MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans, at 1:30 p.m. on January 29, 1998 in Room 423-S-of the State Capitol.

All members were present except: Representative Deena Horst - excused
Representative Tony Powell - excused

Committee staff present: Emalene Correll, Legislative Research Department
Robin Kempf, Legislative Research Department
Norman Furse, Revisor of Statutes
Lois Hedrick, Committee Secretary

Conferees appearing before the committee:
Ronald Hein, Baxter International
Gary Mitchell, Secretary, Kansas Department of Health and Environment
Joseph Kroll, KDHE Director, Bureau of Adult and Child Care
Sandra Strand, Kansas Advocates for Better Care

Others attending: See Guest List (Attachment 1)

The minutes of the committee meetings held on January 20, 21, 22, and 26, 1998 were distributed for review and by policy will be approved as read if no changes are reported to the Chairperson by 5:00 p.m. January 29.

Chairperson Mayans opened the meeting for possible introduction of bills. Ronald Hein, representing Baxter International, requested the committee to sponsor a bill to make technical amendments to the Board of Pharmacy law to authorize certain current business practices in the home delivery of dialysis supplies to be in compliance with the law. Mr. Hein stated that Baxter International had reviewed the laws of several states (including Kansas) and determined such amendments were warranted. Representative Morrison moved, seconded by Representative Gilmore, that the bill be introduced. The motion carried.

The Chairperson then opened the hearing on **HB 2669** - Investigations of abuse, neglect or exploitation of certain persons. Gary Mitchell, Secretary of Health and Environment, discussed the bill's implications for KDHE; described the department's policies and procedures relating to the reporting and investigation of allegations of abuse, neglect or exploitation in adult care home settings; and the impact **HB 2669** dictates for KDHE in terms of budget and staffing. (See Mr. Mitchell's testimony, Attachment 2.) Mr. Mitchell suggested reliance on home administrators for investigations may be more effective as they realize their professional lives are at stake and that they already sign off on the investigation reports. KDHE licenses administrators and disciplines them in appropriate instances. Nine were disciplined last year. Perhaps the banning of admissions where such grievances were proven would be more effective.

Mr. Mitchell stated two or three surveyor positions are constantly open and recruitment for qualified replacements is ongoing. Mr. Mitchell suggested, as funding becomes available, that a computerized complaint tracking system will allow the department to do a better job in knowing the parameters of the complaints and their resolution, and in providing quicker responses to complainants.

Chairperson Mayans asked what is the average number of complaints their investigators (surveyors) handle in a year. Joseph Kroll, KDHE Director ofthe Bureau of Adult and Child Care, answered that, as an average, it takes one 11-hour day per complaint--which includes travel, investigation and write-up time. Representative Henry asked for a brief history: are there less investigators and more complaints now? Mr. Kroll replied that KDHE does not have a report ready on the exact number, but the April 1996 restructuring in federal funding impacted KDHE and its staffing; and also there is a reduced number of patients in nursing homes in light of home-based care and assisted living facilities.

Secretary Mitchell, from an agency management standpoint, indicated that the assisted living facilities will be a real challenge to the state due to the varied physical and mental conditions of the residents. The Secretary indicated he and the Secretary of Aging are studying that issue this coming summer and will report their findings to the 1999 Legislature.

Representative Showalter questioned if facilities are forewarned of a complaint investigation, and Mr. Kroll replied there is no notice given and stated the law requires KDHE to provide a letter on the conclusion of an investigation to the complainants if they request it. KDHE's policy is to report on all kinds of complaints except general complaints (i.e., dirty floors, etc.) where a follow up report is given only if requested. Secretary Mitchell noted Governor Graves' program to improve constituents relations includes KDHE, who is

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striving to respond with timely responses to complainants. There is a toll-free telephone number to make it easy for citizens to report abuse. Emalene Correll pointed out Kansas law also requires six categories of professionals to report complaints.

Chairperson Mayans then introduced Sandra Strand, Kansas Advocates for Better Care. Ms. Strand, in describing the reasons her organization requested **HB 2669**, asked members to support the bill and provide funding for KDHE to investigate all complaints. (See written testimony, Attachment3.) Representative Wells asked if the Legislature passes the bill and provides the additional funding, will Ombudsmen still be needed? Ms. Strand answered yes; for example, a guardian's complaint of a care worker taking advantage of a patient. Representative Storm noted that 3,200 complaints were logged last year, and asked what percentage was for abuse, neglect or exploitation--which the bill covers. Ms. Strand answered that she did not know the percentage. Representative Gilmore, describing the legitimate issue of retaliation to care workers who file complaints, stated that issue was not addressed by this bill. Ms. Strand noted there are no teeth in the law that makes retaliation illegal. She also noted this bill takes us back to where we were before the federal funding cutbacks.

Chairperson Mayans then closed the hearing on **HB 2669**. He also stated, in view of the time, the hearing on **HB 2670** (investigations and proceedings conducted by board of healing arts) is postponed.

The meeting was adjourned at 2:55 p.m.

The next meeting is scheduled for February 2, 1998.

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HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES GUEST LIST JANUARY 29, 1998

NAME	REPRESENTING
John Pinegar	Pinegar - Smith
Rosalie Sparks	~~SRS~~ AMS
Julie Thomas	DOB
Carolyn Middendorf	KSNA
Martha Hodgesmith	Attorney General
DB Vally	VanChesti
Rebecca R[illegible]	KOA
Michelle Hoyd	KAPS
Sandra Strand	Ks Advocates for Better Care
Joseph F. Kroll	KDHE
GARY Mitchell	KDHE
Danielle Noe	Governor's Office
Michelle Peterson	Peterson Public Affairs
Mark Stafford	Bd of Healing Arts
KEITH R LANDIS	CHRISTIAN SCIENCE COMM. ON PUBLICATION FOR KS
John Kiefhaber	Ks Health Care Assn.
Don Brown	KDHE
Ron Hein	Baxter International
Dawn Reid	KSNA

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HOUSE COMMITTEE ON
HEALTH AND HUMAN SERVICES GUEST LIST
JANUARY 29, 1998

NAME	REPRESENTING
Charles Moore	KDOA
PATRICK NICHOLS	KTLA
Lee Smith	
Susan Anderson	Hein + Weir
D Zehr	KAHSA

HOUSE COMMITTEE ON
HEALTH AND HUMAN SERVICES GUEST LIST
JANUARY 29, 1998

NAME	REPRESENTING
[illegible]	ACLU
ACLU	

KANSAS

DEPARTMENT OF HEALTH & ENVIRONMENT

BILL GRAVES, GOVERNOR

Gary R. Mitchell, Secretary

TESTIMONY PRESENTED TO

THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

Thursday, January 29, 1998

by

Gary R. Mitchell
Secretary of Health and Environment

HOUSE BILL 2669

Mr. Chairman and members of the committee, thank you for the opportunity to appear before you today to discuss House Bill 2669 and its implications for the Kansas Department of Health and Environment. We are all aware of the need for meaningful dialogue on issues of long-term care for adults, and I commend the committee for starting work on this issue early in the 1998 legislative session. My comments will be brief. I will describe the current KDHE policies and practices for reporting and investigating allegations of abuse, neglect or exploitation in adult care home settings. I will describe the changes I believe House Bill 2669 would dictate for KDHE, and I will outline the impact of those proposed changes should they be implemented by the Legislature and the Governor.

Current KDHE Procedures for Allegations of Abuse, Neglect or Exploitation

- The most serious category of abuse, neglect or exploitation is always investigated by KDHE surveyors.

- Complaints suggesting "immediate jeopardy" or a resident currently being harmed are investigated by KDHE surveyors.

- Some of the less-serious complaints are handled through facility self-investigation. The facility follows KDHE prescribed protocol to investigate the complaint and provides a full report to KDHE. Based on that information, KDHE may still send surveyors (I have attached a copy of the facility investigation paperwork).

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- In 1997, KDHE received 3,209 complaints. 798 were facility-investigated only, 2411 were investigated by KDHE surveyors.

- Approximately 80 percent of all complaints of abuse, neglect and exploitation received by KDHE can not be substantiated based on investigation findings.

Changes Proposed by House Bill 2669

- All complaints would be investigated by KDHE surveyors (or SRS, depending on the type of facility and licence).

Impact of Proposed Changes on KDHE

- Fiscal impact to survey approximately 800 additional complaints annually would be at least $165,000 and three FTEs added to my staff of field surveyors.

- Additional travel and scheduling concerns associated with the extra workload.

- We would still need to prioritize complaints to make sure the most serious allegations are immediately addressed.

I can appreciate the difficulty you as lawmakers face in dealing with issues of long-term care for adults. I face the same problems every day as Secretary of KDHE. I am confident that we are doing a good job under the current statutes, regulations, and policies in place. My goal is to continue to improve. I wish you the best as you debate this legislation. Please consider me a resource for information as you work through the process. Thank you for your time and consideration, and I would be pleased to answer any questions from the committee.

Bureau of Adult and Child Care, 900 SW Jackson, Suite 1001 Topeka, KS 66612-1290
(785) 296-1240 FAX (785) 296-1266
Printed on Recycled Paper

Attachment

State of Kansas

Bill Graves Governor

Department of Health and Environment

Gary R. Mitchell, Secretary

Date:_______________

Complaint Case No._______________

Notice to Required Reporter

The Kansas Department of Health and Environment (KDHE) operates an Adult Care Complaint Program. Complaints including allegations of abuse, neglect, or exploitation are processed in one of two ways: 1) onsite investigation; or 2) facility driven investigation.

Onsite investigations are conducted when allegations of abuse, neglect, or exploitation are received from an identified individual who is not a representative of a long term care agency.

Kansas Deparment of Health and Environment's "Facility Complaint Investigation Report" forms will be completed by the long term care agency when a representative of the agency or an unidentified individual has reported an alleged incident of abuse, neglect, or exploitation. At the time the complaint is received by the Adult Care Complaint Program, the reporting agency will be sent a KDHE "Facility Complaint Investigation Report" form for completion. The completed form and the agency investigative documentation must be forwarded to the appropriate KDHE Regional Manager within seven days of the date the complaint was initially reported to the Adult Care Complaint Program. An onsite investigation will not be conducted unless determined necessary following review of the agency's investigative documentation.

Please forward all reports, documentation and a completed Facility Complaint Investigation Report Form (enclosed) to the address provided below **within seven days** of the date of this letter.

You will be provided notice of the outcome of this complaint case.

Thank you for your participation in this program.

Bureau of Adult & Child Care
900 SW Jackson, Suite 1001, Topeka, KS 66612-1290

Phone: (913)296-0126
FAX: (913)296-1266

- The investigation must be completed within 10 working days following receipt of the complaint to determine whether abuse, neglect, or exploitation has occurred.

- Written findings are due at the Topeka office within 14 days of receipt of the complaint.

- Any delay of this process must be documented by the Program Director or Regional Manager.

For investigations that are facility self-reported:

- When the reporting facility contacts the Complaint Intake Specialist to report an allegation of abuse, neglect, exploitation, or failure to provide adequate care, the requirement for an "initial contact" by KDHE to the facility shall be considered met.

- After entering the complaint intake information into the automated computer complaint tracking system, the Complaint Intake Specialist will mail to the reporting facility: (1) required reporting cover letter; (2) "Facility Complaint Investigation Report" form; and (3) "Alleged Perpetrator Information" form, if appropriate.

- The reporting facility is directed to mail the completed forms and supporting investigative documents to the appropriate Program Director or Regional Manager within seven days of the facility reporting the allegations to the Complaint Intake Specialist.

  Facility investigative documentation shall include:

  1 Completion of the "Facility Complaint Investigation Report" form (CP-101).
  2 Completion of the "Alleged Perpetration Information" form (CP-007), if appropriate.
  3 Inclusion of any supporting investigative documents.

  An onsite investigation will be assigned by the Program Director or Regional Manager if but not limited to the following:

  1 The reporting facility fails to forward the required investigative documentation to the Program Director or Regional Manager within seven days of the date the reporting facility reported the incident to the Complaint Intake Specialist.

  2 The reporting facility fails to provide information that would indicate that the facility has conducted a thorough investigation:

  3 Does the facility documentation include the following information:
     a Specific description of the incident (the date, time, and location of the alleged incident);
     b The names, social security numbers, and cognitive status of the resident(s);

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c Whether or not the resident(s) was injured and, if injured, a description of the injury;

d Names, addresses, telephone numbers, and position or relationship of witness(es);

e Is the resident(s) still in danger;

f Has the facility taken corrective actions and what were those corrective actions; and

g Was the attestation statement signed and dated?

h Were the issues identified by the complainant's report substantiated or unsubstantiated (documented on the back page of the "Facility Complaint Investigation" form)?

i Does the facility documentation reflect that there has been infliction of physical or mental injury or deprivation by a caretaker of services which are necessary for the resident to maintain physical and mental health (abuse)?

j Does the facility documentation reflect that there has been a failure of a caretaker to maintain reasonable care and treatment to such an extent that the resident's health or emotional well-being is injured (neglect)?

k Does the facility documentation reflect that there has been intentional taking of an unfair advantage of an adult's physical or financial resources for another individual's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person (exploitation)?

l Can (a staff member) perpetrator(s) of abuse, neglect, and/or exploitation be named and substantiated? If so, has an "Alleged Perpetrator Information" form been completed and submitted?

4 The reporting facility fails to provide definitive or identifying information about an alleged perpetrator, or **the individual is a repeat alleged perpetrator.**

5 The reporting facility's documentation reflects significant violations of state or federal regulations has occurred, and a deficiency needs to be cited.

6 The facility has been identified as a "poor performing facility."

7 The Program Director of Regional Manager feels that an onsite investigation needs to be conducted.

8 There appears to be or has been: 1) a systems problem; 2) a serious injury occurred or there was/is a potential for serious injury; 3) an elopement; and/or 4) a high profile case (criminal, rape, death, etc.).

The HCFA-670 form is to reflect the Regional Manager's packet review time.

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Bureau of Adult and Child Care
Adult Care Complaint Program

CP No. ____________

FACILITY COMPLAINT INVESTIGATION REPORT FORM

(Please attach additional sheets as needed.)

REPORTING FACILITY

Name: ____

Address: ____
(street/PO box) (city/state) (zip code)

REPORTING PARTY

Name: ____
(last) (first) (middle initial) (title/position)

Address: ____
(street/PO box) (city/state) (zip code)

Telephone: ( ) ____________________ ( ) ____________________
Work Home

INCIDENT INFORMATION

Date of Incident (on or about):

Information upon which this report is being made is as follows: (Please include a specific description of the incident, including the date, time, and location of the alleged incident.)

(over)

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Bureau of Adult and Child Care
Field Services

ALLEGED PERPETRATOR (AP) INFORMATION FORM

TO BE COMPLETED BY THE FACILITY

Facility:

City:

ALLEGED PERPETRATOR INFORMATION:

Name: ____
Last First MI Other

Address: ____
Street/Box City State Zip Code

Telephone No.: ( ) ____________________ Social Security No.: ____________________

Date of Hire: ____________________

AP Suspended? ☐ Yes ☐ No Date: __________ AP Terminated? ☐ Yes ☐ No Date: __________

CREDENTIALING/LICENSURE INFORMATION

Certificate or License No.: ____________________
(Attach copy of certificate/license.)

Type of Certification (check those that apply): ☐ NAT ☐ CNA ☐ CMA ☐ HHA ☐ AD ☐ SSD ☐ QMRP

☐ Other ______________________________

NAT = Nurse Aide Trainee I or II CNA = Certified Nurse Aide CMA = Certified Medication Aide
HHA = Home Health Aide AD = Activities Director SSD = Social Services Designee
QMRP = Qualified Mental Retardation Professional

OR

Type of License (check those that apply):

☐ ACHA ☐ RN ☐ LPN ☐ RPT ☐ OT ☐ LMHT ☐ LSW ☐ Other __________

ACHA = Adult Care Home Administrator RN = Registered Nurse LPN = Licensed Practical Nurse
RPT = Registered Physical Therapist OT = Occupational Therapist
LMHT = Licensed Mental Health Technician LSW = Licensed Social Worker

THIS SECTION TO BE COMPLETED BY THE REGIONAL MANAGER

Case No.: __________ Code No.: __________ Type: __________

The above-named perpetrator has been found to have:

Regional Manager Signature: ____________________ Date: __________

KANSAS ADVOCATES FOR BETTER CARE

913 Tennesee, Suite 2 • Lawrence, Kansas 66044-6904 • (913) 842-3088

TESTIMONY

TO: House Committee on Health and Human Services

FROM: Sandra Strand, Legislative Coordinator

DATE: January 29, 1998

SUBJECT: HB 2669

Kansas Advocates for Better Care requested the introduction of this bill to correct a problem that has existed since January 1996. At that time, the Kansas Department of Health and Environment (KDHE), in response to budget shortfalls, began delegating responsibility to nursing homes for investigating some complaints of abuse and neglect of residents.

If a complaint is self-reported by a nursing facility or if it is anonymous, KDHE may allow the facility to investigate the complaint internally, and to submit a written report. In many cases, KDHE investigative staff take no further action on these complaints. KDHE permits facilities to investigate complaints of abuse, neglect, and exploitation of residents which do not involve immediate jeopardy to residents.

A Performance Audit Report submitted in August 1996 by the Legislative Division of Post Audit summarizes our core concern about the KDHE policy:

> "We agree that State and federal regulations require a nursing home administrator to self-investigate complaints of abuse, neglect, and exploitation. However, this investigation is an internal management tool for the facility, and shouldn't be substituted for the external oversight that a regulatory agency can and should provide through an independent investigation of the facts" (p. 51).

When auditors asked KDHE field services staff (who actually conduct complaint investigations) if this new policy adequately protects residents from harm, fewer than half (48.8%) agreed or strongly agreed. One-third of staff who commented on significant problems in the complaint process said facility investigations of complaints aren't always adequate (p. 50).

KDHE management has justified this policy as a more efficient use of resources and says that the complaints they are turning over to nursing homes are those which are the most difficult for KDHE staff to prove. This practice does not make sense as responsible public policy. Just because a complaint is hard to prove does not mean KDHE shouldn't investigate it. If anything, these are the very complaints KDHE should be developing more effective procedures to investigate.

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While we recognize that adult care complaints are difficult to investigate, the consumers who contact us for help tell us KDHE needs to do a better job. When Legislative Post Audit surveyed people who had complained about nursing homes, only 45.6% agreed that their complaint issues were resolved appropriately (p. 44). Of the 3,000 adult care home complaints the agency received last year, fewer than 25% were substantiated.

The most recent Annual Report issued by Long Term Care Ombudsman (1995) noted:

> In the state ombudsman's opinion, KDHE survey staff simply do not have the resources necessary to accomplish the task. . . .Consumers report that even when they provide data, records, and other hard evidence, complaints are not confirmed. Because of the reliance on a medical record review, it often appears that if the nursing facility staff fails to document the incident into the record, the investigating agency staff cannot find the information in the chart upon which to document a "confirmed" abuse situation. Such a system is seriously flawed (p.18).

Concerning the delegation of certain complaint investigations to nursing home staff, the State ombudsman wrote:

> The State Long Term Care Ombudsman is concerned about retaliation by some administrators against residents and staff who have made complaints. Many of these types of complaints are related to resident rights, dignity and psychological abuse. If the facility administration had dealt with the issues to begin with, the complaints would not have been reported (p.19).

We all know that many nursing home residents are vulnerable and powerless. They can be literally at the mercy of adult care home staff. There are too many opportunities and too many reasons for a provider to overlook or even cover up problems that could harm a facility's reputation. That doesn't mean it always happens in every facility, but in the cases where it does happen, the health and safety of residents depend on an independent investigation by state government.

In light of the level of dissatisfaction with the results of the complaint program, it seems obvious that KDHE needs to do more, rather than less, to respond to the complaints it receives. Delegating responsibility for many of their investigations is exactly the opposite of what they need to be doing.

We ask you to support this bill which clarifies that KDHE and SRS are responsible for conducting independent investigations of adult care complaints in facilities they license. We also ask you to support funding for enough staff to conduct the investigations.

Thank you. I will be happy to respond to questions.