided health screenings and had total responsibility for the pioneer school. As teachers no longer perform these tasks, the current language should reflect that testing be completed by an appropriatly trained professional. Referral for further vision examination by an opthalmologist, or optometrist should be based on the professional judgement of the registered professional nurse or vision specialists who has been designated by the board of education.

Hearing screenings are not conducted by general classroom teachers. Referral for further hearing examination by a qualified physician or ear specialist should be based on the professional judgement of the registered professional nurse, speech therapists, or audiologists who has been designated by the board of education.

The proposed bill shows some disparity in regard to vision testing being required to be completed every two years and hearing testing being required to be completed every three years. Both vision and hearing testing are of equal importance and should be completed every two years.

<u>Recommendations</u>

The Kansas School Nurse Organization recommends that the Committee amend HB 2881 to read:

page #1

line 20> ..(hearing screening) .....every 2 years

line 36-39> delete......(parent notification of test date)..

line 40-43> ....competent in the use of a calibrated audiometer. Referral of the pupil for further examination by a qualified physician

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shall be made based on the test results in conjunction with the professional judgement of a registered professional nurse, speech therapist or audiologist.

page #2

line 9-12> delete.......(parent notification of test date)..

line 12-13> All tests shall be performed by a person competent in testing for visual acuity for distance and near vision, muscle balance and color blindness. Referral of the pupil for further examination by an opthalmologist or optometrist shall be made based on the test results in conjunction with the professional judgement of a registered professional nurse or vision specialist.

line 19> delete qualified physician..insert opthalmologist or optometrist..

line 23> delete qualified physician..insert opthalmologist or optometrist..

These recommendations accurately reflect practices as they currently exist within Kansas schools. These proposed changes in HB 2881 should require no additional funding to implement.

Respectfully submitted,

Ileen Meyer, RN

Ileen Meyer, B.S., R.N.
President - Kansas School Nurse Organization
Health Services Coordinator
Emporia Unified Schools - USD #253

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Session of 1992

KSNO RECOMMENDATIONS

HOUSE BILL No. 2881

By Representatives Hackler, Amos, Brown, Gilbert, Jones, Lahti, Love, Lynch, Macy, Parkinson, Praeger, Scott, Thompson and Webb

2-6

AN ACT relating to schools and school districts; concerning the provision of vision screening and hearing screening to certain pupils; amending K.S.A. 72-1205 and 72-5205 and repealing the existing sections.

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

Section 1. K.S.A. 72-1205 is hereby amended to read as follows: 72-1205. (a) Every pupil enrolled in a school district or an accredited nonpublic school shall be provided basic hearing screening without charge during the first year of admission and not less than once every ~~three~~ years thereafter. --------two

(b) Every pupil enrolled in a school district shall be provided basic hearing screening by the board of education of the school district in which the pupil resides and is enrolled.

(c) Every pupil in an accredited nonpublic school shall be provided basic hearing screening either (1) by the board of education of the accredited nonpublic school in which the pupil is enrolled, or (2) upon request therefor by the pupil's parent or guardian, by the board of education of the school district in which the pupil resides. No board of education of a school district shall be required to provide basic hearing screening outside the school district. If the accredited nonpublic school in which the pupil is enrolled is located within the school district, basic hearing screening shall be provided in the nonpublic school. If the accredited nonpublic school in which the pupil is enrolled is located outside the school district, basic hearing screening shall be provided in a school of the school district.

~~(d) The parents or guardian of the pupil, when possible in conjunction with other information provided by the school to the parents or guardian, shall be notified by the school of the approximate date such tests will be given.~~ --delete

All tests shall be performed by a person competent in the use of a calibrated audiometer. ~~and who has been designated by the board of education which provides the basic hearing screening.~~ ~~The results of the test and, if necessary, the desirability of examinations by a qualified physician shall be~~

Add: Referral of the pupil for further examination by a qualified physician shall be made based on the test results in conjunction with the professional judgement of a registered professional nurse, speech therapist or audiologist.

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KSNO RECOMMENDATIONS

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1 ~~reported to the parents or guardians of such pupils.~~ *If the test*
2 *results indicate that examination by a qualified physician may be*
3 *desirable, such information shall be reported to the parents or guard-*
4 *ian of the pupil, otherwise no report to the parents or guardian is*
5 *required. All test results shall be kept on file.*
6 Sec. 2. K.S.A. 72-5205 is hereby amended to read as follows:
7 72-5205. Each school board shall provide basic vision screening with-
8 out charge to every pupil in its school not less than once every two
9 ~~(2)~~ years. *The parents or guardian of the pupil, when possible in*
10 *conjunction with other information provided by the school to the*
11 *parents or guardian, shall be notified by the school of the approx-*
12 *imate date such tests will be given.* ~~All such tests shall be performed~~
13 ~~by a teacher or some other person designated by the school board.~~
14 ~~The results of the test and, if necessary, the desirability of~~
15 ~~examination by a qualified physician or optometrist shall be~~
16 ~~reported to the parents or guardians of such pupils: Provided,~~
17 ~~That the information so reported shall not show preference in~~
18 ~~favor of any such professional person.~~ *If the test results indicate*
19 *that examination by a* ~~qualified physician~~ *or optometrist may be*
20 *desirable, such information shall be reported to the parents or guard-*
21 *ian of the pupil. The information so reported shall not show a*
22 *preference in favor of any such professional person. If the test results*
23 *fail to indicate that examination by a* ~~qualified physician~~ *or optom-*
24 *etrist may be desirable, no report to the parents or guardian is*
25 *required. All test results shall be kept on file.*
26 Sec. 3. K.S.A. 72-1205 and 72-5205 are hereby repealed.
27 Sec. 4. This act shall take effect and be in force from and after
28 its publication in the statute book.

(lines 9–12) --delete

Add: All tests shall be performed by a person competent in testing for visual acuity for distance and near vision, muscle balance and color blindness. Referral of the pupil for further examination by an opthalmologist or optometrist shall be made based on the test results in conjunction with the professional judgement of a registered professional nurse or vision specialist.

(line 19) opthamologist

(line 23) opthamologist

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Emporia Unified School District No. 253

501 Merchant Street • Box 1008 • Emporia, Kansas 66801
Phone 316/342-4455

Testimony presented to

House Public Health and Welfare Committee

by

Emporia Unified School - USD #253

House Bill 2881.

The Nurses employed by Emporia Unified Schools, USD #253, support HB 2881.

We echo the recommendations set forth by Kansas School Nurse Organization with regard to proposed changes in the language of the vision and hearing mandates for Kansas school children.

<u>Recommendations</u>

The Kansas School Nurse Organization recommends that the Committee amend HB 2881 to read:

page #1

line 20> ..(hearing screening) .....every 2 years

line 36-39> delete......(parent notification of test date)..

line 40-43> ....competent in the use of a calibrated audiometer. Referral of the pupil for further examination by a qualified physician shall be made based on the test results in conjunction with the professional judgement of a registered professional nurse, speech therapist or audiologist.

page #2

line 9-12> delete.......(parent notification of test date)..

line 12-13> All tests shall be performed by a person competent in testing for visual acuity for distance and near vision, muscle balance

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and color blindness. Referral of the pupil for further examination by an opthalmologist or optometrist shall be made based on the test results in conjunction with the professional judgement of a registered professional nurse or vision specialist.

line 19> delete qualified physician..insert opthalmologist or optometrist..

line 23> delete qualified physician..insert opthalmologist or optometrist..

These recommendations accurately reflect practices as they currently exist within Kansas schools. Our school district already recognizes the need for increased evaluation of hearing and has followed the every 2 year schedule for testing for some time.

Respectfully submitted,

Anita Mesecher, R.N.
Elementary School Nurse
Empooria Unified Schools - USD #253

Mary Ginavan, B.S.N., R.N.
Middle School Nurse
Emporia Unified Schools - USD #253

Brenda Nickel, B.S.N., R.N.
Elementary School Nurse
Emporia Unified Schools - USD #253

Ileen Meyer, B.S., R.N.
Health Services Coordinator
Emporia Unified Schools - USD #253

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SACRED HEART ELEMENTARY SCHOOL
102 COTTONWOOD STREET
EMPORIA, KANSAS 66801-3898
(316) 343-7394

February 26, 1992

House Public Health & Welfare Committee
by Mary Ann Luby, Principal
HB 2881

To Whom It May Concern:

Sacred Heart School presently receives the benefits of HB 2881. As a parochial school, we are therefore, extremely interested in its continuation of HB 2881 with specific clarifications.

First, we would like to see the frequency for vision and hearing screenings be set at every two years. With children's rapid growth and physical changes during the elementary years, I am continually receiving requests from teachers for evaluations. Waiting for testing of either vision or hearing for three years would be a true hardship. With the screenings set at every two years, an average child will be evaluated two to three times during their kindergarten through five experience at Sacred Heart.

Second, it is vital that this be done by a school nurse trained in audio-metric and vision screening techniques. Even in a parochial school where we have no nurse, parents would soon disregard the results without the professionalism of our public school nurses. Children need the best screenings we can provide with the most qualified personnel.

Children are our future and HB 2881 serves all children. Please find it a high priority to make sure our students sight and hearing are ensured for educational excellence.

Sincerely,

Mary Ann Luby

Mary Ann Luby, Principal
MAL:mh

Written only
FEB 26 1992
Att #11.

CHRIST CENTERED, VALUE ORIENTED QUALITY EDUCATION