Approved 4-7-92
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

10:00 a.m./p.m. on March 31, 1992 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisor's Office
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Terri Roberts, Kansas State Nurses Association
Elizabeth Taylor, Kansas Federation of Licensed Practical Nurses, Inc.
Jana Floyd RN, Morton County Hospital
Linda McCulloch RN, Topeka
Vera Streit RN, Kansas Council of Practical Nurse Education
Nona Grieshaber RN, Manhattan

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

The Chairman asked for consideration of the minutes of March 23, 24, 25, 26 and 27, 1992. Senator Hayden made a motion to approve the minutes as presented, seconded by Senator Walker. No discussion followed. The motion carried.

Continuation of Hearing on HB 3071 - Grounds for disciplinary actions by board of nursing.

Terri Roberts, KSNA, submitted written testimony and stated support for many of the new elements in **HB 3071**, however, KSNA has been working with the Kansas State Board of Nursing and other nursing groups to come to a consensus on language that would provide specific direction to licensed practical nurses' responsibilities related to IV infusions. A balloon of the bill was submitted that contained two proposed amendments -- the first would delete the broad delegatory authority by physicians, and the second would delete the word "push" on page 2, line 9. (Attachment 1) Ms. Roberts stated the use of a PCA that is administered by a physician or registered nurse on a patient is still being debated as to whether or not an LPN should be allowed to use this device. LPNs and RNs would like to have some perimeters as to what the role of an LPN is in relation to administering IVs. The LPN is uncertain of that role, as there always is the threat they would exceed that scope and be disciplined. In regard to education requirements, Ms. Roberts stated the LPN does have some education in IV, but not intense IV therapy which is medication directly into the vein.

Elizabeth Taylor stated KFLPN offers its support of **HB 3071** that would allow the KSBN to assess administrative fines and KSBN to investigate and levy proceedings against nurses not in compliance with the law; however, the language in the bill, while approved by all interested parties after long, hard negotiations, is the most appropriate language to allow the LPN to function as they have been trained while still serving under the supervision of the RN. Ms. Taylor stated they do not want any further amendments to the bill. (Attachment 2)

Jana Floyd, Morton County Hospital, submitted written testimony and stated she is supportive of LPNs administering IV fluids and medications under the supervision of registered nurses and specified protocols by policy and procedure is most beneficial, but has a concern that the bill as amended by the House Committee remains too restrictive in regard with IV push medications, and

offered an amendment addressing this concern. (Attachment 3)

Linda McCulloch RN, submitted written testimony and stated she is opposed to LPNs performing any intravenous therapy at all in any setting but especially the hospital institutional setting. Ms. McCulloch stated from personal experience as an LPN she was not prepared to perform critical thinking and problem solving in this atmosphere. (Attachment 4)

Vera Streit RN, speaking on behalf of the Kansas Council of Practical Nurse Education, stated **HB 3071** as amended by the House Committee is extremely restrictive and does not offer flexibility for the efficient delivery of nursing care or the appropriate use of educated nurses. Ms. Streit expressed support for retaining the original bill. (Attachment 5)

Nona Grieshaber RN, and an active member of KSNA, submitted written testimony and expressed strong opposition to portions of **HB 3071** regarding allowance of administration of IV push medications of any category by an LPN. Ms. Grieshaber explained in detail the procedure involved in IV push medication and stressed language be added to the bill that would prohibit LPN and IV administration of any sort to pediatric age patients. (Attachment 6)

Written testimony was submitted on **HB 3071** from the following: Tom Bell, KHA; Susan Fry, Kansas Organization of Nurse Executives, with amendment; Donna J. Bauer RN, Mulvane; and Chip Wheelen, KMS, with amendment. (Attachments 7 - 9)

Written testimony was submitted on **HB 2913** from the following: Representative Barbara Allen; Representative Kent Glasscock; John E. Moore, Cessna Aircraft Company;Jerry Slaughter, KMS; and Robert L. Epps, SRS . (Attachments 10- 14)

Written testimony was submitted on **HB 3045** from the following: Donna Whiteman, SRS; Marilyn Bradt, Kansans for Improvement of Nursing Homes, Inc.; Joe Kroll, Health and Environment; Basil Covey, Kansas Retired Teachers Association; Arris Johnson, Kansas Silver Haired Legislature; Walter H. Crockett, AARP; Lyndon Drew, Department on Aging; Mary Stutterheim, Prairie Village; and Rosemary Harris, Older Citizens Information. (Attachments 15 - 23)

Pages assisting at the Committee meeting were sponsored by Senator Walker.

The meeting was adjourned at 11:00 a.m. The next meeting of the Committee is scheduled for April 1, 1992, 10:00 a.m., Room 526-S..

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 3-31-92

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
George Goebel	AARP-SLC-CCTF
Walter H. Crockett	AARP
Suzanne L. Frost	KACAD
Carolyn Middendorf	KSNA
Marilyn Bradt	KINH
Linda Byrne	KSNA
Doug Bowman	Children & Youth Advisory
Wendell STROM	AARP CCTF
Cleta Renyer	Right to Life of Ks.
Jana Floyd	DON Elkhart, Ks
Refugia Moore	KSBE
Vera Streit	KCPNE
DAN STREZT	
Linda McCulloch	
Joseph Kroll	KDHE
Kay LeMoss	JAAA
Louise KARNOWSKI	
MARY STUTTERHEIM	Independent
Richard Spencer, DDS.	Independent
Terri Roberts	KSNA

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 3-31-92

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Roger D. Korkwood	AARP	CCTF Topeka
Peter Pyle	AARP	CCTF Clf SHL
Jean Grant	SHL	
Tom Bell	KS. Hosp	Assn
Susan Ty		KONE
Jane Glynn		KSBN - Topeka
Pat McKelvy		KSBN
Pat Johnson		KSBN Topeka EV IN FLOWER - SOUTHEASTER
Richard D. Charlton Jr		PARALYZED VETERANS OF AMERICA
Nona Grieshaber: NONA GRIESHABER		Independent
Mary Kapp		KSNA
Jo Ann Thomas		KSNA
Agnes M. Johnson		KSHL
Rosemary C Harris		Older Citizens Dirs.
Lyndon Dunn		KDOA
Robert Epps		SRS
Peggy Haalter		SRS
Lisa Getz		Wichita Hospitals

KSNA

the voice of Nursing in Kansas

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 31, 1992

HB 3071 ACT CONCERNING DISCIPLINARY ACTIONS BY THE KANSAS STATE BOARD OF NURSING

Chairperson Ehrlich and members of the Senate Public Health and Welfare Committee, my name is Terri Roberts and I am the Executive Director of the Kansas State Nurses' Association.

The Kansas State Nurses' Association supports many of the new elements in House Bill 3071 including the adoption of a new category of disciplinary action **public censure** of licensees. We believe that by expanding the current options for the Board of Nursing from **revocation, limitation and suspension** that the Board of Nursing can more effectively discipline licensees that violate the Nurse Practice Act. KSNA is also supportive of the change on page 1 line 29 that speaks to the inability to practice with reasonable skill and safety. This revised language mimics the Kansas Risk Management Law and provides consistency to both the Board of Nursing and licensees related to implementing mandatory reporting.

The Kansas State Nurses' Association has been working with the Kansas State Board of Nursing and other nursing groups to come to consensus on language that would provide specific direction to licensed practical nurses responsibilities related to IV (intravenous) infusions. A task force of representatives from various nursing organizations met for two months and drafted compromise language that was forwarded to the Board of Nursing. The Board of Nursing did not accept the proposed language and recommended other language. KSNA believes it is absolutely essential that the statutory language provide LPN's and RN's with specific parameters for this area of practice. It is crucial in light of the broad delegation language that is in HB 2882 this be addressed in statute.

The Kansas State Nurses' Association supports the language in new number (7) as amended by the house with two exceptions.

Senate P. H. & W.
Attachment #1
3-31-92

Attached is a balloon that contains two proposed amendments. The first deletes the broad delegatory authority by physicians.

The language that precedes the LPN IV restrictions in the bill currently allows an exception for those LPN's who have been delegated to by physicians.

KSA 65-2872 (g) reads as follows:

> Persons whose professional services are performed under the supervision or by order of or referral from a practitioner who is licensed under this act.

The only check and balance to this broad delegatory authority by physicians was added by the legislature in 1986 during tort reform listed in KSA 65-2837 (26) under the definition of unprofessional conduct that reads:

> Delegating professional responsibilities to a person when the licensee knows or has a reason to know that such person is not qualified by training, experience or licensure to perform them.

This provision was added to establish a parameter for what may not be delegated by physicians.

Exempting physicians who delegate to LPN's is in direct conflict with purposes of the unprofessional conduct provision KSA 65-2837 (26). LPN's will be specifically prohibited from administering certain IV's. They will be disciplined for violating this provision. The exception for physician delegation to LPN's will create 2 standards.

We also are recommending the removal of the word "push" from line 9, page 2.

This will clarify that LPN's will be able to administer the following IV medications:

> Simple IV Solutions (that are generally used for hydration), D5W, Lactated Ringers, Normal Saline and various combinations of these solutions.
>
> IV Antibiotics
> IV Anti-Emetics (Nausea/Vomiting)
> and IV Diuretics (Removal of excess fluidds)

The language also permits LPN's to start IV's by inserting IV canulas into peripheral veins. First doses of any IV medication will be administered by the registered nurse.

Senate A&H
attach 1-2
3-31-92

I have attached a copy of a memo prepared by the Kansas Organization of Nurse Executives (KONE) and the Kansas Hospital Association (KHA) on January 13 to amend the Nurse Practice. The language contained in lines 8-14 on page 2 is directly from that memo and what was proposed during one of two meetings to come to consensus on this issue. Both KONE and KHA opposed this bill in its original form in the House Public Health Welfare, but did not offer amendments. KSNA offered amendments and after an intense subcommittee meeting the language on lines 8-15 (page 2) was adopted. KSNA's original position was no IV push medication administration by LPN's, however we have supported the language you have today in the **spirit of compromise.**

Licensed Practical Nurses receive no formal education in their basic programs regarding the insertion of IV's and/or the administration of IV push medications and complex IV solutions.

Attached is a letter from the Kansas Council of Practical Nurse Education which indicates their opposition to "Inclusion of IV therapy education in the basic curriculum for practical nurses."

Basic fluid administration, such as D5W and the monitoring of fluid infusion is covered in basic LPN preparatory programs. Historically, LPN's have not been responsible for the administration of IV's. We believe that the practice setting has changed and that the administration of simple IV fluids is, with additional education such as an IV course, acceptable practice for LPN's. We do not however, believe that LPN's should be responsible for the administration of complex IV solutions such as blood and blood products, investigational medications, thrombolytic (blood thinning) solutions, antineoplastic (anti-cancer) medications, oxytoxins (labor inducing drugs) and cardiogenics (heart). We further believe that the process of initiating the initial dose of any IV's medication should be the responsibility of Registered Nurses and or Physicians.

The language that we have proposed addresses these concerns and gives strict parameters that all RN's and LPN's will understand. This is very important for the more than 8,500 LPN's and more than 24,000 RN's in Kansas that these responsibilities are clearly delineated. It will assist Directors of Nursing in Hospitals, Long-Term Care and Home Health in their work and staffing concerns. The voluntary nature of this provision will also assist LPN's who choose not to seek additional education and assume responsibility for IV's. It is our sincere hope that pressures from Hospital Administration will respect the permissiveness of these provisions for LPN's not inclined to pursue the additional education and assume IV administration responsibilities.

We hope that this committee will make the two revisions proposed and pass this bill out favorably for passage.

Thank you.

and blood products, human plasma fractions, antineoplastic agents, investigational medications or intravenous medications as prohibited by rule and regulation, (b) infusing by central venous catheter or (c) initiating total parenteral nutrition; or

(7) ~~unless delegated under subsection (g) of K.S.A. 65-2872 and amendments thereto,~~ to have only a license to practice as a practical nurse and to be guilty of: (a) Administering blood and blood products, investigational medications, or the following categories of intravenous ~~push~~ medications: analgesics, anesthetics, antianxiety agents, anticonvulsants, biological response modifers, cardiovascular preparations, hemostatics, immunosuppressants, muscle relaxants, human plasma fractions, oxytocics, sedatives, tocolytics, thrombolytics and antineoplastic agents; (b) infusing by central venous catheter; (c) initiating total parenteral nutrition; or (d) administering the first dose of any intravenous medication; or

(8) to have a license to practice nursing as a registered nurse or as a practical nurse *publicly censured,* denied, revoked, limited or suspended by a licensing authority of another state, agency of the United States government, territory of the United States or country or to have other disciplinary action taken against the applicant or licensee by a licensing authority of another state, agency of the United States government, territory of the United States or country. A certified copy of the record or order of denial, suspension, limitation, revocation or other disciplinary action of the licensing authority of another state, agency of the United States government, territory of the United States or country shall constitute prima facie evidence of such a fact for purposes of this paragraph (8).

(b) *Proceedings.* Upon filing of a sworn complaint with the board charging a person with having been guilty of any of the unlawful practices specified in subsection (a), two or more members of the board shall investigate ~~such~~ *the* charges, or the board may designate and authorize an employee or employees of the board to conduct ~~such~~ *an* investigation. After investigation, the board may institute charges. ~~In the event such~~ *If an* investigation, in the opinion of the board, ~~shall reveal~~ *reveals* reasonable grounds for believing the applicant or licensee is guilty of the charges, the board shall fix a time and place for proceedings ~~thereon~~, which shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

(c) *Witnesses.* No person shall be excused from testifying in any proceedings before the board under this act or in any civil proceedings under this act before a court of competent jurisdiction on the ground that such testimony may incriminate the person testifying,

KSNA Proposed Amendments
March 31, 1992

delete language

delete "push"

Note: If the delegation language is not deleted consider the following:

unless performed under
the direct supervision
of a person licensed
to practice medicine
and surgery in this state

KANSAS COUNCIL OF PRACTICAL NURSE EDUCATION

January 14, 1992

Terri Roberts, J.D., R.N.
Kansas State Nurses' Association
700 Jackson, Suite 601
Topeka, Ks 66603

Dear Ms. Roberts:

I have been asked to express to you in writing the Kansas Council of Practical Nurse Educators' opinion on intravenous therapy for Practical Nurses. It was the concern of several practical nurse educators that the KCPNE be accurately represented in any presentation to the legislature.

At this time, the KCPNE has not issued a public statement on IV therapy for practical nurses. The council has discussed the issue at length, however, with a great degree of concensus on several points:

1. The KCPNE supports voluntary certification in IV therapy for practicing LPNs.
2. The KCPNE does not recommend, at this time, the inclusion of IV therapy education in the basic curriculum for practical nurses. The primary opposition to inclusion of IV therapy is time constraint. Within current practical nurse curriculum, there is inadequate time to teach underlying theory for IV therapy without removing other, more pertinent, content.
3. The KCPNE recommends that KSBN establish uniform criteria for IV therapy certification for LPNs to maintain quality standards of care.

Although this is not an official statement, I believe it is representative of KCPNE opinion. I hope it is helpful to you in any discussion of IV therapy for practical nurses.

Sincerely,

Jo Klaassen

Jo Klaassen, M.N., R.N.
Secretary/Treasurer, KCPNE

cc. Vera Dixon, President, KCPNE
Myrna Bartel

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

January 13, 1992

TO: KSBN Consensus Building Task Force on LPN Scope of Practice in IV Therapy

FROM: KONE
KHA

SUBJECT: **Proposed Language to Amend KSA 65-1120**

(8) To have only a license to practice as a practical nurse and to be guilty of administering: (1) blood and blood products, (2) investigational medications, (3) the following categories of intervenous push medications: analgesics, anesthetics, antianxeity agents, anticonvulsant, biological response modifiers, cardiovascular preparations, hemostatics, immunosuppressants, muscle relaxants, human plasma fractions, oxytocics, sedatives, tocolytics and thrombolytics and (4) infusion by central venous catheter.

√antineoplastic agents

(9) To have only a license to practice as a practical nurse and to be guilty of initiating total parenteral nutrition.

1-6

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

KANSAS FEDERATION OF LICENSED PRACTICAL NURSES, INC.

Affiliated with NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.

933 Kansas Avenue Topeka, KS 66612 913-354-1605

TESTIMONY PRESENTED IN SUPPORT OF HB 3070 & HB 3071
March 30, 1992

presented to the Senate Public Health & Welfare Committee
Honorable Senator Roy Ehrlich, Chairman

presented by Elizabeth E. Taylor, Legislative Consultant to KFLPN

SUPPORT FOR HB 3070 - The KFLPN offers its support of HB 3070 allowing the Kansas State Board of Nursing to assess administrative fines and allowing the KSBN to investigate and levy proceedings against nurses not in compliance with the law.

LPNs believe that where responsibility as defined by the law is not being upheld, the professional not acting responsibly should be held to that responsibility and that the regulating body should have these authorities.

HB 3071 - KFLPN sat on an 18-month long Task Force of the Kansas State Board of Nursing which concluded just weeks ago. Also on that Task Force were representatives from KSNA, Nurse Educators, Mental Health Technicians, several hospitals, the Hospital Association and others who hashed and hashed many times over the responsibilities of the LPN within the health care system. The definition you see on page 1, lines 40 through page 2, line 3 is the language WE ALL AGREED TO AFTER THOSE LONG MONTHS OF DEBATE. The KFLPN upholds its agreement then as our agreement still today.

Medical/nursing times are rapidly changing. All levels of nursing have become expected to perform and a higher and higher level. The time has come (and it did come over the last 18 months of deliberation and negotiation among all of the interested parties) that the language of the bill BEST MEETS THE NEEDS OF THE CARE PROVIDER AND THE PUBLIC AT LARGE.

The KFLPN is sorry to see that we are still, in this room, not beyond the "turf" issues of yesterday and cannot get beyond the issue of control. The LPN has always worked under the supervision of an RN, and we believe we should remain under that supervision (direct or indirect). We also believe that the LPN with appropriate training should be allowed to perform as she has been trained to perform and not be withheld from being a more necessary part of health care delivery simply because the RN wants control beyond what they have today. The RN will still be the supervisor of the LPN. The RN will still be the one to make the decision of what she delegates to the LPN. The RN will still be responsible for knowing the capacity of her LPN support team. Why then should the LPN not be allowed to perform as she has been trained under continued supervision. The language of HB 3071 allows the LPN to do just this, perform as she has been trained while still under some supervision by the RN.

We believe the language of HB 3071, while approved by all interested parties after long, hard, negotiation, is the most appropriate language to allow the LPN to function as she has been trained while still serving under the supervision of the RN. We fully support HB 3071.

Senate PHW
Attachment # 2
3-31-92

Serving Southwest Kansas with Quality Health Care

Morton County Hospital

445 Hilltop • P. O. Box 937
Elkhart, Kansas 67950 Phone (316) 697-2141

LOWELL M. HONSON
Chief Executive Officer

3-30-92

Senate Public Health and Welfare Committee
State Capitol Building
Topeka, Kansas 66612

Senators,

I am Director of Nursing at Morton County Hospital, Elkhart Kansas. Before I assumed these duties I was Supervisor of Intensive Care for 10 years. Currently I am an Advanced Cardiac Life Support Affiliate Faculty for the Kansas Affiliate of the American Heart Association. I consider it an honor to be able to testify before this committee. Health care has been an important part of my life for more than 30 years.

Morton County is the most southwestern county in our fine state, and as you can see from the star noted on the state map located in the upper left hand corner of this letterhead, Elkhart is indeed located in rural southwest Kansas. Morton County Hospital is a progressive 40 bed facility with an outstanding staff of physicians, nurses, and ancillary personnel. Our nursing staff consists of registered nurses (RN), licensed practical nurses (LPN), certified nurses aides (CNA), and ward clerks. These 40 beds include medical-surgical, intensive care, obstetrical, and a 10 bed Gero-Psychiatric unit, all of which require RN coverage. In addition to staffing these units, our operating room and emergency room departments require RN coverage. Thank goodness we have 6 excellent LPN's whose duties include administration of intravenous (IV) medications and IV fluid therapy which brings us to the subject at hand, House Bill 3071 as amended by House Committee.

I can express to you that LPN's administering IV fluids and medications under the supervision of registered nurses and specified protocols by policy and procedure is most beneficial, not only in terms of assisting the registered nurse, but also in assuring timely initiation of IV therapy and IV medications to the patient. I can assure you (from experience) that it is possible to provide approved education and orientation so that the LPN is sufficiently trained and able to utilize the knowledge, skills, and competencies required to perform such therapy.

It is my concern and the concern of our RN's, LPN's, physicians, and administration that HB 3071 as amended by House Committee remains too restrictive. Our concerns are with the following categories of IV push medications: 65-1120 (a). (7).

Senate P. H&W
attachment #3
3-31-92

(a) **analgesics** (drugs that relieve pain), **antianxiety agents** (drugs that reduce anxiety), **anticonvulsants** (drugs that control seizures), and **cardiovascular preparations** (drugs used to control heart rate and rhythm and to improve heart function and blood pressure). I don't believe I need to elaborate on the consequence to patient care if an RN was not readily available to administer any of these medications. Perhaps you should personalize the issue and ask yourself "would I want to wait for the RN who might be occupied with another patient, or would I prefer a properly trained LPN to assume this duty and administer the medication in a timely manner?";

(b) **infusing by central venous catheter**: taking everything into consideration, the difference between administration of fluids or medications by a central line and a peripheral line is about 12 to 24 inches (the distance the fluid or med administered to reach central circulation), and a matter of a few seconds (the time it would take the fluid or med administered to reach central circulation). Central lines are those introduced into the superior vena cava or right atrium of the heart by a physician. Peripheral lines are those located most generally in the veins of the upper extremities. Certainly there are precautions to be taken when administering fluids or medications through central lines but they are very similar to precautions that should be taken with peripheral lines. LPN education regarding central lines would be no more difficult than any other IV course curriculum;

(c) **initiating total parenteral nutrition (TPN)**: TPN is a specially formulated nutritional fluid administered IV through a central catheter. Again there is no reason an LPN who is properly trained should be restricted from initiating TPN fluids. It is a simple procedure with specific protocols;

(d) **administering the first dose of any intravenous medication**: the person administering the first dose of any IV medication is not going to prevent an allergic reaction or adverse effect. There are specific guidelines to follow if this occurs. RN's and LPN's are trained to recognize such reactions and to intervene immediately. It is a well known fact that patients can have a reaction or adverse effect to any medication any time, not just initially.

I would like to propose further amending this bill to read beginning on line 7 of page 2: "and to be guilty of (a) administering blood and blood products, investigational medications, or the following categories of intravenous push medications: anesthetics, biological response modifiers, hemostatics, immunosuppressants, muscle relaxants, human plasma fractions, oxytocics, sedatives, tocolytics, thrombolytics, and antineoplastic agents".

Morton County Hospital has provided extensive IV therapy, IV medication, TPN, and central line education for our RN's and LPN's through approved courses such as Intravenous Fluid Therapy and Advanced Cardiac Life Support (ACLS). As a matter of fact our ACLS instructors have affirmed/reaffirmed over 125 RN's, LPN's, physicians, and para-professionals representing some 15 towns in southwest Kansas and the Oklahoma Panhandle. This course provides instruction in treating cardiac emergencies and includes IV medications, fluids, and IV therapeutic techniques. We require our RN's and LPN's to be ACLS Providers if they work in high risk areas. I say this to illustrate that all types of education is possible even in distant rural areas of the state.

Standard of care and quality care is our goal. We are proud of what our nurses have achieved to help us in attaining this goal. It takes not only education but hard work and perseverance. It takes good Risk Management and Quality Assurance programs. It takes teamwork. House Bill 3071 does not need to be so restrictive in order to protect the public health, safety, and welfare of the citizens of Kansas.

Thank you,

Jana Floyd, RN

Jana Floyd, RN, BSN
Director of Nursing Service
Morton County Hospital
Elkhart, Kansas

March 30th, 1992

Dear Senator and Committee Members,

I am quite concerned that in today's world of high tech, health care institutions (namely hospitals), there is a push on to make education less of a priority and to make money a higher priority. With the high acuity in the hospital setting, do you really think the less educated individual will be able to respond safely and appropriately in the delivery of health care. I am speaking about bill number 3071. I totally oppose the LPN performing any Intravenous therapy at all in any setting but especially the hospital institutional setting. I was a practicing LPN for five years and I can tell you from my educational experience that I was not prepared to perform critical thinking and problem solving using the proper educational background for my rationale. Intravenous therapy is critical and not to be taken lightly. Delegating this to the LPN will vastly affect the quality of care our patient's receive. It is because of the high acuity that is present in the hospital, that we need the registered nurse to remain responsible for performing Intravenous drug therapy.

And I question whether there will be any saving passed on to the consumer of health care or will the profit go to the hospital itself.

And I also question whether there is a registered nurse shortage. It is my understanding that just recently several registered nurse graduates of a BSN program in Wichita were turned down for positions at a local Medical Center. This particular Medical Center is pushing hard for the LPN to perform Intravenous therapy and lots of other things that should not be within their scope.

I am presently a practicing Critical Care Registered Nurse in the state of Kansas and I would feel much more secure in having my family member receive Intravenous medications from a registered nurse who has the proper educational background as opposed to receiving medications from an LPN who took a quickie hospital inservice, organized for the sole purpose of legitimately allowing cheaper trained labor to perform responsibilities that should be restricted to registered professional nurses.

Thank You and Sincerely,

Linda S. McCulloch, R.N.C.C.R.N.

Linda S. McCulloch, RNCCRN

Senate P. H&W
attachment #4
3-31-92

HOUSE BILL #3071

March 30, 1992 10:00 a.m.

Vera Streit, Nursing Program Coordinator
North Central Kansas Area Vocational Technical School
Beloit-Hays-Norton
and
Cloud County Community College
Concordia, Kansas

Kansas Council of Practical Nurse Education - President

Reasons for consideration

1. Practical nurse education is well based and has been proven successful in basic nursing care.
2. LPNs are employed in various positions throughout the state.
3. Nursing knowledge and demands are rapidly changing.

Summary

1. Knowledge can be more appropriately acquired by an experienced practical nurse.
2. Safety for the citizens of Kansas needing health care could be more closely guarded.
3. Nurses could function in the capacity for which they are educated.

Senate P&HEA
attachment #5
3-31-92

Thank you for allowing me to express my concerns regarding House Bill #3071.

My name is Vera Streit. I am a registered nurse, a nurse educator for practical and associate degree programs, and a consumer of health care. Today, I am speaking on behalf of the Kansas Council of Practical Nurse Education. This group meets periodically throughout the year to guarantee continuity in the quality and requirements of the states' practical nursing programs. It is composed of the directors of those programs.

H.B. 3071, as amended by the House Committee, is extremely restrictive. It does not offer flexibility for the efficient delivery of nursing care or the appropriate use of educated nurses.

Practical nurse education is based on the fundamentals of bedside care. It is a monumental task to convert a lay person to a pivotal member of the health care team in one year. Utilizing the nursing process, individuals learn a full range of skills in assessment, planning, implementation, and evaluation. The area of expertise deals with chronic illnesses or recognized alterations in health. To demand more during the initial educational experience would dilute the program; less time would be available to become proficient in the essential basic skills. The quality of practitioners available to the citizens of Kansas would be drastically reduced.

Practical nurses are employed in various settings

throughout the state. Approximately 80% are in extended care facilities; many are in leadership capacities. Their contribution to health care in Kansas is observable and documentable.

To ensure that the PN's theoretical knowledge is allowed to expand and the individual nurse is encouraged to be accountable for career expanding decisions, certain restrictions must apply. Any such course should be available only to experienced LPNs. They would bring insights and judgments from practical experience to the course. These decision making skills are initiated in the basic curriculum but are refined in the practice setting. This program should be on a voluntary basis; an employer should not force an individual to work beyond capacity either by statement or implication.

Since nursing knowledge and demands are rapidly changing, any dictates must avoid extensive enumeration of techniques, medication, etc. (the proverbial laundry list). Such lists are self limiting; they are very rapidly outdated.

As with all matters dealing with the intimate topic of personal health care, this is a very complicated issue. We believe that health care providers and lawmakers of Kansas should reconsider the data (both facts and opinions) and arrive at a proposal that will more fully consider the welfare and safety of the public while appropriately delineating responsibilities to the various levels of nurses by retaining the original House Bill #3071.

Dear Senator Ehrlich and Members of the Senate Public Health and Welfare Committee:

My name is Nona Grieshaber. I am a registered nurse from Manhattan. I am a night hospital supervisor at one of the hospitals in Manhattan, and I also work as a Neonatal Intensive Care Nurse in Kansas City. I received my Bachelor of Science in Nursing from Fort Hays in 1971. Since 1974, I have held nursing management positions, either at the head nurse/ unit manager level, or as hospital supervisor. I am retired from the US Army Nurse Corps.

As an active member of the Kansas State Nurses' Association, I am appearing today to express strong opposition to a portion of the language contained in House Bill 3071. The language that causes great concern is the allowance of administration of IV PUSH medications of any category by a licensed practical nurse. While I can acknowledge the position of KSNA on the language as it now stands, I understand that this represents compromise language reached during good faith negotiations. I have repetitively asked licensed and registered nurses in Manhattan and Kansas City over the past four weeks how they feel about the language as it now stands. I have received unanimous expressions of concern, and I am appearing today to express those concerns to the committee for their consideration.

For purposes of clarity, I would like to briefly define for the committee the methods of IV medication administration. Upon the physician's order, an intravenous catheter is placed, and the prescribed solution is attached to the catheter. The basic solution may have medications added to it, as warranted by the patient's clinical picture. The solution is infused at the rate ordered by the physician. When other medications are needed, the physician may elect to order those medications to be administered by IV route. Current practice utilizes the IV route of administration frequently. Research has proven that medications administered by the IV route enter the blood stream more quickly, are maintained at a more therapeutic level, and can more effectively be utilized in the body. The IV route of administration is also far less painful to the patient than a medication that requires repetitive intramuscular injection. In the event that a patient does not need the therapy of additional fluids, the physician may order intermittent needle therapy. The IV catheter is placed in the vein, and then it is capped. The patency of the INT or HEP LOCK is maintained by periodic flushing of the catheter with small amounts of saline or a very weak heparin solution.

IV medications may then be administered either by PIGGYBACK or by PUSH. A piggyback administration is the medication diluted in 50 to 100 cc of solution, attached to the IV line or INT, and allowed to infuse over 30 to 60 minutes. This solution is prepared by the pharmacist prior to infusion. The administration of an IV PUSH

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medication involves withdrawing a medication from a vial, attaching the syringe to the IV tubing or the INT, and pushing the medication into the patient's vein over the course of a matter of minutes. The IV PUSH medication is not prepared by the pharmacist. It is directly drawn from the vial by the person administering the medication.

In my discussions over the past several weeks with nurses regarding LPNs administering IV PUSH medications, I heard unanimous disagreement with this practice. The concerns expressed were as follows:

1) An IV PUSH medication is irretrievable. The medication is instilled over a very short period of time. The effect in the body occurs within seconds. The solution is in a much more concentrated form than a piggyback delivery system. A patient's adverse reaction to the medication would most likely occur after the delivery of the full contents of the syringe. With a piggyback administration, the solution is more dilute, it is administered over a period of 30 to 60 minutes, and a patient's adverse reaction would most likely be manifested before the entire dosage was administered. The infusion of a piggyback medication could easily be terminated if adverse symptoms occur.

2) Given the irretrievability of a medication when administered by IV PUSH route, one would question the advisability of any IV PUSH medications when one considers patient safety. The practice of IV PUSH medications occurs precisely for the immediacy of the effect. Therein lies the other concern expressed to me by nurses I interviewed. Across the board, no nurse could conceive of any situation in which an IV PUSH medication was ordered that was not one of a critical nature for the patient's welfare. Patients who are in such unstable, critical status that an IV PUSH medication must be administered must have a professional registered nurse at the bedside. The patient's status must be assessed prior to administration of the IV PUSH medication, it requires assessment during the administration of the medication, and it mandates registered nurse assessment following administration to determine the efficacy of the therapy. These assessments that are necessary for optimal patient therapy are profoundly beyond the scope of the technical training and practice of the practical nurse.

3) In addition to the two preceeding statements, I have concerns that the language of the proposed changes does not give any consideration to the age of the patient receiving IV solution or medications administered by an LPN. In the course of my interviews, I contacted the Chief, Nursing Education and Training at Irwin Army Community Hospital, Ft. Riley. Due to the mission of the Army Medical Department of caring for the casualties of war, the Army trains its medical paraprofessionals to a higher level than civilian programs. While their scope of practice in the times of combat is much broader than civilian medical personnel, in noncombat situations, their scope of practice is more aligned with their civilian counterparts. The scope of practice for LPNs and IV administration at Ft. Riley DOES NOT include the administration of ANY IV PUSH medications. An additional limitation to their scope of practice is that no LPN may administer any IV therapy (solution or medication) to a patient under 12 years of age.

In conclusion, I would like to reiterate my opposition to the changes to the practice act that would allow LPNs to admininster any IV PUSH medications. The three classes of medications that the current language DOES NOT prohibit are the IV PUSH administration of antibiotics, diuretics, and antiemetics. In addition, I would encourage the committee to consider addition of language to prohibit LPN and IV administration of any sort to pediatric age patients.

I would like to thank Senator Ehrlich and the Members of the Senate Public Health and Welfare Committee for this opportunity to speak to this issue.

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 26, 1992

TO: Senate Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: **HB 3071**

The Kansas Hospital Association appreciates the opportunity to provide comments regarding House Bill 3071. This bill would provide significant limitations upon the practice of LPNs in Kansas.

Anytime limitations on a particular health care provider's scope of practice are proposed, the Legislature is placed in a difficult situation. On the one hand, state laws must strive to assure the highest possible level of quality in the delivery of health care services. On the other hand, as personnel shortages grow more acute, any state laws must also recognize that a certain amount of flexibility is needed to ensure that health care services are available. HB 3071 does not strike this balance.

We are opposed to the current provisions of HB 3071 for the following reasons:

(1) The total prohibition on LPNs giving the first dose of any IV medication is in our opinion unreasonable. There are, in fact, some situations where this should be allowed;

(2) When combined with the first dose prohibition, the laundry list of prohibited acts also creates unnecessary problems. We are not opposed to such a listing, but we now feel it should be done at the regulatory level so that such a list can be more easily kept current;

Senate P. H&W
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(3) When the bill is considered in light of the additional amendments proposed by the Kansas State Nurses' Association, it would substantially limit the effectiveness of LPNs in the State of Kansas.

Regardless of what happens with HB 3071, hospitals will continue to be liable for acts that occur within their facilities. Physicians will also be responsible for actions taken by persons to whom they have delegated authority. Instead of concentrating on limiting what LPNs can do, we think it would be more productive to recognize that LPNs can and should play a major role in the delivery of health care services. Passage of HB 3071 in its current form will not help this recognition.

Thank you for your consideration of our comments.

TLB / pc

Senate Pub. Health
attach. 7-2

Testimony
to the
Senate Health & Welfare Committee
from the
Kansas Organization of Nurse Executives
March 30, 1992

Chairperson Ehrlich and Members of the Committee:

My name is Susan Fry and I am Chief Nurse Executive at the University of Kansas Hospital. I am here today representing the Kansas Organization of Nurse Executives (KONE). KONE represents over 200 Nurse Executives and Nurse Managers from all areas of the state.

I appreciate the opportunity to provide comment on House Bill 3071. We are opposed to House Bill 3071 as currently proposed and request that you reconsider two provisions of the Bill.

We request that the "laundry list", Sec. 1 KSA 1991 Supp. 65-1120 (7)(a) be removed from the Bill and instead authorize the Kansas State Board of Nursing to adopt rules and regulations to deal with those drugs that LPNs may not administer. The healthcare field, especially the drug field, is changing so rapidly that there is the potential need for the Bill to be amended each year either by adding or deleting categories of intravenous push medications. There could be advances in current categories that make the drugs

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safer for LPNs to administer or, more importantly, there will probably be the development of new categories that would be inappropriate for LPNs to administer, but because they would not be on the list, they could administer the drugs.

The best approach would be to not have any categories of drugs prohibited by either regulation or statute, but rather based on professional standards. If some regulation is felt to be needed, then rules and regulations that can be adjusted by professionals with medication knowledge would provide the best compromise.

The second provision that we request you reconsider is (d) of KSA 1991 Supp. 65-1120 (7), "administering the first dose of any IV medication."

One of the major differences between LPNs and RNs is the RNs ability by education, training, and licensure to assess a patient's response to medications and initiate treatment if that reaction is not desired. Some medications have very delayed response times and it makes no difference who gives the medication, but rather who assesses the patient when the drug begins to work. By prohibiting LPNs from giving any IV push medication, additional work will be added to the RN.

At the University of Kansas Hospital, some of our LPNs currently administer drugs from almost every category on this list.

8-2

We have no data to suggest that patients have any different outcomes if IV medications are administered by LPNs or RNs.

This Bill as proposed would add considerable workload to our current RN staff. The more RN time that is needed to care for patients, the more increased healthcare costs there will be to all users. During these times of limited resources, it is critical that all care givers be appropriately utilized to maximize our healthcare dollars. We do not feel House Bill 3071 in its current form meets the needs of the patients or nurses of Kansas.

Thank you for your consideration of our comments.

8-3

March 27, 1992

Senator Roy Ehrlich
Chairman, Senate Public Health and Welfare Comittee
State Capitol Room 138 North
Topeka, Ks. 66612

Dear Senator Ehrlich,

I regret that I will be unable to attend the hearing on H.B. 3071 by the Senate Public Health and Welfare Committee on Monday, March 30. I am compelled to write you to express my concerns regarding an amendment to section 7, which addresses the administration of IV medications by licensed practical nurses.

Following is my understanding of the background of this amendment. Due to a lack of educational preparation, LPNs have historically not been allowed to administer IV medications. Unfortunately, as this had never been challenged, there has been no language placed in the nurse practice act prohibiting this administration. Recently, in response to the nursing shortage and as a cost cutting measure, hospitals have begun to allow LPNs to administer IV medications upon completion of an IV course.

In response, the Kansas State Board of Nursing has had to consider what implications this would have for public safety. Due to intense pressure from the Kansas Hospital Association and the resulting belief that an amendment prohibiting all IV administration by LPNs would not be passed by the legislature, the KSBN decided to compromise by allowing LPNs to administer **selected** IV medications only. Therefore, the admendment specifying IV medications that could **not** be administered by LPNs was introduced. The KHA does not support this amendment, and I fear that their intent is to suppress this amendment or reintroduce the amendment in the 1993 legislative session with fewer or no restrictions. Meanwhile, hospitals would continue to allow unrestricted IV medication administration by LPNs for at least another year.

As an RN and nursing educator, I am very alarmed by these developments. I strongly believe that the administration of IV medications by LPNs will jeopardize the public safety.

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I currently teach in a Bachelor of Science in Nursing (BSN) program, and taught previously in an Associate Degree (AD) nursing program. The AD program I taught in allowed LPNs to enter in the second year of the program, and write the RN licensure exam upon completion of the associate degree in nursing. I and my colleagues on the nursing faculty noted that the students who were LPNs were very different in their approach to nursing care.

It became obvious that the LPNs had been taught in a very task oriented manner. Although they knew the correct procedure for a nursing skill, they often did not understand the scientific rationale for performing a skill in a particular manner, and therefore were unable to adapt to situations in which the unexpected occurred.

Due to the immediate, systemic effect of IV drugs, the nurse administering these medications must assess the patient's condition prior to giving the drug and make a decision, based on knowledge of the patient's condition and an understanding of the drug's expected action, regarding the appropriateness of the drug, the dose, and the route (IV) for that particular patient. After administering the drug, the nurse must assess the patient's response to the drug and be able to take immediate action when unexpected and undesirable side effects occur.

This decision-making process requires extensive knowledge of pathophysiology and pharmacology, as well as critical thinking skills, which are not in the educational base of LPNs. This decision-making process becomes even more critical as patients in hospitals experience increasingly complex health problems, and newly developed IV medications are frequently introduced into the health care system. A brief course in IV therapy cannot adequately bridge these gaps in the LPN knowledge base.

The Kansas Hospital Association has defended the administration of IV medications by LPNs as "just a task". I believe that this is the root of the problem - that LPNs **would,** in fact, approach IV medication administration as a task, i.e., performing the procedure without fully understanding the implications of the action, and that this would represent a grave danger to the public.

Even if it were agreed that some IV medications could be given safely by LPNs, I believe that the proposed amendment to section 7 will result in a great deal of confusion among members of the health care team as to which IV medications can and cannot be given by LPNs per statute. An "all or nothing" approach would be much more manageable.

Another consequence of this amendment which would negatively impact health care in Kansas is that hospitals may decide to replace RN positions with LPNs whenever possible for solely economic reasons. The nursing shortage can no longer be cited for this, as there has been a marked alleviation of the shortage, with more licensed RNs in the state than ever before in our history. Although economic reform of our health care system is essential, I believe that cost cutting efforts that endanger the health care consumer are not justifiable.

For these reasons, I would urge you to consider amending section 7 to read: (7) to have only a license to practice as a practical nurse and to be guilty of administering **any** medication, blood or blood product, or total parenteral nutrition intravenously. I sincerely believe that any other action will jeopardize the health of Kansans, and is therefore unacceptable.

Historically, legislators for the State of Kansas have ensured that health care providers have adequate basic education to be safe in their area of practice. I believe the adoption of the amendment proposed in this letter will ensure the continuation of this policy.

Thank-you for your interest in ensuring quality health care in Kansas.

Sincerely,

Donna J. Bauer, M.N., R.N.
1530 Rockwood Blvd.
Mulvane, Kansas 67110

cc: Senate Public Health and Welfare Committee Members:
Paul Bud Burke
Leroy Hayden
B.D. Kanan
Audrey Langworthy
Edward F. Reilly, Jr.
Alicia Salisbury
John Strick
Ben Vidricksen
Doug Walker
Jim Ward

3/30/92

and blood products, human plasma fractions, antineoplastic agents, investigational medications or intravenous medications as prohibited by rule and regulation, (b) infusing by central venous catheter or (c) initiating total parenteral nutrition; or

(7) unless ~~delegated under subsection (g) of K.S.A. 65-2872 and amendments thereto~~, to have only a license to practice as a practical nurse and to be guilty of: (a) Administering blood and blood products, investigational medications, or the following categories of intravenous push medications: analgesics, anesthetics, antianxiety agents, anticonvulsants, biological response modifers, cardiovascular preparations, hemostatics, immunosuppressants, muscle relaxants, human plasma fractions, oxytocics, sedatives, tocolytics, thrombolytics and antineoplastic agents; (b) infusing by central venous catheter; (c) initiating total parenteral nutrition; or (d) administering the first dose of any intravenous medication; or

(8) to have a license to practice nursing as a registered nurse or as a practical nurse *publicly censured,* denied, revoked, limited or suspended by a licensing authority of another state, agency of the United States government, territory of the United States or country or to have other disciplinary action taken against the applicant or licensee by a licensing authority of another state, agency of the United States government, territory of the United States or country. A certified copy of the record or order of denial, suspension, limitation, revocation or other disciplinary action of the licensing authority of another state, agency of the United States government, territory of the United States or country shall constitute prima facie evidence of such a fact for purposes of this paragraph (8).

(b) *Proceedings.* Upon filing of a sworn complaint with the board charging a person with having been guilty of any of the unlawful practices specified in subsection (a), two or more members of the board shall investigate ~~such~~ *the* charges, or the board may designate and authorize an employee or employees of the board to conduct ~~such~~ *an* investigation. After investigation, the board may institute charges. ~~In the event such~~ *If an* investigation, in the opinion of the board, ~~shall reveal~~ *reveals* reasonable grounds for believing the applicant or licensee is guilty of the charges, the board shall fix a time and place for proceedings ~~thereon~~, which shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

(c) *Witnesses.* No person shall be excused from testifying in any proceedings before the board under this act or in any civil proceedings under this act before a court of competent jurisdiction on the ground that such testimony may incriminate the person testifying,

performed under the supervision or direction of a person licensed to practice medicine and surgery in this state

KMS

KANSAS MEDICAL SOCIETY

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Chip Wheelen
Director of Public Affairs

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HOUSE OF
REPRESENTATIVES

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JUDICIARY
PENSIONS, INVESTMENTS AND BENEFITS
RULES AND JOURNAL

March 31, 1992

Mr. Chairman, members of the Committee:

Thanks for the opportunity to appear before you today. I'm here as a proponent of **H.B. 2913,** the Kansas Healthy Kids Program Act, which provides the structure for the creation of a school enrollment-based health insurance program for children in Kansas. The concept behind a school enrollment-based health insurance program such as Healthy Kids is to provide health insurance benefits to uninsured children, based on family income.

The bill is modeled after a "Healthy Kids" law passed by the state of Florida in 1990. Florida's program has been slow in implementation, but school children in that state started receiving health care services on March 1 of this year.

The bill would create a quasi-governmental corporation called the Kansas Healthy Kids Corporation, which is directed to develop a health insurance program, based on ability to pay, for all Kansas school aged children (K-12), and their pre school-aged siblings, who are not otherwise covered by public or private insurance programs. The corporation is required to have the benefits package and the location of three pilot school districts established by July 1, 1993; and have children signed up and be providing services in at least three pilot school districts by July 1, 1994. The benefit package must include preventive and primary care services and basic dental care.

The corporation would be governed by a 17 member Board of Directors, which is directed to establish benefits, establish eligibility criteria, publicize the program, accept monies, develop funding sources, and contract for administration of the program. The Healthy Kids Trust Fund could accept both public and private contributions. The corporation is directed to coordinate the Kansas Healthy Kids Program with other public and private initiatives, and to report on its activities to the Governor and to the Legislature by February 1 of each year.

Details of the program, such as the insurance benefits package and the program eligibility requirements, will be determined by the Board of Directors. However, it is my hope that the Board will enact

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guidelines which will provide that children from families who do not qualify for Medicaid, but who do qualify for the National school lunch program, would be eligible for this health insurance plan at free or reduced rates. This would cover all children from families between 0-185% of the Federal Poverty Level (FPL.)

Children from families who fall above the income cutoff level for eligibility in the school lunch program (186% FPL and up) could still participate in the plan by purchasing the coverage at a full premium. Premiums would be set on a sliding scale, with family income determined by that which is reported to the school for participation in the National school lunch program.

Children should have to be actively attending school, ineligible for public programs, and be uninsured for 6 months, in order to qualify.

I think everyone interested in this subject would agree that a need exists for some type of statewide initiative regarding health care for children - that is to say, that there is a significant population of children in Kansas who do not have health insurance, who are not eligible for existing programs, and who are not receiving proper medical care. The goal is obvious - but the question still remains as to what the best method is for ensuring that every child in Kansas has access to health care services?

I believe the structure contained in **HB 2913** is the right first step toward meeting our goal. The bill creates an <u>independent</u> entity, as opposed to a government program, which has broad flexibility in creating the Healthy Kids Program, through a public-private partnership. The private sector will have strong and significant input into this program, both through board membership and through funding sources. By creating this umbrella structure, the Healthy Kids Board can work with other public and private initiatives already in place, to develop the most cost-effective and efficient program for providing health care services to needy, uninsured children in Kansas.

I would like to direct your attention to a letter attached to my testimony from Thomas L. Miller, President and CEO of Blue Cross and Blue Shield of Kansas. He states that BCBSK wholeheartedly supports the passage of the Healthy Kids Act, and that he believes the Caring Program can serve as an important stepping stone to the development of the Healthy Kids Program.

10-2

For those of you who are not familiar with the Caring Program, it is a joint venture between BCBSK, the Kansas Medical Society, and the Kansas Hospital Association, which places free health care insurance into the hands of uninsured children living in low-income households. It currently covers 600 children, and serves only the "poorest of the poor" - those children from families under 100% of the FPL. The cost of the program is minimized through health care provider donations (50% of normal fees), and through limited benefits. The Caring Program is in 5 counties - Shawnee, Ellis, Crawford, Saline and Sedgwick, and is funded only with private sector donations.

Should **HB 2913** be enacted into law, the Kansas Healthy Kids Corporation would work with the Caring Program, using research, information, and networks the Caring Program has already developed, to create the best program for ensuring that all children in Kansas have access to health care services.

Statistics show that children are 37% more likely to be uninsured than adults. Estimates are that 13.7% of the children in Kansas are not covered by public or private health insurance. This means that between 60,000 - 90,000 children in Kansas could be eligible for this program.

Early childhood preventive care will allow us to reduce the costs of health care later in life. Obviously, it is more cost effective to provide children's health care early, so that small health problems don't become larger and more costly later in life.

In addition, this proposal is good for the family. Healthier kids make better students who are more likely to stay in school, and to perform at their best. The bill is an incentive for parents to keep their children in school, because participants must stay in school to be eligible for the program.

Mr. Chairman, **HB 2913** is a positive first step toward a statewide public-private partnership to provide health insurance for uninsured children in Kansas. I urge the committee's favorable support, and will be happy to stand for questions.

Blue Cross
Blue Shield
of Kansas

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Carry the Caring Card®

Thomas L. Miller
President and
Chief Executive Officer

March 27, 1992

Representative Barbara Allen
Capitol Building
Topeka, Kansas 66612

Dear Representative Allen:

I want to thank you for your time and effort on the Healthy Kids Act and your work with representatives of our company on the subject. Please be assured that we wholeheartedly support the passage of the Healthy Kids Act.

Please also be assured that such passage, in no way, has an adverse impact on our operation of the Caring Program for Children; and in fact, we believe the Caring Program for Children can serve as an important stepping stone as the Healthy Kids Program is developed.

Sincerely,

Thomas L. Miller
President and CEO

TLM:mm

10-4

STATE OF KANSAS

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: TAXATION
ENERGY & NATURAL RESOURCES
RULES & REGULATIONS

March 31, 1992

PUBLIC HEALTH & WELFARE COMMITTEE HB 2913

Mister Chairman and Members of the Committee:

I am delighted to stand as a cosponsor today in strong support of the Kansas Healthy Kids Act.

In my estimation, the health care crisis in this country and in this state should be met by the kind of targeted programming which this bill seeks to create. By targeting the most vulnerable segment of the Kansas population - our children - we are taking aggressive, positive, common sense action in the health care arena. At the same time, we are making a fiscally sound and socially sensitive investment in our state's future.

By asking the Kansas Healthy Kids Corporation to create a comprehensive health insurance product and supporting preventive care program for school children, we are recognizing that healthier Kansas kids ultimately will give us a financially and socially healthier state of Kansas.

By estbalishing a structure designed to receive corporate and private foundation funds as well as federal and state grants, this act presupposes that uninsured children are <u>everyone's</u> responsibility - not just government's - and that the burden of meeting that responsibility must be shared by the private sector as well as the public.

By targeting the children of moderately low income families - in fact, the working poor - we are recognizing that the chances of being uninsured in America is nearly 40% higher for a child than for an adult. It is not the child's fault that his family can't provide for his health needs, yet it is the child who will suffer - some for the rest of their lives.

Finally, by focusing on prevention and early treatment this act makes long term fiscal good sense. Preventive care for children saves significant dollars in emergency rooms never used, in serious illnesses having been averted, and in a child coming to school healthy and ready to learn.

Senate PH&W
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The time is right, with the new emphasis on chldren led by Speaker Barkis, to translate talk into action. I feel comfortable in supporting Representative Allen as a cosponsor of this bill, because I believe in being socially responsible and in having a common sense vision of the future with a common sense plan to get there.

This bill makes long term fiscal good sense while at the same time being socially sensitive to children whose health is being neglected. It's the right vision and it's the right plan and I urge your favorable consideration.

TESTIMONY OF JOHN E. MOORE

BEFORE

THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

REGARDING

HOUSE BILL NO. 2913

MARCH 30, 1992

Senate P. H & W
Attachment #1.2
3-31-92

CHAIRPERSON EHRLICH AND OTHER MEMBERS OF THE COMMITTEE, I AM JOHN E. MOORE, SENIOR VICE PRESIDENT OF THE CESSNA AIRCRAFT COMPANY. BY WAY OF FURTHER INTRODUCTION, I HAD THE PLEASURE OF SERVING AS ONE OF FIVE BUSINESS ADVISORS TO THE 1991 SPECIAL COMMITTEE ON CHILDREN'S INITIATIVES. I AM ALSO FINANCIAL VICE PRESIDENT OF THE KANSAS CHAMBER OF COMMERCE AND INDUSTRY AND CO-CHAIRMAN OF ITS CHILDREN'S COMMITTEE.

I SUPPORT THIS PROPOSED LEGISLATION FOR THREE MAIN REASONS. THE FIRST IS THAT THE OBJECTIVE OF THE BILL -- TO PROVIDE COMPREHENSIVE HEALTH COVERAGE TO SCHOOL AGE CHILDREN NOT OTHERWISE COVERED BY PUBLIC OR PRIVATE INSURANCE -- IS SO SOUND IT CANNOT BE QUESTIONED. THE INABILITY OF CHILDREN TO HAVE ACCESS TO THIS MOST BASIC NECESSITY HAS CONSISTENTLY BEEN SHOWN TO SO DISADVANTAGE THEM, OFTEN AT A VERY EARLY AGE, THAT THEIR CHANCES OF EVENTUALLY PARTICIPATING IN THE ECONOMIC MAINSTREAM ARE SIGNIFICANTLY DIMINISHED. THE APPROACH OF EARLY INTERVENTION AND PREVENTION CONTAINED IN THIS BILL IS ALSO RECOGNIZED TO BE THE MOST EFFECTIVE AND COST EFFECTIVE METHOD. INDEED, THIS APPROACH IS AS SOUND AND APPROPRIATE AS THE BILL'S OBJECTIVE.

SECONDLY, I BELIEVE THE BODY POLITIC CALLED FOR IN THE BILL IS A PROPER VEHICLE TO ASSURE THAT FOCUS REMAINS ON THIS ISSUE. THE PUBLIC/PRIVATE PARTNERSHIP CALLED FOR BY VIRTUE OF THE COMMITTEE'S COMPOSITION APPEARS TO ME TO BE AN EXCELLENT WAY TO APPROACH THIS IMPORTANT CHILDREN'S ISSUE. I STRONGLY SUSPECT BUSINESSES WILL SUPPORT THIS EFFORT BECAUSE THERE IS AN AWARENESS IN THE KANSAS BUSINESS COMMUNITY TODAY THAT

12-2

THE WELL BEING OF THE STATE'S CHILDREN IS A BUSINESS ISSUE. IN FACT, I AM CONFIDENT THAT IF IT IS ASKED TO PARTICIPATE IN THE MANNER DISCUSSED HERE, THE BUSINESS COMMUNITY WILL RESPOND AS IT HAS BEEN DOING TO CHILDREN'S ISSUES FOR SOME TIME NOW.

FINALLY, HOUSE BILL NO. 2913 SHOULD BE SUPPORTED BECAUSE OF ITS PRUDENT USE OF PILOT PROJECTS TO BEGIN IMPLEMENTATION. THERE ARE A NUMBER OF PILOT PROJECTS THAT HAVE ALREADY BEEN CREATED TO ADDRESS CHILDREN'S ISSUES AND THOSE WITH WHICH I AM FAMILIAR ARE PROCEEDING AS PLANNED. WHILE THIS APPROACH APPEARS TO DELAY FULL AND AGGRESSIVE ATTENTION TO THESE ISSUES, BUT IT WILL INEVITABLY INCREASE THE EFFECTIVENESS OF EFFORTS WHICH OCCUR AT LATER DATES ON A STATE-WIDE BASIS. BY PROVING A PARTICULAR APPROACH CAN BE SUCCESSFUL AND THEN EXPANDING IT, YOU WILL BE ABLE TO UTILIZE LIMITED RESOURCES IN WAY WHICH MAXIMIZE THEIR EFFECTIVENESS.

FOR THESE REASONS, I WOULD ASK YOUR SUPPORT OF HOUSE BILL NO. 2913.

THANK YOU FOR RECEIVING THIS TESTIMONY.

KANSAS MEDICAL SOCIETY
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WATS 800-332-0156 FAX 913-235-5114

March 31, 1992

TO: Senate Public Health and Welfare Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: HB 2913; Concerning the Kansas Healthy Kids Program Act

The Kansas Medical Society appreciates the opportunity to support HB 2913, the Kansas Healthy Kids Program Act. This bill would establish a program under which many children in Kansas would have access to health insurance benefits, based on their ability to pay.

As the larger question of overall reform of the health care system continues, this program provides a positive step forward. Not only is there a great need to assure that all children have access to health insurance, but this program could serve as an important model upon which larger reforms in the health care system could be built. Additionally, making sure that Kansas children have access to health insurance will likely produce healthier citizens and improve their performance in school.

We commend the sponsors of the bill and are pleased to offer our support.

JS:ns

Senate P. H&W
Attachment #13
3-31-92

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

Senate Committee on Public Health and Welfare
Testimony on House Bill 2913

March 31, 1992

Mr. Chairman, Members of the Committee, thank you for this opportunity to comment on House Bill 2913. This bill would create a quasi-governmental corporation to plan and implement a school-centered health care plan for most children and their non-school siblings younger than 18 years of age living in three pilot school districts. It is intended to fill the gaps in both major medical and preventive health care coverage for children whose families presently can't afford health insurance. It would be a secondary payer to public programs, such as Medicaid. The Department of Social and Rehabilitation Services (SRS) endorses the concept of providing access to primary and preventive health services to children and supports HB 2913. The agency would like to offer a number of observations and suggestions.

SRS recommends that the program envisioned in this bill be placed within an existing state agency rather than establishing a separate public corporation to administer a health insurance fund for children. The duplication of staff and financial resources can be minimized by attaching the program to an existing state agency.

The second area of SRS concern is with the exclusion from coverage under Kansas healthy kids program, services covered by Medicaid. Federal law prohibits federal cost-sharing on any Medicaid service when Medicaid is primary payer to any other payment resource.

Determining the actual health coverage to be provided and the population to be covered is one of the main tasks of the Board created by this bill. Also, the method of financing the benefits is to be developed by the Board. Consequently, it is not possible to assess the fiscal impact of the services ultimately provided.

Finally, this bill does not address those children under school age who have no school age siblings. Health care coverage is most crucial to young children in this preschool age group. It is this population for which preventive health care has the greatest impact - in terms of both better health and future cost avoidance.

Thank you for the opportunity to comment on this bill.

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

Senate P. H&W
Attachment #14
3-31-92

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

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

March 30, 1992

While we supported the original draft of this bill and its stated purpose of establishing a category for one-to-five bed adult care homes, we feel the amendments have since strayed from the intent of the original bill and would create problems for the nursing facilities and intermediate care facilities for the mentally retarded programs as well as for the agency in prioritization of services.

Section (1) would amend the manner in which Intermediate Care Facilities and Skilled Nursing Facilities are currently licensed by KDHE. We are not clear why the license classification needs to be changed to nursing facilities. OBRA 87 mandated the term "nursing facilities" for the Medicaid program. However, OBRA 87 did not mandate that states change their licensing law for facilities participating in the Medicaid program. We are concerned over the broad ramification changes in the licensing law will have by altering the licensed category from skilled and intermediate to that of nursing facilities. There is further confusion brought about by the new designation of one-to-five bed "adult care homes" and whether or not this would apply to intermediate care facilities for the mentally retarded that were not affected by OBRA 87.

An additional amendment to the bill proposes to eliminate the current 300% income cap used to determine eligibility for nursing home coverage. This is found in Section 8, Page 21 of the bill. The Department does not support eliminating the cap. We feel the legislative action to limit nursing home expenses is needed. The Department cannot continue to support the present increase in nursing home expenditures without impacting our ability to provide assistance under other programs. The cap has begun limiting the number of new clients who are eligible for nursing home care and is expected to provide savings over the long term. Unless we take measures to limit the escalating costs in the Medicaid Program, we face the potential of having to further scale back other programs and services currently available.

While Medical Services supports the intent of HB 3045, we do not support the passage of this bill in its present form.

Donna L. Whiteman
Secretary

Senate PHEW
Attachment #15
3-31-92

LATEST FACTS ON 300% OF SSI NURSING HOME CAP

Kansas Department of Social and Rehabilitation Services

Division of Management Service–Budget Office

1) **Nursing Home Cost of Affected Population in Recent Months....**

Dec 1991	$147,667
Jan 1992	160,388
Feb 1992	152,742
3 mo total	**$460,797**

2) **Annualized Amount Based on Above Data.....** **$1,843,188**

3) **Outyear Projections Based on Latest $1,843,188 of All Funds Savings** in FY 92.....**

Year	*Average # of Patients Over 300%*	*Annual Projected Pop Growth*	*Avg Annual Cost Per Patient*	*Annual Projected Cost Growth*	*Projected Total $'s*
1992	445	2.9%	$4,142	11.5%	1,843,188
1993	458	2.0%	4,618	12.4%	2,114,754
1994	467	2.0%	5,191	9.0%	2,424,523
1995	476	2.0%	5,658	9.0%	2,695,585
1996	486	2.0%	6,167	9.0%	2,996,951
1997	496	2.0%	6,722	9.0%	3,332,011
1998	506	2.0%	7,328	9.0%	3,704,529
1999	516	2.0%	7,987	9.0%	4,118,696
2000	526	2.0%	8,706	9.0%	4,579,166
2001	537	2.0%	9,489	9.0%	5,091,117
2002	547	2.0%	10,343	9.0%	5,660,303
2003	558	2.0%	11,274	9.0%	6,293,125
2004	569	2.0%	12,289	9.0%	6,996,697
2005	581	2.0%	13,395	9.0%	7,778,928
2006	592	2.0%	14,601	9.0%	8,648,612
2007	604	2.0%	15,915	9.0%	9,615,526
2008	616	2.0%	17,347	9.0%	10,690,542
2009	629	2.0%	18,908	9.0%	11,885,745
2010	641	2.0%	20,610	9.0%	13,214,571

** Note: It is critical to note here that the above data disregards the fact that the individuals initially affected by this policy in FY 1992 were "grandfathered" in. This offseting issue has little bearing on the long term savings of this policy. These patients will, for the most part, not be in the Nursing Facilities beyond FY 1993.

JAS file 123r3/rach9293/300%ssi/t50

KINH Kansans for Improvement of Nursing Homes, Inc.

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

TESTIMONY PRESENTED TO
THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING HB 3045

March 31, 1992

Mr. Chairman and Members of the Senate Public Health and Welfare Committee:

Kansans for Improvement of Nursing Homes supports HB 3045 as amended to include HB 2844. At first sight the bill might appear to be the marriage of an odd couple. On careful examination, however, we believe it makes good sense philosophically.

HB 2844 was an attempt to assure that elderly and disabled people are assisted financially, when such assistance is necessary, to pay for the level of care they have been determined to need according to an evaluation of their functional and medical capabilities. HB 3045 would broaden the range of care alternatives available, with the ultimate goal of caring for individuals in the least institutional and least costly level consistent with their needs.

We will not repeat here the arguments we have already made in support of the Senate version (SB 548) of HB 2844. KINH supports the concept of providing the widest possible range of care alternatives for the elderly and disabled and we believe the state has a responsibility to assure that any element of the full range of care is made available according to the care needs and the financial capabilities of the individual. What, we must ask, is the use of providing a range of alternatives and evaluating the needs of the individual as to which would be most appropriate for their care, if some of those alternatives are out of reach of the consumer no matter what the need may be?

KINH agrees that the state should determine what level of care the person seeking nursing home admission requires, and should not pay for a higher level of care than is needed if a lesser alternative is reasonably available. HB 3045 encourages development of another element in the continuum of care possibilities and, as amended, provides that every element in the continuum will be made financially available as needed, including institutional care when that is appropriate.

Our only reservation, expressed in our testimony before the House Public Health and Welfare Committee on HB 3045, is that we hope that the Department of Health and Environment will draft somewhat more explicit regulations for the standards of care to be provided by the one to five bed homes than the current minimal regulations for the present category of one and two bed homes, and will be able to provide adequate monitoring and oversight of these small facilities.

KINH urges you to support HB 3045 as amended.

Marilyn Bradt
Legislative Coordinator

Senate P. H&W
Attachment #16
3-31-92

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

on

Amended House Bill 3045

The Kansas Department of Health and Environment supports, with one exception, the amendments to the Adult Care Home definitions proposed in Amended House Bill 3045. Our testimony is limited to this issue and we take no position on new Section 2, amending K.S.A. 39-785.

The one- and two- bed adult care homes can provide whatever level of care they are deemed capable of providing. 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 supports the family model as long as it is limited in size and scope. Extending this concept from two to five residents has no negative impact and is consistent with recommendations made by the Department on Aging, the Department of Social and Rehabilitation Services, and this Department in the Long Term Care Recommendations submitted to the Legislature.

Eliminating the intermediate nursing home classification and redefining skilled nursing home as nursing facility makes state law consistent with federal terminology and contemporary nursing home practice. The distinction between intermediate and skilled has been non-distinguishable for several years and this amendment will help simplify laws defining nursing home care.

The Department is opposed to the provision which would redefine boarding care home so that reception, accommodation, board, and supervision could be provided for up to five persons without regulatory oversight. We believe this classification should remain as is so that any operator providing such care to more than three non-relatives is subject to the minimum regulatory oversight this Department provides.

Senate P. H&W
attachment #17
3-31-92

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

It is important to note that the persons provided for in these facilities need certain services, accommodation, and supervision by reason of aging, illness, disease or infirmity, and are unable to sufficiently or properly care for themselves. We believe this is sufficient reason to limit the threshold subjecting such facilities to regulatory oversight to the current level of three.

The Department respectfully requests House Bill 3045 be recommended favorably with the exception noted above.

Presented
by: Joseph F. Kroll, Director
Bureau of Adult and Child Care
March 31, 1992

Kansas Retired Teachers Association

"All Things Excellent"
1991 – 1992

March 31, 1992

Members of the Senate Public Health and Welfare--Committee

My name is Basil Covey and I am the chairman of Kansas Retired Teachers legislative committee.

We support HB 3045 which changes the names of certain categaries of adult care homes making persons eligible for medical assistance coverage of adult care costs.

The 300% of SSI on Medicaid eligibility for nursing home services disturbed and worried thousands of elderly citizens including retired teachers. A family case was brought to the attention of an Interim Committee last summer that the division of assets legislation passed in 1988 could no longer apply.

The Silver Haired legislature took up the issue and made recommendations to raise the income Cap. Other organizations representing the elderly joined with recommendations.

HB 2844 and SB 548 were introduced to solve the problem. HB 3045 was amended to include provisions of HB 2844. It passed the House 120-0.

There is wide support across the state to make the division of assets available to elderly married couples if serious illness of one occurs..

We urge the Committee to give HB 3045 a favorable vote.

Thank you,

Basil Covey

Basil Covey

Senate P. Hlth
Attachment #8
3-31-92

SB 3045

I am Arris Johnson, Speaker of the Kansas Silver Haired Legislature and I thank you for the opportunity to appear before this committee to speak in favor of the removal of the 300% cap, I am certain that you are aware that the Silver Haired Legislature which represents some 450,000 Kansas seniors, voted unanimously last October by special resolution to ask that the cap be removed. It was also considered by them to be the most pressing issue of our session. This observation is not meant to be a threat but it is a fact.

We feel that to continue the cap will, in a period of time depending upon the size of family savings, create another problem, that of welfare. Examples are usually more clear than simply words so I refer to the example of the Manhattan, Kansas family whose situation was presented last fall in Kansas newspapers. The husband's income was approximately $1800 ($1836 actual) and the wife's was approximately $200 ($199 actual). The nursing home bill for the husband was approximately $3000. Before the cap, the wife could have retained $984 per month to live on but with the cap they could not divide the income. With the cap in place, all of the husband's income, plus approximately $1200 from savings would be required for his care, leaving only $200 for the wife per month, plus whatever she needed to withdraw from savings. It is easy to see how soon the savings would have been gone and welfare would be called for. The figures above are approximate of necessity but the reality is not. It seems to us that it is not only good business but also very humane to allow the healthy spouse to continue to live in dignity and with security. At this point, mental health which is also a very important factor among the elderly, becomes a serious factor also.

Another factor which requires attention is that of saving in preparation for the latter years of life. Not only the cap, but also much of the present thinking, does not allow for good planning and saving. We seem to be saying to people, if you do not save we will take care of you but if you save, you will be penalized.

There are those who believe that the federal law requires a cap. Those who have thoroughly studied the law tell me that establishing a cap is optional with each state. We believe that the division of income/assets was working well in Kansas before the cap. We ask you to empathize with our seniors by placing yourself in their positions and decide how you would like to be treated when you reach their status.

Statistics furnished in the March 20, 1992 issue of Legislative Report by the Department on Aging indicate that removing the cap will result in a savings of about $103,000 in the short term. The longer term would result in an increased expenditure of approximately $294,000, representing about three-tenths of one percent of the governor's recommendation for state adult care home expenditures in fiscal year 1993. In addition, the cost of removing the cap will be <u>less</u> than the state funds expected to be saved by implementing an estate recovery program as proposed in Senate Bill 607.

I have a very good, long-time friend and colleague, now retired from Fort Hays State University, whose wife has been in a nursing home since the early 1980's. She has a very serious condition which requires full-time care. Until the Division of Assets law came into effect in Kansas in 1988, he spent all of his income to keep his wife in the nursing home, using only enough to purchase groceries for himself. After the division of assets was allowed, he told me that, for the first time in several years, he could begin to enjoy life again by having a few of the amenities which he deserves. We believe that all of our seniors deserve to spend their final years in dignity and security. They have worked all their life toward that goal. We ask your support.

Senate Attachment #19
3-31-92

TESTIMONY FOR THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
CONCERNING HOUSE BILL 3045

Topeka, Kansas, March 31, 1992

Mr. Chairman and Members of the Committee:

I am Walter H. Crockett, Chair of the State Legislative Committee of Kansas AARP.

I am back to testify once again in favor of eliminating the cap that prohibits Medicaid assistance to nursing home residents when their income exceeds 300% of the poverty level. In the interests of time, I will do no more than remind you that removing this cap will save the state money in the short run, because federal dollars will again help to defray the costs of individuals who have been "grandfathered" in under previous regulations. Nor will I dwell on the misery this cap has imposed on people whose income barely exceeds it, or on those who have been impoverished by its effects on our division of assets law.

Those are powerful arguments. I believe them implicitly. But you have heard them already. The Department of Social and Rehabilitation Services and others who favor the cap concede that those arguments are valid. So I will try to sketch out, instead, why I think the idea of a cap is misguided in the first place.

As I understand it, the argument for the cap is based not so much on the present cost of assisting individuals whose income exceeds $1,266 a month as on the fear of future costs of adult-care assistance. The dramatic increase in the number of very old citizens in our population terrifies many of us because it suggests that Medicaid payments to adult-care homes will soon consume the lion's share of the SRS budget. Something must be done to avert that disaster. But, surely, striking everyone with an income above some arbitrary level off of the Medicaid rolls is reaction of panic, not of reason, to this very real threat.

Instead, we recommend a compassionate, rational, coordinated set of programs that will attack our over-reliance on institutionalization without, at the same time, imposing intolerable burdens on the sick, the poor, and the helpless. May we remind you that SRS has proposed such a set of programs? It will take a year or two before a coordinated policy of this sort can be put in place. During that interval, the 300% cap can be abandoned at a saving to the state, and with immeasurable relief to individuals whose lives it has thrown into turmoil.

Mr. Chairman, Members of the Committee, I urge you to report this bill favorably to the Senate and I thank you for this opportunity to address you.

Senate P. H&W
Attachment #20
3-31-92

Testimony on HB 3045
300% Cap on Medicaid Eligibility

before the
Senate Public Health & Welfare Committee

by the
Kansas Department on Aging
March 31, 1992

The Kansas Department on Aging supports House amendments to HB 3045 to remove the 300% cap on medicaid eligibility for nursing home care. The Senate Public Health and Welfare Committee approved these same provisions in SB 548. We recommend your adoption of HB 3045 so that older disabled Kansans will not continue to be arbitrarily excluded from the Medicaid program.

State Options

The 1992 Kansas Legislature has the option to restore the division of assets protection to older Kansans and to help older individuals who have no where else to go. By passing HB 3045, the Legislature can restore medicaid benefits as they existed before September 1, 1991.

The 1992 Kansas Legislature does not have to wait on the federal government to change its regulations. Those regulations only prevent us from treating couples differently than individuals. HB 3045 helps both individuals and couples who can never afford nursing home care and who cannot qualify for medicaid assistance no matter how desperately they may need it.

Cost

Ironically, HB 3045 will save the state money in the short run. The fiscal note says the savings will be $103,000. The state is now paying the full cost of the care of 445 people grandfathered into the medicaid program. HB 3045 will allow the state to get 59% of the costs paid by the federal government.

In the long run, HB 3045 will cost the state $294,000. This figure is well short of the millions of dollars projected for future nursing home costs. The people above the cap are the least expensive medicaid recipients because they pay most of the costs out of their own incomes.

Conclusion

People with incomes above the cap have been denied medicaid coverage regardless of need. Where are they to go? What are they to do? These are unanswered questions.

Senate P. H & W
Attachment #2
3-31-92

Home and family care may be appropriate for some; but, we should make these decisions based on need as proposed in Sub. HB 2566, the pre-admission assessment and referral bill.

Even with the creation of alternatives such as one- to five-bed homes as proposed in HB 3045, many people will continue to need nursing home care. We should not abandon them just because they are old and disabled and have nowhere else to go.

FACT SHEET

300% of SSI Cap on Medicaid Eligibility For Nursing Home Services

1. The short term fiscal impact of removing the 300% of SSI cap is a **savings** of about $103,000 in state funds. The longer term impact will result in an increased expenditure of about $294,000 in state funds. This $294,000 represents about three-tenths of one percent of the governor's recommendation for state adult care home expenditures in FY 93.

2. The cost of removing the cap is **less** than the state funds expected to be saved by implementing an estate recovery program (SB 507) and changing the way in which transfers of property into irrevocable trusts are considered for Medicaid eligibility purposes. These two measures are expected to generate about $338,000 in state funds savings in their first year of operation with an increasing amount in future years.

3. The cost of removing the cap is also **less** than the state funds expected to be saved (about $478,000) by implementing pre-admission assessment for nursing home applicants (HB 2566).

4. An amount ($3.3 million) equal to about 11 times the cost of removing the cap is currently being lapsed from SRS' budget because of **underspending** in the long-term care medical assistance account.

5. Although there have been sizeable increases in Medicaid expenditures for long-term care, the increases have been less than that of the rest of the Medicaid program. Thus the percentage of the Medicaid budget going for long-term care has actually been decreasing.

6. In 1990 Kansas ranked 41st in the amount of its general fund (8.2%) spent on Medicaid. The average state spent 12%.

7. The national percentage of the Medicaid budget spent on the elderly was virtually unchanged in 1991 (38%) compared to 1974 (37%).

8. Out of pocket health expenditures by the elderly have more than doubled between 1961 ($1589 in 1991 dollars) and 1991 ($3305) even though Medicare was established in 1965 to help pay for such expenses. As a percentage of after tax income, average out of pocket health care expenditures by elderly families have increased from 10.6% in 1961 to 17.1% today.

SEE OTHER SIDE FOR SOURCES

SOURCES

1. Fiscal note on SB 548; Governor's Budget Report.

2. Legislative Research Department's analysis of SRS' budget; economic Impact Statement on K.A.R. 30-6-56.

3. Three Year Long Term Care Plan of the Department of Social and Rehabilitation Services.

4. SB 547

5. 1990 SRS Annual Report

6. 1991 position paper of the Kansas State Legislative Committee of the Kansas Chapter of the American Association of Retired Persons.

7. 1991 edition of Aging America: Trends and Projections

8. Wall Street Journal of February 26, 1992 p. B5 citing a Families U.S.A. report.

Prepared by the Kansas Department on Aging
March 20, 1992
gad:300%cap2.sht

SUMMARY

What does Bill 3045 offer Alzheimers and their families that is better than what is now available?

1) It offers a family less expensive and more reliable respite care for a loved one who is often not covered by Medicare/Medicaid.
2) It offers better care for the person since
a) skilled nursing would be given at least 6 hours a day, 5 days a week, with family counseling.
b) Burn out and possible abuse less likely as family caregivers are given respite, and the provided employed caregivers would be working 6 hour shifts a day, only 5 days a week.
3) It would be less stressful for the person and their families:
a) the stress of providing DAILY transport is avoided since the person is brought to the care facilty on Monday and returns home on Friday.
b) Stress for the person with Alzheimers is lessened because in essence, he/she would have a familiar home away from home during the (family caregiver) work week, and yet be home with their family on weekends.
4) Use of a single resident house encourages location convenience, allows for increased economic feasibility, as well as accessibility to more rural situations.

The facts are supported in the handout sheets provided. On page 6 of the handout sheets, there are Budget Explanations. This Bill is NOT asking for any financial help from the taxpayer. It provides people with an important, and less expensive alternative than 24 hour/7 day week care that many family caregivers are now providing.

Senate P. H&W
Attachment #22
3-31-92

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

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 (Alzheimers and Related Dementias), who are often non medicaid/non medicare qualifying.
[See figure 1 - AD (Alzheimers) 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 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,

limited services, and daily transport demands.

B) Adult Day Care Programs - 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 UKMC, Center on Aging, had examined several other factors that specifically pertain to non success of 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) Private Pay Respite Care - the most "in demand" care is for home 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) Nursing Homes and Special Care Units 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) One and Two Bed Adult Care Homes - are economically not 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 simple nursing care with no guarantee of 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 nurse/caregiver service for 6 hours of the day. This "quality

assurance" compares to figure 3, 14 SCU's (Special Care Units) of SNF's (Skilled Nursing Facilities), 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 families felt guilty or 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

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 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 decrease 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 Facility; residents are only "admitted" under daily 6 hour supervision, assessment, coordination of nursing services by a professional health provider.
3. What would be the suggested qualification's of the

licensee/operator?

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" could 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 <u>these</u> services? There is great demand for in home <u>affordable</u> 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 <u>independently</u> 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 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.

ALZHEIMER'S ASSOCIATION
Someone to Stand By You.

Fig 1

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. $2,000 to $3,000 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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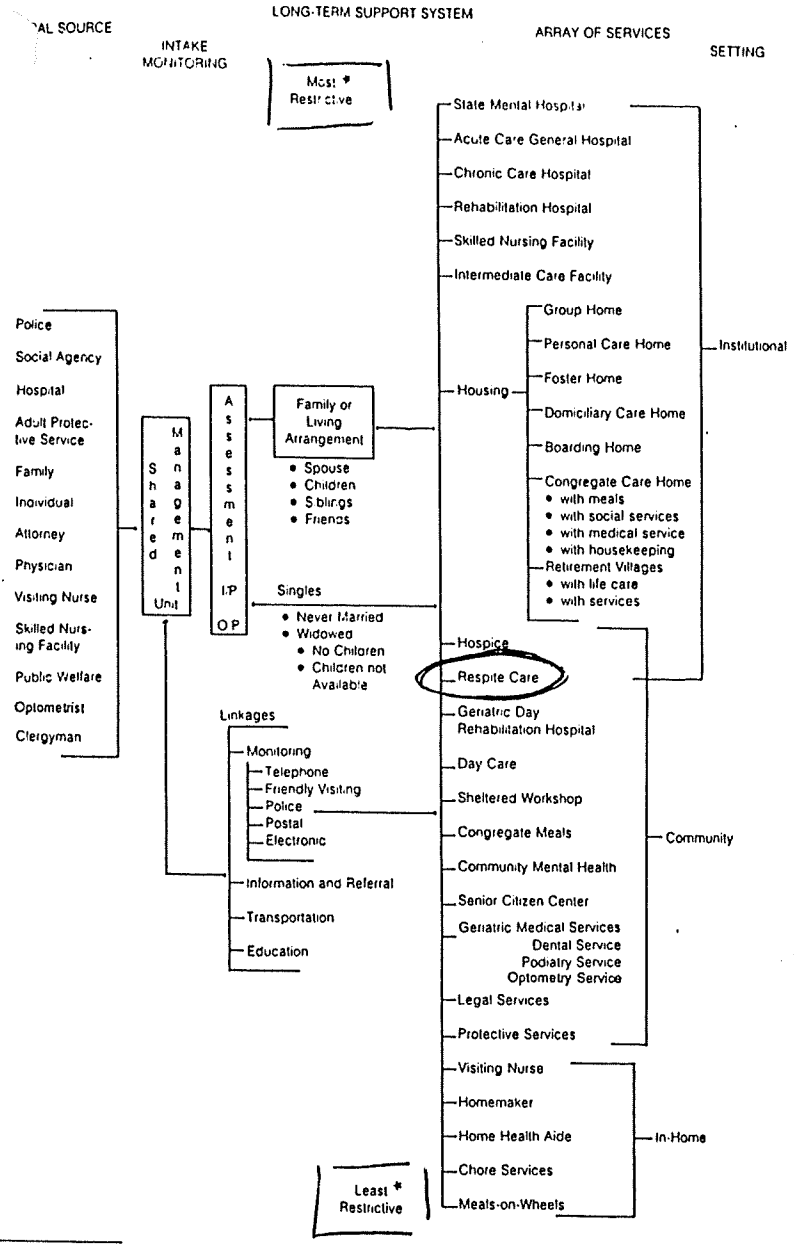

* The classification of from most to least restrictive is a general view of services and may vary within each service.

Figure 1. Inventory of Recommended Available Services, Appropriate to a Long-Term Care ...nport System. Reprinted by permission of American Journal of Public Health 7(...n S.J. Brody and C. Masciocchi. 1980. Data for long-term care planning by he... ...stems 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			Aides		
	Day	Evening	Night	Day	Evening	Night
	RN + LPN					
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 were not consistent. Where these were included, however, there was a 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.

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 Association of Retired Persons, (AARP), and The Travelers Companies Foundation. For purposes of this research, a caregiver was defined as someone who provides unpaid assistance 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 instrumental activities of daily living IADL-grocery shopping, managing finances, housework, meal preparation, transportation, administering medications, etc.)

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

The AARP and The Travelers Companies Foundation research reports on persons currently providing care (65%) as well as persons who had been caregivers within the 12 months prior to the survey (35%). In addition, 63% of respondents reported being 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 in close proximity to the older person; eighteen percent because they have a closer 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 be $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 living with children 12 through 17.
- Fifty-five percent of caregivers are employed; 42% are employed full-time and 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

NORTHWEST MISSOURI AREA AGENCY ON AGING

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 ~~use~~ 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.

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.

TO: Legislators HB 3045

RE: 300% Medicaid Cap

I am the director of a senior citizen information and referral agency in Topeka. I am writing to share this information about clients whose lives were affected by the cap on division of assets.

The first case that I encountered in which the 300% cap made a difference was a gentleman who had worked and provided for his family until his retirement. His wife had a brain tumor. He was trying to care for her in his home and had done so for at least two years. The day he came into our office his wife had placed her glasses in the microwave and started a fire. His eyes filled with tears and he turned his face away from me. He wanted to know about division of assets.

Once we discussed division of assets it soon became apparent that they were not eligible because he made $1,300 a month. They were over the limit of $1,266 a month. He was so tired of trying to cope with the problem and you could really see the frustration when he found out he had no options. He had already used up the bulk of their savings for her diagnosis, care and medicine.

The nursing home cost would be $1,700 a month and up. They did not receive that much per month. He did not have enough to put her in the nursing home and have enough left over to live. His last question to me was," What can I do? Why did they have division of assets if it does not work?"

The second case was a woman who had been in the nursing home when the income went over the cap. I met her husband when I was doing outreach. He had her at home and was taking care of her. The family's combined income was $1,298 a month. This was not enough to pay the $1,700 monthly nursing home bill and certainly would not allow him to have any money to keep himself in the home which they had lived in all their married lives.

He had never cooked for himself and he was having to prepare meals for both of them. He was at his breaking point and someone at his church heard about his plight. The church bought a hospital bed and all the necessities she needed. The church women took turns going into the home and helping out. They even built ramps so he could take her in and out to the doctor.

The last time I saw him he had lost a lot of weight and seemed very preoccupied. I do not know how long the church people can keep up the pace and magnitude of what they are doing.

If the 300% medicaid cap was removed these people could be helped!

Rosemary Harris
Older Citizens Information,
A service of the Community Resources Council

Senate Ways & Means
Attachment 23
3-31-92