Approved 3-31-92
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Roy M. Ehrlich at
Chairperson

3:00 a.m./p.m. on March 23, 1992 in room 521-S of the Capitol.

All members were present except:

Committee staff present:

Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Lyndon Drew, Department on Aging
John Grace, Kansas Association of Homes for the Aging
John Kiefhaber, Kansas Health Care Association
John C. Peterson, Manor Health Care
Karren Weichert, Hospice

Chairman Ehrlich called the meeting to order at 3:00 p.m. and announced continuation of hearing on **HB 2566** - Assessment and referral service prior to admission to an adult care home.

Lyndon Drew, Department on Aging, submitted written testimony and stated the Department supports the bill with the amendments presented by SRS, which was a joint effort of the Departments of SRS, Health and Environment and Aging, and one of the key features is the requirement that information on long term care be distributed by nursing homes, physicians and hospitals. **HB 2566** is one component of a long term care system, and to be successful, the other components must be in place, such as the House has proposed in **HB 2720** an expansion of the Senior Care Act to a statewide program, and the House Appropriations Committee will be discussing long term care issues in the SRS budget. Mr. Drew emphasized that in-home services must be available in the communities if people are assessed pursuant to **HB 2566** and diverted from nursing home care. (Attachment 1)

Written testimony in support of **HB 2566** was received from Gina McDonald, Kansas Association of Centers for Independent Living, Terri Roberts, Kansas State Nurses Association, and Joseph Kroll, Health and Environment, with recommendations. (Attachments 2, 3, and 4)

John Grace, Kansas Association of Homes for the Aging, submitted written testimony on **HB 2566** and stated KAHA has concern with language on page 2, (d), lines 24 - 27, defining who can be designated providers of assessment and referral services, and on page 3, (f), lines 19-23, regarding an individual's right to choose that 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. (Attachment 5)

John Kiefhaber, Kansas Health Care Association, submitted written testimony and expressed his concern with **HB 2566** regarding (1) the duplication of comprehensive assessment and the forms required which would consume up to 6 hours of valuable time to complete, and (2) residents who do not need to be in a nursing facility are automatically identified by the use of the MDS. (Attachment 6)

John C. Peterson, Manor Health Care, submitted written testimony and stated **HB 2566** would create a new bureaucracy that is going to be paid $1.468 million to conduct 12,250 screenings on non Medicaid individuals each year. There is no fiscal analysis that shows projected savings from

this program for private pay individuals or no analysis of the amount of money that private pay individuals have when they enter a nursing home. (Attachment 7)

Karen Weichert, Association of Kansas Hospices, submitted written testimony and stated they are asking that all Hospice Medicare Benefit certified hospices in the state be exempt from **HB 2566** because an assessment is carefully made by the physician, nurse, and social worker, and that the role of the nurse and social worker and other members of the hospice team is to help the patient understand his/her options and make the choice that best meets that patient's need. Those persons served by these hospices are in the last six months of their lives and are terminally ill, and to require them to go through an assessment, in addition to the assessment that they will go through with the hospice staff, seems burdensome. (Attachment 8)

Written testimony was received from Monica Flask, Halstead Hospital, expressing the following concerns with the bill: (1) mandatory pre-screening would be a duplication of services for many people, (2) it would not be cost-effective to do a comprehensive "needs assessment" of community-based services, and (3) very few people enter a nursing home because they are unaware of existing services. (Attachment 9)

The meeting was adjourned at 3:45 p.m. The next meeting of the Committee is scheduled for March 24, 1992, 10:00 a.m., Room 526-S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 3-23-92
PM

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Lyndon Drew Topeka	KDOA
John Gore	KAHCA
Ellen J. Elliston	St. Francis Reg. Med. Cntr, St. Francis Regional Med Cntr. (WICHITA HOSPITALS)
Lisa Getz	Ks Governmental Consulting
Heather Epstein	" " "
Roger Fowler	
Chip Wheelen	Ks Medical Soc.
KAREN WEICHERT	Assoc of Ks Hospices
Chris Stanfield	SRS
John Kitchener	Ks. Health Care Assn.
Katie Pyle	AARP

Testimony on Sub. HB 2566
Pre-Admission Assessment and Referral

before the
Senate Public Health & Welfare Committee

by the
Kansas Department on Aging
March 23, 1992

The Kansas Department on Aging supports the Sub. HB 2566 with the amendments presented by SRS. The bill comes to you as a joint effort of the Departments of SRS, Health & Environment, and Aging. We believe that it is an important component of a long term care system in Kansas.

Need for Information

One of the key features of the substitute bill is the requirement that information on long term care be distributed by nursing homes, physicians, and hospitals. This information would be provided by the Department on Aging through the area agencies on aging. This information would also be available in area offices of SRS, in local health departments, in senior centers, and from the area agencies on aging.

In 1991, Minnesota studied its pre-admission screening process and found that people often got information on alternative services too late. If an assessment is performed after a person has applied for nursing home care, that person has probably exhausted community-based resources in trying to stay out of the nursing home. The nursing home becomes the last and only resort.

Minnesota, therefore, chose to add a public awareness campaign to its system to inform people in need of long term care about services. Sub. HB 2566 adds this feature to the Kansas system so that people will get information sooner rather than later. If people can find alternative services first, the need for nursing home care may be delayed.

Need for In-Home Services

Sub. HB 2566 is one component of a long term care system. To be successful, the other components must be in place. The House has proposed in HB 2720 an expansion of the Senior Care Act to a statewide program. The Senate Ways and Means Committee began this morning to consider this budget. The House Appropriations Committee is discussing long term care issues in the SRS budget (SB 507) this week. In-home services must be available in our communities if people are assessed pursuant to HB 2566 and diverted from nursing home care.

Senate P. H&W
Attachment #1
3-23-92 PM

Multiple Assessment Agencies

Another feature of the bill is the freedom provided consumers in choosing an agency for an assessment. Sec. 1(c)(2) authorizes SRS to designate agencies to provide assessment and referral services. Thus, consumers may be able to have an assessment performed through a hospital, local health department, area agency on aging, SRS office, or any other agency designated by SRS. SRS, not the consumer, pays for the assessment.

The bill also provides consumers freedom to choose among the alternatives, including nursing home care, after the assessment.

Conclusion

The Department on Aging supports the amendments proposed by SRS to Sub. HB 2566 and urges your approval of the bill as amended.

KANSAS ASSOCIATION OF CENTERS FOR INDEPENDENT LIVING

3258 South Topeka Blvd. ~ Topeka, Kansas 66611 ~ (913) 267-7100 (Voice/TDD)

Gina McDonald
Executive Director

TESTIMONY TO

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

SENATOR ROY M. EHRLICH, CHAIRMAN

MARCH 23, 1992

Member agencies:

ILC of Southcentral Kansas
Wichita, Kansas
(316) 942-8079

Independence, Inc.
Lawrence, Kansas
(913) 841-0333

Independent Connection
Salina, Kansas
(913) 827-9383

LINK, Inc.
Hays, Kansas
(913) 625-2521

Resource Center for
Independent Living
Osage City, Kansas
(913) 528-3105

Resource Network
for the Disabled
Atchison, Kansas
(913) 367-6367

The WHOLE PERSON, Inc.
Kansas City, Missouri
(816) 361-0304

Three Rivers Independent
Living Resource Center
Wamego, Kansas
(913) 456-9915

Topeka Independent
Living Resource Center
Topeka, Kansas
(913) 267-7100

Thank you for the opportunity to testify in support of H.B. 2566. My name is Gina McDonald and I represent the Kansas Association of Centers for Independent Living (KACIL).

KACIL is an organization comprised of nine Centers for Independent Living. Our mission is to assist people with disabilities to live independently in the community, and to make changes in the community so that independent living is possible. On a day to day basis, staff from Centers work with and are themselves individuals with physical, psychiatric and/or cognitive disabilities. In that role we all to often receive calls from young people with disabilities who are living in nursing homes because they, or their parents or the local S.R.S. office was not aware of community services available. Last year, with the assistance of Center for Independent Living staff, twenty four (24) young people with disabilities moved out of Adult Care Homes to live independently in the community. They never should have entered nursing homes, or adult care homes in the first place.

H.B. 2566 will require that all individuals receive assessment and referral services prior to entering an adult care home. It further requires that information about community services be made available to individuals and that data be collected to determine where there is need for additional community services.

KACIL wishes to offer our strong support for H.B.2566. It is our belief that this bill is critical to insuring that individuals have options to Adult Care Home placement. Those options will be available if the Secretary of S.R.S assures that individuals who complete these screenings are aware of community alternatives, and that the screeners encourage community living alternatives.

Thank you for the opportunity to speak in support of this important bill.

Senate P. H & W
attach # 2
3-23-92 PM

KSNA

the voice of Nursing in Kansas

NURSING
SHAPING THE FUTURE OF HEALTH CARE
NATIONAL NURSES WEEK, MAY 4-10, 1992

FOR MORE INFORMATION CONTACT:

Terri Roberts, J.D., R.N.
Executive Director
Kansas State Nurses' Association
700 S.W. Jackson Suite 601
Topeka, Kansas 66603-3731
(913) 233-8638
March 23, 1992

SUBSTITUTE H.B. 2566 PRE-ADMISSION SCREENING FOR NURSING HOME ADMISSION

Senator Erhlich and members of the Committee for Public Health and Welfare: My name is Carolyn Middendorf, and I am a registered professional nurse licensed to practice in the state of Kansas. Presently I am an Assistant Professor of Nursing at Washburn University in Kansas. Thank you for letting me offer this written testimony in support of Substitute HB 2566 regarding pre-admission assessment for individuals who are considering nursing home admission.

This bill not only would require the pre-admission assessment in order to provide appropriate recommendation for placement, but require that information regarding options and available services to individuals and their families. We know that community based services are sparse across the state, but this would require that information concerning these services be compiled for use in referral services by a number of providers. SRS would also have available the data that directs the services which are available as well as the services which are needed by citizens in Kansas.

Fiscal impact provided by SRS indicates there could be nearly $500,000/yr. net savings to the State in nursing home costs by using this technique to accurately assess services needed and referral and placement. As nurses we believe such action is imperative in the effort to turn around the soaring costs of nursing home care in this State. We believe that the shortage of services will be overcome when there is hard data to indicate such services are needed and in which areas.

We would appreciate your support of Substitute H.B. 2566 as one means of reversing the rising health care costs to our citizens.

Thank you for your attention.

a:hb2566
Testimony 1992

Senate S. HPW

Attach. #3
3-23-92 PM

State of Kansas
Joan Finney, *Governor*

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

Reply to:

Testimony Presented to the

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

Substitute for House Bill 2566

1991 House Bill 2566 was considered by the House Public Health and Welfare Committee. The bill was tabled due to a number of concerns the committee had, with the understanding being that SRS would come back with revisions or a proposed substitute for 1992 legislative consideration.

Substitute House Bill 2566 is the result of a collaborative effort by KDHE, SRS, and the Department on Aging to develop a bill that affirmatively addresses the issue of providing information on alternatives to those seeking nursing home admission. The bill also provides a means for such information to be developed and distributed, assures a standardized yet simple assessment tool and guarantees that a person not under Medicaid retains freedom of choice.

The Kansas Department of Health and Environment, as a partner with SRS and the Department on Aging, recognizes that Kansas has devoted significant resources to long term institutional care and that non-institutional community resources have not been made available to the extent of becoming a viable option for persons needing assistance. We think that the provisions in Substitute HB 2566, which require the Department on Aging to compile comprehensive resource information on long term care, coupled with the requirement that adult care homes, hospitals, and physicians provide this information to persons seeking nursing home placement, will confirm that non-institutional alternatives are badly needed and help identify the types of such services needed.

To assure that such assessments are done uniformly, the bill authorizes the Secretary of SRS to develop a uniform needs assessment instrument and directs that this instrument be as concise and short as needed. We also commend this language in that the interest

Senate P. H&W
attach. #4

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of all three agencies is not in developing a new burden of paperwork, but only to identify the kind of non-institutional community resources that are needed.

The Department of Health and Environment has some concern with provisions added to the bill during House committee deliberations. Therefore, KDHE makes the following recommendations:

1. The effective date of the bill should be changed to January 1, 1993. We do not think it is feasible to expect the Department of SRS to develop an assessment tool and network to conduct these assessments by July 1, 1992. Although the elements of an assessment tool are readily available, a network of providers to conduct the assessments must be developed and fully trained. It will be better to delay implementation of the program and do it correctly than to rush and doom the bill's intent to failure because inadequate time for preparation was not allowed.

2. We believe that Section (e) (2), line two, needs to include language that excludes residents of boarding care homes, personal care homes, or one and two bed homes from the list of persons exempted from this admission assessment. These types of facilities are limited to the provision of simple nursing tasks and someone coming from such a facility needs to be assessed to see if other non-institutional options to nursing home placement are appropriate.

3. We recommend that Section (e) (3) include language to assure that an assessment be completed prior to the end of the 30th day. This exception to assessment prior to admission is an important provision to allow nursing facility stays for short terms, but will become a significant loophole in that many people may be admitted who will not benefit from the assessment and perhaps unknowingly remain in the nursing home when other options are available.

4. We recommend that the exception found in Section (e) (4) be deleted. Persons whose care is paid for by the Veterans Administration have a right to know what other options are available in their community. Deleting this exception in no way compromises a person covered under VA benefits from selecting the nursing home if they so choose.

5. We recommend that the exception found in Section (e) (5) also be deleted. An assessment done in another state, even within three months of proposed admission to a Kansas nursing home, is of no benefit. The primary purpose of this bill is to identify and apprise people of options to nursing home care existing in Kansas.

The Kansas Department of Health and Environment supports House Bill 2566 with the exceptions noted above. We support this bill because it properly focuses attention on the

need to identify alternatives to nursing homes and will help identify the type, location, and quantity of such alternatives.

The Kansas Department of Health and Environment does not recognize this bill as a major cost saving measure, but it will serve to improve the entire long term care system and should be supported for this reason.

The Kansas Department of Health and Environment respectfully requests that Substitute House Bill 2566 be favorably recommended after amended as recommended above.

Presented by:

Joseph F. Kroll, Director
Bureau of Adult and Child Care
Kansas Department of Health and Environment
March 23, 1992

KAHA
Kansas Association of Homes for the Aging

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

To: Senator Roy Ehrlich, Chairman
Public Health & Welfare
From: John Grace, President/CEO
Kansas Association of Homes for the Aging
Date: March 23, 1992
Re: HB 2566

Mr. Chairman, members of the Committee, thank you for the opportunity to testify today.

KAHA supports the practice of fully informing individuals of their choices for care and expanding the continuum of care available to the frail elderly. However, I would like to direct your attention to concerns that KAHA has with two sections of HB 2566.

My first concern is with section (d), defining who can be designated providers of assessment and referral services. I am specifically concerned with the language on lines 24-27, stating that, "No person licensed to operate an adult care home under the adult care home licensure act, or any agent or employee of such person, shall be designated as a provider of assessment and referral services under this subsection."

This will be a significant hardship in rural areas where the only person available to perform the assessment is the local physician, who is also on staff at the nursing home. There is little likelihood that a health care professional, particularly a doctor, will be inappropriately biased towards nursing home placement. There may, however, be a bias from home health providers or from a developing assessment industry that may encourage inappropriate types of care that are incapable of meeting the medical needs of a person that can actually result in harm to the individual.

Therefore, KAHA does not support the restriction against nursing home administrators or agents or employees from performing the assessment.

The second concern regards section (f), lines 19-23, which states that, "An individual's right to choose does not supersede the authority of the secretary of social and rehabilitation services to

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-OVER-

Senate P. H. & W.
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determine whether the placement is appropriate and to deny eligibility for long-term care payment if inappropriate placement is chosen."

I am concerned that a private pay resident who has chosen to live in a nursing home will be denied Medicaid coverage several years later when his/her condition worsens and all of his/her resources are exhausted.

A related issue is the possible difference in assessment instruments, if the intent is for the assessment and referral tool to be simple for the designated provider to use. It will have to be significantly different from the complex assessment tool currently being used to determine medical necessity for medicaid coverage. Currently, every person applying for medicaid coverage of nursing home care goes through an extensive evaluation to determine the medical necessity for this level of care. If the placement is not appropriate, SRS will deny eligibility.

The authority of SRS to deny coverage should continue under this bill, but should not be expanded to penalize a person who exercises free choice in determining his/her long term care resource. Under the proposed bill, a person can enter a nursing home and pay for their care privately. However, if the designated provider of assessment and referral services uses a simplified assessment tool and concludes that the placement is not appropriate, the person will later be penalized even though their condition may worsen or the more complete medicaid assessment determine that nursing home placement is appropriate. This result is obviously unfair. Alternatively, if the assessment tool is to be the MDS+, the proposed bill has eliminated most people who are trained to use it.

Therefore, I would ask that the Committee address these concerns before taking action on this bill.

Thank you for the opportunity to testify.

State of Kansas
Department of Social and
Rehabilitation Services

MINIMUM DATA SET PLUS FOR NURSING FACILITY RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)

(Status in the last seven days, unless otherwise indicated)

State of Kansas
Department of Health
and Environment

MS-2101
10-91

FACILITY _____

Assessment Date ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year)

Original (O) or Correction (#) ☐

Signature of
RN Assessment Coordinator _____

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	RESIDENT NAME	First: _____ (M.I.) Last: _____	
2.	SOCIAL SECURITY NO.	☐☐☐☐☐☐☐☐☐	
3.	MEDICAID NO. (If applicable)	☐☐☐☐☐☐☐☐☐☐☐☐☐☐	
4.	MEDICAL RECORD NO.	☐☐☐☐☐☐☐☐☐☐	
5.	REASON FOR ASSESSMENT	1. Initial admission assessment 2. Hosp./Medicare reassessment 3. Readmission, not Medicare 6. Quarterly 4. Annual assessment 7. Other 5. Significant change in status (e.g., UR)	
6.	CURRENT PAYMENT SOURCE(S) FOR STAY	*(Billing Office to code payment sources)* 0. Not Used 2. Ancillary 1. Per Diem 3. Both Medicaid ☐ VA Medicare ☐ Self pay/Private insur. CHAMPUS ☐ Other	
7.	RESPONSIBILITY/ LEGAL GUARDIAN	*(Check all that apply)* Legal guardian a. ☐ Family member responsible d. Other legal oversight b. ☐ Resident responsible e. Durable power attrny./ health care proxy c. ☐ NONE OF ABOVE f.	
8.	ADVANCED DIRECTIVES	*(For those items with supporting documentation in the medical record, check all that apply)* Living will a. ☐ Feeding restrictions f. Do not resuscitate b. ☐ Medication restrictions g. Do not hospitalize c. ☐ Other treatment h. Organ donation d. ☐ NONE OF ABOVE i. Autopsy request e. ☐	
9.	DISCHARGE PLANNED WITHIN 3 MOS.	*(Does not include discharge due to death)* 0. No 1. Yes 2. Unknown/uncertain	
10.	MARITAL STATUS	1. Never married 4. Separated 2. Married 5. Divorced 3. Widowed	

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	*(Persistent vegetative state/no discernable consciousness)* 0. No 1. Yes (Skip to SECTION H.)	
2.	MEMORY	*(Recall of what was learned or known)* a. Short-term memory OK - seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK - seems/appears to recall long past 0. Memory OK 1. Memory problem	
3.	MEMORY/ RECALL ABILITY	*(Check all that the resident is normally able to recall during last 7 days)* Current season a. ☐ That he/she is in Location of own rm. b. ☐ a nursing facility d. Staff names/faces c. ☐ NONE OF ABOVE are recalled e.	
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	*Made decisions regarding tasks of daily life* 0. Independent - decisions consistent/reasonable 1. Modified independence - some difficulty in new situations only 2. Moderately impaired - decisions poor; cues/supervision required 3. Severely impaired - never/rarely made decisions	
5.	INDICATORS OF DELIRIUM - PERIODIC DISORDERED THINKING/ AWARENESS	*(Check if condition over last 7 days appears different from usual functioning)* Less alert, easily distracted a. Changing awareness of environment b. Episodes of incoherent speech c. Periods of motor restlessness or lethargy d. Cognitive ability varies over course of day e. NONE OF ABOVE f.	
6.	CHANGE IN COGNITIVE STATUS	*Change in resident's cognitive status, skills, or abilities - in last 90 days* 0. No change 1. Improved 2. Deteriorated	

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	*(With hearing appliance, if used)* 0. Hears adequately - normal talk, TV, phone 1. Minimal difficulty when not in quiet setting 2. Hears in special situation only - speaker has to adjust tonal quality and speak distinctly 3. Highly impaired/absence of useful hearing	
2.	COMMUNICATION DEVICES/ TECHNIQUES	*(Check all that apply during last 7 days)* Hearing aid, present and used a. Hearing aid, present and not used b. Other receptive comm. technique used (e.g. lip read) c. NONE OF ABOVE d.	
3.	MODES OF EXPRESSION	*(Check all used by resident to make needs known)* Speech a. ☐ Communication board d. Writing messages to express or clarify needs b. ☐ American Sign Language or Braille e. Signs/gestures/ sounds c. ☐ Other f. NONE OF ABOVE g.	
4.	MAKING SELF UNDERSTOOD	*(Expressing information content - however able)* 0. Understood 1. Usually understood - difficulty finding words or finishing thoughts 2. Sometimes understood - ability is limited to making concrete requests 3. Rarely/Never understood	
5.	SPEECH CLARITY	*Speech unclear* 0. No 1. Yes	

EXAMPLE:

Code the appropriate response = ☐

Check all the responses that apply = a.

5-3

Resident: _____ SS#: _____ Facility #: _____

SECTION C. CONT.

6.	ABILITY TO UNDER-STAND OTHERS	*(Understanding verbal information content - however able)* 0. Understands 1. Usually understands - may miss some part/ intent of message 2. Sometimes understands - responds adequately to simple, direct communication 3. Rarely/never understands	
7.	CHANGE IN COMMUNI-CATION/ HEARING	*Resident's ability to express, understand or hear information has changed over last 90 days* 0. No change 1. Improved 2. Deteriorated	

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. Adequate-sees fine detail, including regular print in newspapers/books 1. Impaired - sees large print, but not regular print in newspapers/books 2. Highly impaired - limited vision, not able to see newspaper headlines, appears to follow objects with eyes 3. Severely impaired - no vision or appears to see only light, color, or shapes	
2.	VISUAL LIMITA-TIONS/DIFF-ICULTIES	Side vision problems - decreased peripheral vision: (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights, sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	*Glasses; contact lenses; lens implant; magnifying glass* 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	SAD OR ANXIOUS MOOD	*(Check all that apply during last 30 days)* VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief)	a.
		DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS Tearfulness, emotional groaning, sighing, breathlessness	b.
		Motor agitation such as pacing, handwringing or picking	c.
		Pervasive concern with health	d.
		Recurrent thoughts of death - e.g., believes he/she about to die, have a heart attack	e.
		Suicidal thoughts/actions	f.
		Failure to eat or take medications	g.
		Withdrawal from self-care, leisure activities	h.
		Reduced communications	i.
		Early morning awakening with unpleasant mood	j.
		NONE OF ABOVE	k.

2.	MOOD PER-SISTENCE	*Sad or anxious mood intrudes on daily life over last 7 days - not easily altered, doesn't "cheer up"* 0. No 1. Yes	
3.	PROBLEM BEHAVIOR	*(Code for behavior in last 7 days)* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently	
		a. WANDERING (moved with no rational purpose; seemingly oblivious to needs or safety)	
		b. VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	
4.	RESIDENT RESISTS CARE	*(Check all types of resistance that occurred in the last 7 days)* Resisted taking medications/injection	a.
		Resisted ADL assistance	b.
		Resisted eating	c.
		NONE OF ABOVE	d.
5.	BEHAVIOR MANAGE-MENT PROGRAM	*Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve only physical restraints and/or psychotropic medications in this category.)* 0. No behavior problem 1. Yes, addressed 2. No, not addressed	
6.	CHANGE IN MOOD	*Change in mood in last 90 days* 0. No change 1. Improved 2. Deteriorated	
7.	CHANGE IN PROBLEM BEHAVIOR	*Change in problem behavioral signs in last 90 days* 0. No change 1. Improved 2. Deteriorated	

5-4

Resident: _____ SS#: _____ Facility #: _____

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVE-MENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		Adjusts easily to changes in routine	g.
		NONE OF ABOVE	h.
2.	UNSETTLED RELATION-SHIPS	Covert/open conflict with and/or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family or friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Avoids interactions with others	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b
		NONE OF ABOVE	c.

SECTION G. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., no naps or naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	NONE OF ABOVE	d.
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most more than 2/3 of time		2. Little less than 1/3 of time	
		1. Some 1/3 to 2/3 of time		3. None	
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*			
		Own room	a.		
		Day/activity room	b.	Outside facility	d.
		Inside NF/off unit	c.	NONE OF ABOVE	e.
4.	GENERAL ACTIVITY PRE-FERENCES (Adapted to resident's current abilities)	*(Check all activities preferences whether or not activity is currently available to resident)*			
		Cards/other games	a.	Going outdoors (walking/ wheeling/sitting)	h.
		Crafts/arts	b.		
		Exercise/sports	c.		
		Music	d.	Watch TV	i.
		Read/write	e.	Gardening/plants	j.
		Spiritual/religious activities	f.	Talking/conversing	k.
				Helping others	l.
		Trips/shopping	g.	NONE OF ABOVE	m.

5.	PREFERS MORE OR DIFFERENT ACTIVITIES	Resident expresses or indicates preferences for other activities or choices. 0. No 1. Yes	
6.	ISOLATION ORDERS	Resident is under medical orders for isolation which prohibits participation in group activities. 0. No 1. Yes	

SECTION H. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. ADL SELF-PERFORMANCE *(Code for resident's PERFORMANCE over all shifts during last 7 days - Not including setup)*
   0. INDEPENDENT - No help or oversight - OR - Help/oversight provided only 1 or 2 times during last 7 days.
   1. SUPERVISION - Oversight, encouragement, or cueing provided 3+ times during last 7 days - OR - Supervision plus physical assistance provided only 1 or 2 times during last 7 days
   2. LIMITED ASSISTANCE - Resident highly involved in activity, received physical help in guided maneuvering of limbs, or other nonweight bearing assistance 3+ times - OR - More help provided only 1 or 2 times during last 7 days.
   3. EXTENSIVE ASSISTANCE - While resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times:
      - Weight-bearing support
      - Full staff performance during part (but not all) of last 7 days
   4. TOTAL DEPENDENCE - Full staff performance of activity during entire 7 days.

			1 Self Performance	2 Support
2.	ADL SUPPORT PROVIDED *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)* 0. No setup or physical help from staff 1. Setup help only 2. One-person physical assist 3. Two + persons physical assist			
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces - to/ from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	LOCO-MOTION	How resident moves between locations in his/ her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
e.	EATING	How resident eats and drinks (regardless of skill)		
f.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

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Resident: _____ SS#: _____ Facility #: _____

SECTION H. CONT.

3.	BATHING	a. How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). Code for most dependent in self-performance and support. Bathing Self-Performance codes appear below. Use support codes on preceding page. 0. Independent - No help provided 1. Supervision - Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence (1 S P / 2 S)	
		b. Tub/whirlpool bath [a.] Shower [b.] Bed bath [c.] Bath lift [d.] NONE OF ABOVE [e.]	
4.	BODY CONTROL PROBLEMS	*(Check all that apply during last 7 days)* Balance - partial or total loss of ability to balance self while standing [a.] Bedfast all or most of the time [b.] Hemiplegia/ hemiparesis [c.] Quadriplegia [d.] Arm - partial or total loss of voluntary movement [e.] Hand - lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid) [f.] Leg - partial or total loss of voluntary movement [g.] Leg - unsteady gait [h.] Trunk - partial or total loss of ability to position balance, or turn body [i.] Amputation [j.] NONE OF ABOVE [k.]	
5.	CONTRACTURES	*(Check all that apply in the prior 7 days)* Contractures - None [a.] Contractures - Face/Neck [b.] Contractures - Shoulder/Elbow [c.] Contractures - Hand/Wrist [d.] Contractures - Hip/Knee [e.] Contractures - Foot/Ankle [f.]	
6.	MOBILITY APPLIANCES/ DEVICES	*(Check all that apply during last 7 days)* Cane/Walker [a.] Brace/Prosthesis [b.] Wheeled self [c.] Other person wheeled [d.] Lifted (manually/ mechanically) [e.] Transfer aid (slide brd) [f.] Trapeze [g.] NONE OF ABOVE [h.]	
7.	TASK SEGMENTATION	Resident requires that some or all of ADL activities be broken into a series of sub-tasks so that resident can perform them. 0. No. 1. Yes	
8.	CHANGE IN ADL FUNCTION	Change in ADL function in last 90 days 0. No change 1. Improved 2. Deteriorated	

9.	ADL FUNCTIONAL REHAB. POTENTIAL	Resident believes he/she capable of increased independence in at least some ADLs [a.] Direct care staff believe resident capable of increased independence in at least some ADLs [b.] Resident able to perform tasks/activity but is very slow [c.] Major difference in ADL Self-Performance or ADL Support in mornings and evenings (at least a one category change in Self-Performance or Support in any ADL) [d.] Self-performance restricted due to absence of assistive devices (e.g., brace or wheelchair) [e.] Tires noticeably during most days [f.] Active avoidance of activity for which resident is physically/cognitively capable (e.g., fear of falling) [g.] NONE OF ABOVE [h.]	

SECTION I. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES	*(Code for resident performance over all shifts.)* 0. CONTINENT - Complete control 1. USUALLY CONTINENT - BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT - BLADDER, 2 + times a week but not daily; BOWEL, once a week 3. FREQUENTLY INCONTINENT - BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. INCONTINENT - Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time	
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	
2.	INCONTINENCE RELATED TESTING	*(Skip if resident's bladder and bowel continence codes equals 0/1 and no catheter used)* Resident has been tested for a urinary tract infection [a.] Resident has been checked for presence of a fecal impaction [b.] There is adequate bowel elimination [c.] NONE OF ABOVE [d.]	
3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan [a.] External (condom) catheter [b.] Indwelling catheter [c.] Intermittent catheter [d.] Did not use toilet rm/ commode/urinal [e.] Pads/briefs used [f.] Enemas/irrigation [g.] Ostomy [h.] NONE OF ABOVE [i.]	
4.	CHANGE IN URINARY CONTINENCE	Change in urinary continence, appliances, and/or programs in last 90 days 0. No change 1. Improved 2. Deteriorated	

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MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last seven days, unless otherwise indicated)

MS-2101
10-91

Resident: _____ SS#: _____ Facility #: _____

SECTION J. SKIN CONDITION AND FOOT CARE

1.	STASIS ULCER	Open lesion caused by poor venous circulation to lower extremities 0. No 1. Yes	
2.	PRESSURE ULCERS	*(Record the number of sites for presence of each stage of pressure ulcers. If none are present at the stage stated, record "0" (zero) in the space provided. Code all that apply to resident during last 7 days.)*	No. at Stage
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone.	
3.	HISTORY OF RESOLVED/ CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days. 0. No 1. Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	Skin desensitized to pain, pressure, discomfort	a.
		Abrasions, bruises	b.
		Burns (second or third degree)	c.
		Surgical wounds	d.
		Cuts (other than surgery)	e.
		Open lesions other than stasis/pressure ulcers, or cuts	f.
		Rashes	g.
		NONE OF ABOVE	h.
5.	ACTIVE SKIN CARE PROGRAM	Protective/preventive skin care	a.
		Turning/repositioning program	b.
		Pressure relieving beds,bed/chair pads (e.g., egg crate pads)	c.
		Surgical wound or pressure ulcer care	d.
		Other skin care/treatment	e.
		Special nutrition/hydration program	f.
		Special application/ointments/medications	g.
		Ostomy care (e.g., trach) (routine/stable)	h.
		NONE OF ABOVE	i.
6.	SPECIAL STOCKINGS	During the past 7 days has the resident used TED or similar stockings? 0. No 1. Yes	
7.	FOOT CARE	*(Check all that apply to resident during LAST 30 DAYS)*	
		Protective/preventive Foot Care: (e.g., special shoes, inserts, pads, toe separators, nail/callus trimming, etc.)	a.
		Active Foot Care Treatments:	
		Foot Soaks	b.
		Dressing with and without topical medications, etc.	c.
		NONE OF ABOVE	d.

SECTION K. DISEASE DIAGNOSES/CONDITIONS

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list old/inactive diagnoses.)

1. DISEASES *(If none apply, check the NONE OF ABOVE box)*

HEART/CIRCULATION		PSYCHIATRIC/MOOD	
Arteriosclerotic heart disease (ASHD)	a.	Anxiety disorder	p.
Cardiac dysrhythmias	b.	Depression	q.
Congestive heart failure	c.	Manic depressive (bipolar disease)	r.
Hypertension	d.	SENSORY	
Hypotension	e.	Cataracts	s.
Peripheral vascular disease	f.	Glaucoma	t.
Other cardiovascular disease	g.	OTHER	
NEUROLOGICAL		Allergies	u.
Alzheimer's	h.	Anemia	v.
Dementia other than Alzheimer's	i.	Arthritis	w.
Aphasia	j.	Cancer	x.
Cerebrovascular accident (stroke)	k.	Diabetes mellitus	y.
Multiple Sclerosis	l	Explicit terminal prognosis	z.
Parkinson's disease	m.	Hypothyroidism	aa.
PULMONARY		Osteoporosis	bb.
Emphysema/ Asthma/COPD	n.	Seizure disorder	cc.
Pneumonia	o.	Septicemia	dd.
		Urinary tract infection in last 30 days	ee.
		NONE OF ABOVE	ff.

2. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

a. _____
b. _____
c. _____
d. _____
e. _____
f. _____

3. PROBLEMS CONDITIONS AND SIGNS/ SYMPTOMS *(Check all problems that apply; last 7 days, UNLESS OTHER TIME FRAME STATED)*

Constipation	a.	Recurrent lung aspirations in last 90 days	j.
Diarrhea	b.		
Dizziness / vertigo	c.		
Fecal impaction	d.	Shortness of breath (Dyspnea)	k.
Fever	e.	Syncope (fainting)	l.
Hallucinations /delusions	f.	Vomiting	m.
Internal bleeding	g.	Respiratory infection	n.
Joint pain	h.	Chest Pain	o.
Pain - Res. complains or shows evidence of pain daily or almost daily	i.	NONE OF ABOVE	p.

4. EDEMA *(Check all that apply in the last 7 days)*

Edema - none	a.
Edema - generalized	b.
Edema - localized not pitting	c.
Edema - pitting	d.
Edema - other	e.

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Resident: _____ SS#: _____ Facility #: _____

SECTION K. CONT.

5.	ACCIDENTS	*(Check all that apply)*				
		Fell - past 30 days	a.	Other fractures in last 180 days	d.	
		Fell - past 31-180 days	b.	NONE OF ABOVE	e.	
		Hip fracture in last 180 days	c.			
6.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, or behavior status unstable—fluctuating, precarious, or deteriorating.			a.	
		Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem.			b.	
		NONE OF ABOVE			c.	

SECTION L. ORAL/NUTRITION STATUS

1.	ORAL PROBLEMS	a. Chewing problem				a.
		b. Swallowing problem				b.
		c. Mouth pain				c.
		d. NONE OF ABOVE				d.
2.	HEIGHT AND WEIGHT	a. Record height in inches			HT (in.)	
		b. Record weight in pounds			WT (lb.)	
		Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice - e.g., in a.m. after voiding before meal, with shoes off, and in nightclothes.				
		c. Weight loss (i.e., 5% plus IN THE PAST 30 DAYS or 10% IN THE PAST 180 DAYS): 0. No 1. Yes				
3.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.	Regular complaint of hunger	d.	
		Insufficient fluid; dehydrated	b.	Leaves 25% + food uneaten at most meals	e.	
		Did NOT consume all/almost all liquids provided during last 3 days	c.	NONE OF ABOVE	f.	
4.	NUTRITIONAL APPROACH	Parenteral/IV	a.	Therapeutic diet	e.	
		Feeding tube	b.	Diet supplement between meals	f.	
		Mechanically altered diet	c.	Plate guard, stabilized built-up utensil, etc.	g.	
		Syringe (oral feeding)	d.	NONE OF ABOVE	h.	

SECTION M. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures and/or removable bridge	b.
		Some/all natural teeth lost - does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses, ulcers, or rashes	e.
		Daily cleaning of teeth/dentures	f.
		NONE OF ABOVE	g.

SECTION N. SPECIAL TREATMENTS, DEVICES, PROC., & SUPPLIES

1.	SPECIAL TREATMENTS AND PROCEDURES	*a. SPECIAL CARE - (Check treatments received during the last 14 days.)*				
		Chemotherapy	a.	Transfusions	g.	
		Radiation	b.	O2	h.	
		Dialysis	c.	Intake/Output	i.	
		Suctioning	d.	Ventilator/Respirator	j.	
		Trach care	e.	Other _____	k.	
		IV meds.	f.	NONE OF ABOVE	l.	
		b. THERAPIES - Record the number of days and total minutes each of these therapies was administered (for at least 10 minutes) in the last 7 days (0 if none)				
		Box A = # of days administered for 10 mins. or more				
		Box B = Total # of minutes administered in last 7 days				A B
		a. Speech - language pathology and audiology services				
		b. Occupational therapy				
		c. Physical therapy				
		d. Psychological therapy (any licensed prof.)				
		e. Respiratory therapy				
		f.. Recreation therapy				
2.	REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation/restorative technique/practice was provided for more than or equal to 15 minutes per day, to the resident in the last 7 days. (Enter 0 if none)*				
		a. Range of Motion (passive)				
		b. Range of Motion (active)				
		c. Splint/Brace Assistance				
		d. Reality Orientation				
		e. Remotivation				
		Training and Skill Practice in:				
		f. Locomotion/Mobility				
		g. Dressing/Grooming				
		h. Eating/Swallowing				
		i. Transfer				
		j. Amputation Care				
3.	DEVICES AND RESTRAINTS	*Use the following code for last 7 days:* 0. Not used 1. Used less than daily 2. Used daily				
		a. Bed rails				
		b. Trunk restraint				
		c. Limb restraint				
		d. Chair prevents rising				

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MINIMUM DATA SET PLUS FOR NURSING FACILITY
RESIDENT ASSESSMENT AND CARE SCREENING (MDS+)
(Status in the last seven days, unless otherwise indicated)

MS-2101
10-91

Resident: _____ SS#: _____ Facility #: _____

SECTION N. CONT.

4.	SUPPLIES	*Record the number of units of the supply listed that have been used or consumed by the resident in the past 7 days. (Enter 0 if none)* a. Sterile Dressings b. Unique/Special Decubitus Care Supplies c. Peritoneal Dialysis Supplies
5.	PHYSICIAN ORDERS	IN THE LAST 30 DAY PERIOD since the resident was admitted, how many times has the physician (authorized assistant/practitioner) changed the resident's orders? (Do not include order renewals without change.)
6.	NO LAB TEST	*Check if no laboratory tests performed in the last 90 days. (Skip to Section O)*
7.	LABORATORY TEST	How many lab samples (blood/urine/etc.) have been collected IN THE PAST 30 DAYS?
8.	ABNORMAL LAB RESULTS	a. How many laboratory tests were returned with abnormal values during the past 90 days? b. How many abnormal values resulted in treatment or care planning in the past 30 days?

SECTION O. MEDICATION USE

1.	NUMBER OF MEDICATIONS	*Record the number of different medications used in the last 7 days. (Enter "0" if none used. Skip to item 5.)*
2.	NEW MEDICATIONS	Resident has received new medications during the last 90 days. 0. No 1. Yes
3.	INJECTIONS	*Record the number of days injections of any type received during the last 7 days.*
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*Record the NUMBER OF DAYS during the last 7 days; enter "0" if not used; enter "1" if long acting meds. used less than weekly* a. Antipsychotics b. Antianxiety/hypnotics c. Antidepressants
5.	PREVIOUS MEDICATION RESULTS	*Skip this question if resident currently receiving antipsychotics, antidepressants, or antianxiety/hypnotics - otherwise code correct response for last 90 days* Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences.) 0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown

SECTION P. PARTICIPATION IN ASSESSMENT

1.	PARTICIPATE IN ASSESSMENT	Resident: 0. No 1. Yes	Family: 0. No 1. Yes 2. No Family	Significant Other: 0. No 1. Yes 2. None

P.2. SIGNATURES OF THOSE COMPLETING THE ASSESSMENT:

a. Name of RN assessment coordinator b. End Date

	Signature	Title	Sections	Date
c.				
d.				
e.				
f.				
g.				
h.				

P.3. CASE MIX GROUP
Medicare [ ][ ][ ][ ][ ] State [ ][ ][ ][ ][ ]

5-9

STATE OF KANSAS
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
ADULT SERVICES

SRS Adult Services
300 S.W. Oakley, West Hall
Topeka, KS 66606 (913) 296-3728

MS-2123
Rev. 7-89

ADULT CARE HOME PRE-ADMISSION SCREENING FORM (LEVEL II)

Resident Name (Last, First, MI)	Social Security Number	Birthdate	Race	Sex

Resident Address City Zip

This form is being completed by: [ ] Adult Care Home; [ ] Hospital; [ ] Attending Physician; [ ] Other (Specify):

1. Does the individual have a diagnosis of mental illness? (See definition on illness stated on back.)	[ ] YES	[ ] NO
2. Does the person have any recent (within the last two years) history of mental illness or been prescribed a major tranquilizer on a regular basis in the absence of a justifiable neurological disorder?	[ ] YES	[ ] NO
3. Is there any presenting evidence of mental illness (except primary diagnosis of Alzheimer's Disease of dementia) including possible disturbances in orientation, affect, or mood?	[ ] YES	[ ] NO
4. Does the individual have a diagnosis of mental retardation or related condition? (See definition of mental retardation or related condition stated on back.)	[ ] YES	[ ] NO
5. Is there any history of mental retardation or a related condition in the identified individual's past?	[ ] YES	[ ] NO
6. Is there any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or a related condition?	[ ] YES	[ ] NO
7. Is the person being referred by an agency that serves persons with mental retardation (or other related condition), and has the person deemed to be eligible for that agency's services?	[ ] YES	[ ] NO
8. If an informant provided any of the above history, please list name & telephone no. _____		

I understand that this report may be relied upon in the payment of claims that will be from Federal and State Funds, and that any willful falsification, or concealment of a material fact, may be prosecuted under Federal and State Laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.

Signature _____ Title _____ Date _____ Telephone Number _____

==========

IF ONE OR MORE OF THE ABOVE QUESTIONS WERE ANSWERED "YES" DO NOT ADMIT THE PATIENT TO THE NURSING FACILITY. HOWEVER, ACCORDING TO THE DEFINITIONS STATED ON THE BACK OF THIS FORM, IF ONE OF THE FOLLOWING CONDITIONS EXISTS: (1) CONVALESCENT CARE; (2) TERMINAL ILLNESS; (3) SEVERITY OF ILLNESS, THE RESIDENT MAY BE ADMITTED. OTHERWISE, REFER THE RESIDENT TO ADULT CARE HOME PROGRAM (TELEPHONE NUMBER 913-296-3728) FOR FURTHER SCREENING AND APPROPRIATE DETERMINATION OF MEDICAL ELIGIBILITY FOR NURSING FACILITY CARE.

IF ALL QUESTIONS WERE ANSWERED "NO" AND THERE IS NO FURTHER EVIDENCE TO INDICATE THE POSSIBILITY OF MENTAL ILLNESS, MENTAL RETARDATION, OR OTHER RELATED CONDITION, THE NURSING FACILITY MUST DECIDE WHETHER OR NOT TO ADMIT THE RESIDENT. ADMISSION TO THE FACILITY DOES NOT CONSTITUTE ELIGIBILITY FOR NURSING CARE.

==========

ROUTING OF FORM

This form must be presented to authorized nursing facility personnel prior to admittance of the resident to the adult care home. Such personnel must determine whether or not admit the resident.

If the individual wishes to apply for Medicaid/MediKan, Form MS-2001 should be submitted to the Area local SRS office in the usual manner. Except for the pre-admission screening process, the procedure for approval of adult care residents remains the same. When the nursing facility submits medical information to the SRS Office, a copy of this form must be attached.

A COPY OF THIS FORM MUST BE PLACED IN EACH RESIDENT'S RECORD IN THE FACILITY.

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DEFINITIONS FOR USE IN CONJUNCTION WITH FORM MS-2123

MENTAL ILLNESS: .An individual is considered to have mental illness if he/she has a current primary or secondary diagnosis of a major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-IIIR), or ICF-9 Codes 290-314 limited to schizophrenic, paranoid, major affective, schizoaffective disorders and atypical psychosis, and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

MENTAL RETARDATION AND RELATED CONDITIONS: An individual is considered to be mentally retarded if he/she has a level of retardation (mild, moderate, severe and profound) as described in the American Association on Mental Deficiencies Manual on Classification in Mental Retardation (1983).

Mental Retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

The provisions of this section also apply to persons with "related conditions", as defined by 42 CFR 435.1009, which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to -
   (1) Cerebral palsy or epilepsy; or
   (2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons. (Any other condition includes autism.)

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following area of major life activity:
   (1) Self-care;
   (2) Understanding and use of language;
   (3) Learning;
   (4) Mobility;
   (5) Self-direction; and
   (6) Capacity for independent living.

CONVALESCENT CARE: Any person with mental illness, mental retardation, or other related condition, as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified nursing facility after release from an acute care hospital for a period not to exceed 120 days as part of a medically prescribed period of recovery.

TERMINAL ILLNESS: An individual with mental illness, mental retardation, or other related condition, as long as that person is not a danger to self and/or others, may be admitted to or reside in a Medicaid-certified nursing facility if he or she is certified by a physician to be "terminably ill," as that term is defined is Section 1861(dd)(3)(A) of the Social Security Act, and requires continuous nursing care and/or medical supervision and treatment due to his/her physical condition.

SEVERITY OF ILLNESS: Any person with mental illness, mental retardation, or other related condition, who is comatose, ventilator dependent, functions at the brain stem level, or has a diagnosis of: Chronic Obstructive Pulmonary Disease, Severe Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis, or Congestive Heart Failure, and any other diagnosis so determined by HCFA may be considered appropriate for placement, or continued residence, in a Medicaid-certified nursing facility.

ADVANCED AGE: This has to be in addition to medical needs provided in a nursing facility.

Readmissions: All Residents who have been approved for residence in nursing facilities are not subject to Level II preadmission screening if they are returning to the same nursing facility after a brief outplacement for medical services if they are not a danger to themselves or others.

KHCA

Member of ahca

Kansas Health Care Association
221 SOUTHWEST 33rd STREET
TOPEKA, KANSAS 66611-2263
(913) 267-6003 • FAX (913) 267-0833

TESTIMONY

before the

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

by

John L. Kiefhaber, Exec. Vice President

KANSAS HEALTH CARE ASSOCIATION

Substitute for House Bill No. 2566

"AN ACT ...providing information and assistance to persons in obtaining appropriate long-term care services; requiring assessment and referral services prior to admission to an adult care home..."

Chairman Ehrlich and Committee Members:

The Kansas Health Care Association, representing over 200 professional nursing facilities throughout the State, appreciates the opportunity to speak in opposition to passage of substitute House Bill 2566. This bill would set up an unnecessary and duplicative resident assessment process that would delay placement of our elderly even while it would promote education and information referral on alternative services.

I would like to bring two points to your attention today:

First, as this Committee is aware, the federal Nursing Home Reform Act of 1987, commonly called OBRA 87, was implemented in October, 1990. That act requires that all residents of nursing facilities go through a

Senate P. H&W

Attach. #6
3-23-92 PM

comprehensive physical, mental and social assessment of their needs within the first 7 to 14 days of their admission to a nursing facility. This is a copy of that comprehensive assessment, called the MDS. According to professional nurses who administer this comprehensive assessment it takes 2-6 hours to complete the survey for an individual. This work is already being done for residents of nursing facilities in Kansas. Another resident assessment form, as required by House Bill 2566, with questions that are already going to be covered by the attending physician, facility nurses and social workers in the nursing home represents an enormous amount of duplication of scarce health care resources.

Second, because the MDS survey is a changing assessment tool for monitoring every change in a patient's physical and mental status, it is designed to trigger the intervention of medical professionals to improve the independence of the resident and, in many cases, send them back to their homes. This system is already working in every facility in the State. Residents who do not need to be in a nursing facility are automatically identified by the use of the MDS.

The Kansas Health Care Association believes that the more information aged citizens can get about their care alternatives the better and we support provisions of the Senior Care Act. But to delay and inhibit their movement to the care setting that they need while waiting for a duplicative assessment form to be filled out by an already overworked state agency staff would be a disservice to the very individuals this bill was meant to help.

Thank you for the opportunity to speak in opposition to House Bill 2566.

TESTIMONY OF
JOHN C. PETERSON

MANOR HEALTH CARE

SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE
SUBSTITUTE HOUSE BILL 2566

Chairman Ehrlich, members of the Committee. My name is John Peterson and I am appearing on behalf of Manor Health Care Corporation. Manor Care owns and operates three nursing care facilities in the state of Kansas; in Topeka, Wichita and Overland Park.

House Bill 2566 was introduced in an attempt to deal with spiraling health care costs and to attempt to assure that the least restrictive environment possible is utilized to meet the needs of Kansas senior citizens.

Section 1, subsection (a), requires the Secretary of Aging to compile comprehensive resource information relating to long-term care resources. Subsection (b) requires adult care homes, hospitals, physicians, senior centers and area agencies on aging to make that resource information available to any person identified as seeking or needing long-term care. This is indeed a commendable goal and we would urge your support for these provisions.

Admittance to a nursing home is indeed one of the most difficult decisions of a lifetime for an individual and their family. No one should be admitted without having information as to all available resources. HB 2566 mandates such information be available. No one should be admitted to a nursing home without a specific physician's order. Anyone in a nursing

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facility should have an extensive evaluation in a timely manner as to the individual's capabilities and limitations. Such a detailed evaluation known as the Minimum Data Set (MDS) is currently in place, under federal law, and utilized in nursing facilities across the country.

Since 1982 Kansas has required prescreening for Medicaid recipients entering nursing facilities. Last year SRS conducted some 2,700 of those screenings.

Substitute for House Bill 2566 proposes to establish a new program to screen individuals who are not on Medicaid. It proposes not to use the family physician, not to use the already required assessment study, but to create a new bureaucracy that is going to be paid $1.468 million to conduct 12,250 screenings of non medicaid individuals each year.

But are the increased costs that we are experiencing at the state level related to increased numbers of individuals going into nursing homes? We know that in the last 10 years nursing home expenditures have increased by 126.2 percent. But in that same 10 year period, there has been a negligible increase of less than 1 percent in the number of individuals in nursing homes. Moreover, during the same period we have had a 26 percent increase in the number of our citizens that are 85 years of age and older. Not only have we had no increase in the nursing home population, we have had a clear decline in that population as a percentage of individuals over age 85.

Nevertheless, this proposal presumes that by reducing the number of individuals who can pay for their nursing home care, we will save the State money.

Yet one of the keys to any successful diversion, whether the individual has resources or not, is availability of local services. The March 1992 SRS publication "Long Term Care for the Elderly" notes that any preadmission screening must be linked to case management:

> so that the elderly person and their family can see clearly how a plan for community based services might work. However, Kansas does not have a comprehensive case management system to help elderly people put together a community care plan if they would rather stay in the community than go into a nursing home.
>
> Kansas also presently does not provide comprehensive statewide community based services. Elderly people who cannot afford services may find themselves unable to get services through either SRS or DOA because of conflicting eligibility requirements and long waiting lists. People who can afford services may find that services are not available in their area.

You cannot divert people to services that don't exist. You've got to provide for effective local services. You must get that information into the hands of individuals considering admission to a nursing facility and let they and their families make a decision as to the best, least restrictive care that they prefer.

SRS has told you that they are going to save money which, after spending the $1.65 million, will result in a net gain to the state. Let's discuss their impact analysis. First we know the operational costs of $1.65 million are hard costs. They <u>will</u> be incurred in FY 1993. The entire remainder of their

analysis is based upon diverting Medicaid eligible individuals. The fact of the matter is that SRS is already screening those Medicaid individuals. If they aren't they should be.

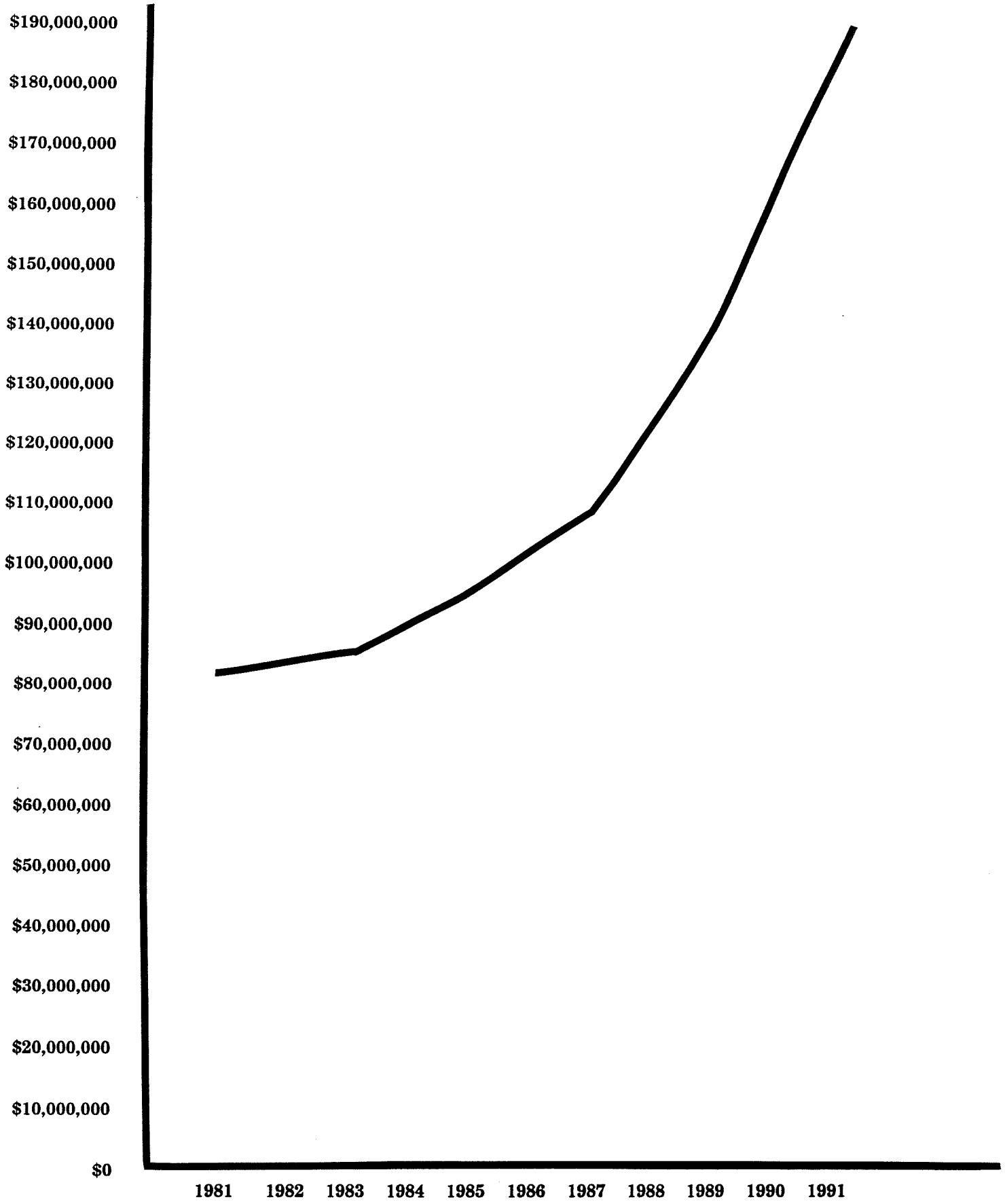
There is no fiscal analysis that shows projected savings from this program for private pay individuals. No analysis of the amount of money that private pay individuals have when they enter a nursing home. No analysis of the number of Medicaid individuals who entered as private pay and the number of months after that entry that they may became Medicaid eligible. Certainly no analysis or theory that any potential savings will be in fiscal year 1993. They are simply showing an analysis of $3.5 million of savings that they should be realizing today because of the institution of mandatory screening for Medicaid patients in 1982.

In addition to expending almost $2 million next fiscal year with no realistic projection of savings and certainly of none during the fiscal year, we believe that this proposal interferes with an individual's fundamental right, if they're using their own money, to make decisions that they deem appropriate about their life. Perhaps we should pass legislation saying that individuals over age 70 shouldn't be allowed to take a cruise or give cash Christmas gifts to grandchildren, because they might be dissipating resources.

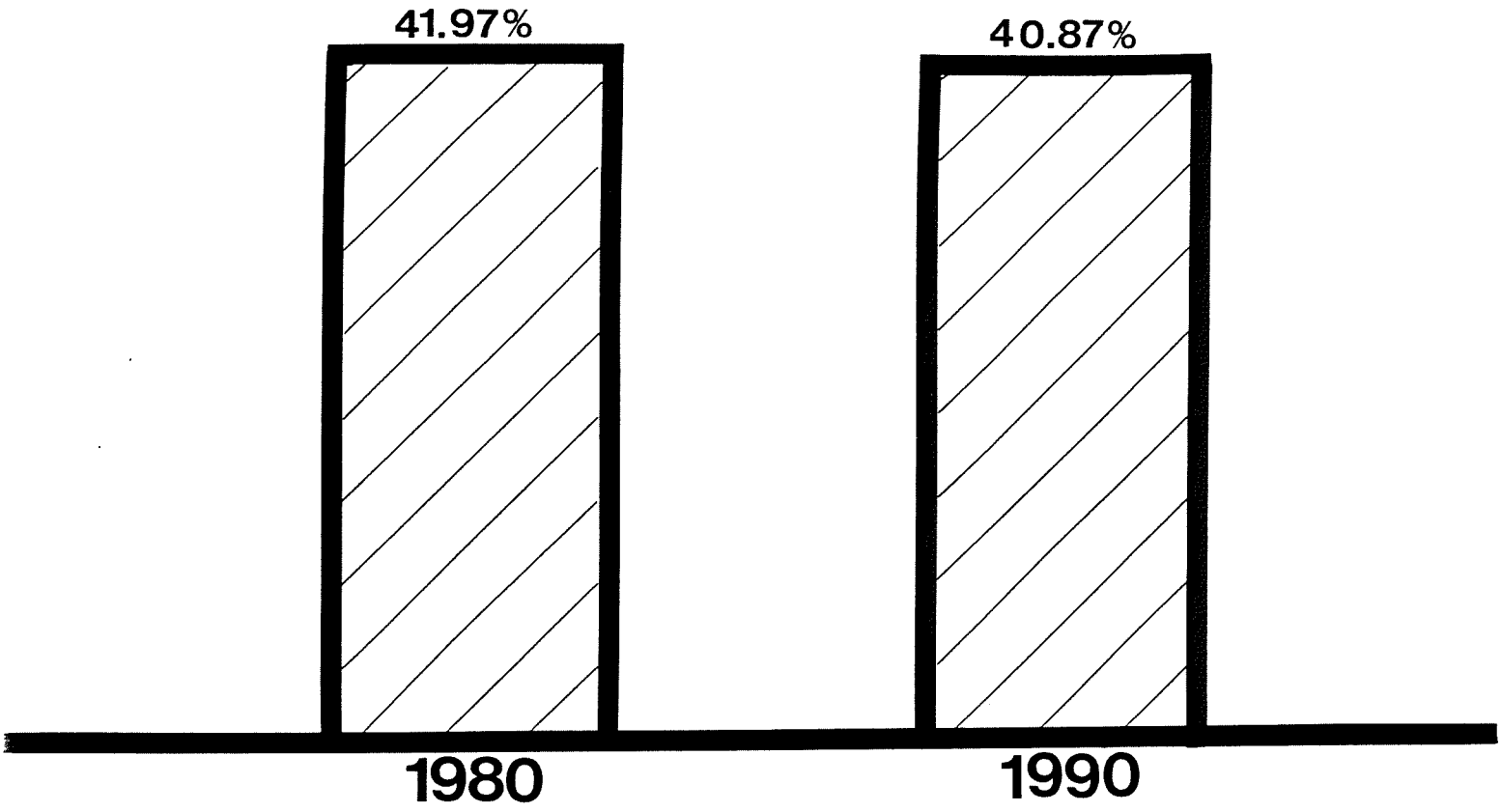
We would urge you to defeat those portions of House Bill 2566 which require assessments of those seeking admission as private pay patients. Thank you for your time and consideration.

7-4

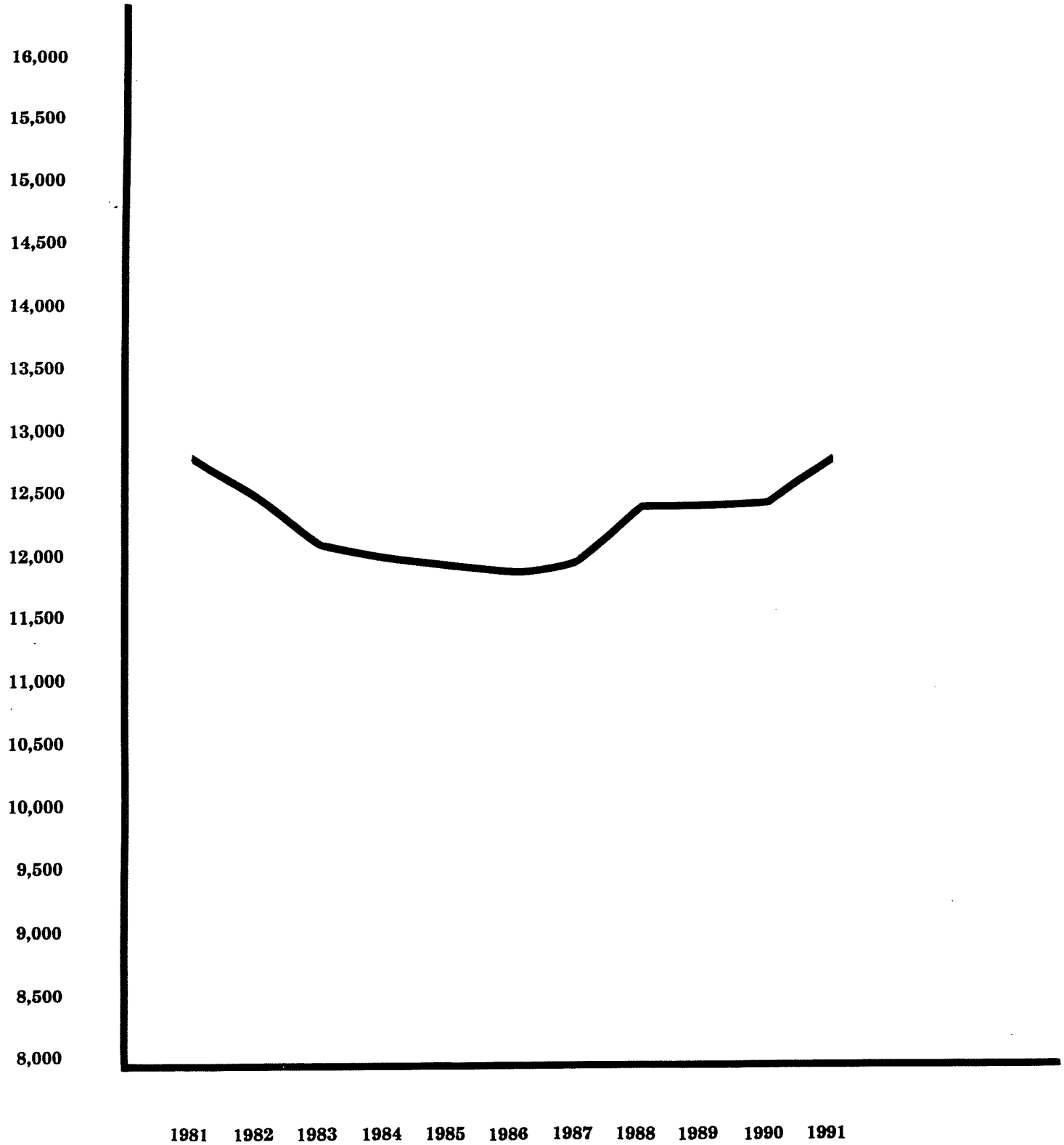
ADULT CARE HOME EXPENDITURES FY 1981 – 1991



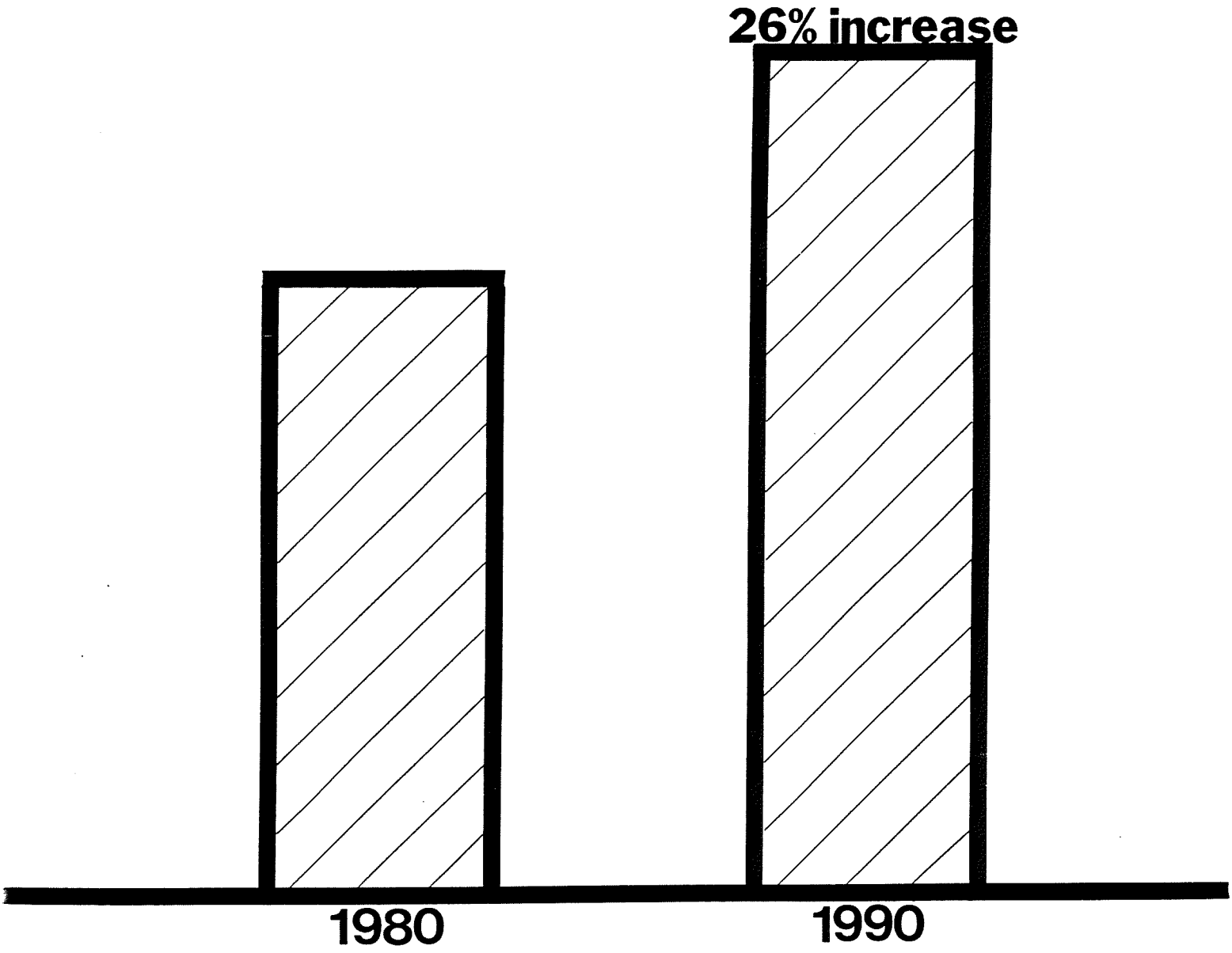
ADULT CARE HOMES
AS % OF TOTAL MEDICAID $



ADULT CARE HOME *AVERAGE # PATIENTS* FY 1981 – 1991



KANSANS OVER AGE 85



ASSOCIATION OF KANSAS HOSPICES

TO: Kansas State Senators

FROM: Association of Kansas Hospices

DATE: March 23, 1992

SUBJECT: House Bill #2566

We are asking that all Hospice Medicare Benefit certified hospices in the state of Kansas be exempt from House Bill #2566.

Please understand that Hospices serve terminally ill patients in the last six months of their lives. These patients are served by a physician, a registered nurse, and a social worker. Before any decision is made about changing a patient's care, an assessment is carefully made by the physician, nurse, and social worker. All Hospice Medicare Benefit hospice patients receive explanation of all options for continuity of care. The role of the nurse and social worker and other members of the hospice team is to help the patient understand his/her options and make the choice that best meets that patient's need. Additionally, it is always the goal of hospice to help the patient stay at home if he/she so chooses.

We are asking for this exemption only for hospices that receive the Hospice Medicare Benefit. We know that this type of assessment occurs in each of these hospices. Every Medicare Certified hospices provide counseling in the home for both the patient and the family. A total assessment of the patient's options is undertaken before any patient makes a change in his/her plan of care. Further, as long as person is a terminally ill patient of a Hospice Medicare Benefit certified hospice, he/she will also receive continuity of care between in-patient facility and home setting.

As you can see, we are asking this exemption for only the hospices that are certified to receive the Hospice Medicare Benefit. Please be aware that those persons served by these hospices are in the last six months of their lives and are terminally ill. To require them to go through an assessment, in addition to the assessment that they will go through with the hospice staff, seems burdensome to us for the patients involved. Please give this careful consideration.

dd

Senate A. H&W
Attach. #9
3-23-92 PM

940 N. Waco • P.O. Box 3395 • Wichita, Ks. 67201-3395 • 316-265-9467 • 1 800 767-4965 • FAX 265-6066

MEMO

DATE: March 23, 1992
TO: Sen. Roy Ehrlich, Chairman
Senate Health and Welfare Committee
FROM: Monica Flask, Director of Social Work
Halstead Hospital
Halstead, KS
Representing the KS Sunflower Chapter, Society for Hospital Social Work Directors
RE: HB 2566

We have unfortunately been unable to send a representative of our organization to the committee hearings today, but would like to present our written opposition to HB 2566. We have included copies of the testimony we presented to the House Health and Welfare Committee and would like to make the following additional comments.

1) We believe mandatory pre-screening would be a duplication of services for many people. Almost 60% of all nursing home admissions are initiated from the hospital where, in most instances, the patient has already been screened by a social worker or other discharge planner. In addition, Medicaid recipients being admitted from home already receive mandatory screening, so the percentage of people who would receive a non-duplicated service appears to be small.

2) It will not be cost-effective to do a comprehensive "needs assessment" of community-based services. In many instances, the needs are already known, the funding is simply not available. Even if we develop a comprehensive needs assessment as a result of the mandatory pre-screening, what good will that do if the funds are not available to implement the services indicated?

3) We believe very few people enter the nursing home because they are unaware of existing services. In most instances, they enter the nursing home because a) the family is employed outside the home or too far away to give necessary care; b) needed services are not available; or c) they don't want to be at home alone anymore.

We believe mandatory pre-screening will not be cost-effective. We would strongly recommend the money for mandatory pre-screening be used instead for expansion of preventive, community-based services, especially home health services.

Please feel free to contact me or Leslie Burkholder (Social Work Director at Abilene Memorial Hospital) at the following numbers if we can provide any further information to you:

Monica Flask: (316) 835-2651 - work
(316) 835-2580 - home
Leslie Burkholder: (913) 263-2100
(913) 263-4214

Thank you for your attention to this matter.

Senate P. H & W
attachm. # 9
3-23-92 pm

MEMO

DATE: January 24, 1992

TO: Members of the Health and Welfare Committee

FROM: Monica Flask, LMSW
Representing the Society of Hospital Social Work Directors
Kansas Sunflower Chapter

RE: HB 2566

After attending the hearing re: HB 2566 on January 23, and after further discussion with members of our organization, we wish to make you aware of some additional points to consider, which I did not include in my testimony.

1) We would like you to be aware of the potential for the pre-admission screening to be a rather degrading experience for the client. When we screen patients at the hospital, we often spend quite a bit of time with them discussing home care alternatives when possible, and encouraging them to grieve, express their anxiety, etc., regarding nursing home when placement is necessary. It is very important to us that this process be done in a way which is respectful and protects the client's dignity.

Too often, screening done with a universal assessment tool can be a degrading experience for the client. Some of the sample questions we have seen on suggested universal tools include, "Who is the president?" "What color is a banana?", "How many times did you fall last month?", etc. While at times is it useful to ask such questions, a universal tool will not give us the flexibility to not ask these questions when the questions are not helpful to the situation. We are very concerned that the mandated screening requirement will turn into such a process despite the best intentions of those who've initiated and supported the bill.

2) We are also concerned that certain assumptions be made which could be erroneous. Some points we would like you to consider:

--We do not actually know that people are admitted to nursing homes due to lack of awareness of resources. Is there any data to support this? It is easy to make such an assumption, but do we actually know?
--Screening is an expensive process with unknown costs. There is very little data to suggest that it a) saves money, b) prevents nursing home admissions, or c) will bring in additional revenue sufficient to offset the cost. Again, it is easy to make such assumptions, but there seems to be very little data, if any, to support these ideas.

This is a very difficult issue. We applaud the efforts of the committee to keep people at home as long as necessary in the most cost-effective way. We believe this is a commendable goal. We simply do not think the mandated screening process is the way to achieve this goal. There are many other options that should be considered (some of which were mentioned during my testimony), including:

1) expanded case management services
2) intensified efforts to make the public aware of services (what about working with the utility companies to publish the phone number for the Dept. of Aging on bills?)
3) "quality assurance" mechanisms or incentives to encourage discharge planners, social workers in the hospital and the community, etc. to be aware of home support services and work to prevent nursing home admissions when possible.
4) putting our money into more preventive services, especially for those who don't quite meet Medicaid criteria at home.

Thank you very much for your thoughtful consideration of this matter. Please do not hesitate to contact any of us if we may be of assistance regarding this or any healthcare issue. We have included a membership list of our organization for your convenience.

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

The above organization has reviewed HB 2566 as it now stands, and wishes to present 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, manadatory 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 maintenance home care available at an affordable cost. Patients often receive 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) Hospitals should be exempt from mandatory screening, as it duplicates services already provided.

3) 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.

4) 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.)

5) Increasing efforts to make discharge planning available to nursing home residents. While we believe most nursing home admissions are justified, many people need not stay in a nursing home permanently if services are available.

6) 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 our opportunity to express our opinion on this matter.