SUNRISE ANALYSIS OF A PROPOSAL TO REGULATE HOME CARE SERVICES

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by the

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Introduction

In 1984, the Legislature amended the Hawaii Regulatory Reform Act, or the "Sunset Law," by incorporating a "sunrise" provision requiring the Legislative Auditor to analyze proposed legislation that seeks to impose licensing or other regulatory controls on unregulated occupations.

The Legislative Auditor is required to assess the probable effects of the proposed measure and to determine whether its enactment would be consistent with state regulatory policies in the Sunset Law. These policies establish criteria for regulation such as the following:

- Regulation is warranted only where reasonably necessary to protect the health, safety, and welfare of consumers.
- Evidence of abuse shall be awarded great weight in determining whether regulation is desirable.
- Regulation shall not be imposed except to protect relatively large numbers of consumers who may be at a disadvantage in choosing the provider of the services.
- Regulation should not unreasonably restrict entry into the occupation by qualified persons.
- The purpose of regulation is to protect the consumer and not the regulated occupation.

During the 1986 legislative session, House Bill No. 1804 relating to home care services was introduced. (If the bill is reintroduced in the 1987 session, it will very likely have a different bill number.) The bill would regulate paraprofessionals providing home care services under a Board of Home Care Services and it would license home care services agencies under the Department of Health (DOH).

This analysis contains some background information on the home care industry, an examination of the need to regulate the delivery of home care services, and an assessment of the proposed legislation.

Background Information

A major impetus behind this bill is concern about the health, safety, and welfare of frail elderly persons receiving home care services. In the United States, the number of persons over the age of 64 is expected to double by the year 2020.[1] In Hawaii, the number of elderly persons is expected to increase somewhat faster than the national average. The demand for home care services is expected to grow rapidly as the population ages since elderly persons need more assistance to carry out normal activities of daily living such as bathing, dressing, grooming, and housekeeping.

The demand for home care services is constrained by the availability of only limited insurance coverage for this level of care. Under the current system, most insurance plans pay for a limited amount of home care provided under the direction

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1. U.S., Congress, House, Select Committee on Aging, *The "Black Box" of Home Care Quality,* A report prepared by the American Bar Association, 99th Cong., 2d sess., August 1986, p. 1.

of a physician. When these benefits are exhausted, consumers must utilize their own resources to pay for care.

The need to provide home care services at a reasonable cost has resulted in the utilization of a wide variety of unlicensed paraprofessional workers, such as personal care attendants, who can deliver services more inexpensively than licensed health professionals. Since there are no uniform job descriptions or standards for the training and supervision of paraprofessional workers, some home care providers have expressed concern that these might pose a threat to the health, safety, and welfare of elderly and disabled consumers.

Types of services offered by the home care industry. The home care industry offers a wide array of services which assist individuals to function in the home environment when they are ill, disabled, or otherwise in need of support. These services range from highly skilled home nursing care to unskilled domestic care. There is little uniformity in the terminology used to describe home care services.

In this report, the term "home care" will be used generically to include all the different levels of service provided in the home. The term "home health care" refers to services provided under the direction of a licensed physician. The term "home nursing care" means services provided under the direction of a licensed nurse. And the term "supportive services" includes other services that may be provided without medical or nursing supervision.

Home health care includes skilled nursing and other therapeutic services delivered to patients under the direction of a licensed physician. Home health care is provided by licensed health professionals and by unlicensed paraprofessionals who work under the supervision of a licensed health professional. Home health services

are usually covered by health insurance plans. In addition, most states license home health agencies.

Home nursing care includes nursing services provided by licensed nurses and unlicensed paraprofessionals working under their supervision. Home nursing care is distinguished from home health care because only one type of therapeutic service (nursing) is offered and because medical direction is not required. Home nursing care is covered by health insurance when it is ordered by a physician. Otherwise, consumers must pay for their nursing care directly. State laws governing the practice of nursing regulate this level of care.

Supportive services include personal and domestic services which assist individuals to carry out normal activities of daily living such as bathing, dressing, toilet assistance, and housekeeping. Most of this type of care is provided by relatives and friends. It is also provided by unlicensed paraprofessionals who are employed by home care agencies or hired directly by consumers. Supportive services are rarely covered by health insurance, and they are not regulated.

Unlicensed paraprofessional workers are given a variety of titles which reflect the level of care that is provided. Paraprofessionals working for home health agencies are usually called "home health aides" or "homemaker–home health aides," while those working for home nursing agencies are called "nurse's aides" or "nursing assistants." Paraprofessionals who do not necessarily work under medical or nursing supervision are called "personal care aides," "homemakers," "chore workers," "companions," or other similar titles. All these workers provide some personal and domestic care. However, home health aides and nurse's aides usually provide additional health care services which are delegated and supervised by a licensed physician or nurse.

In Hawaii, DOH licenses public and private home health agencies that provide skilled nursing and one other therapeutic service under the direction of a physician. In 1986, there were 15 licensed home health agencies.[2] There were also a number of other unlicensed home nursing and community-based organizations. It is estimated that between 400 and 500 paraprofessional workers were employed by Hawaii home care providers in 1985.[3]

History. The home care industry was established in the nineteenth century when public health nursing programs and private nonprofit "visiting nurse associations" began to deliver nursing care to patients at home. During the 1950s, these home nursing agencies augmented their services with paraprofessional workers who provided basic nursing, personal, and domestic care.

In 1960, the National Health Council sponsored a conference to discuss guidelines for the delivery of personal care by paraprofessional workers. This conference resulted in guidelines for the training and supervision of "homemakers" who care for ill and disabled persons.[4] Two years later, the National HomeCaring

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2. Hawaii, Department of Health, "Home Health Care Agency," Honolulu, September 1986.

3. Testimony on House Bill No. 1804 submitted by Franklin Sunn, Director, Department of Social Services and Housing, to the Honorable Reynaldo Graulty, Chairman, House Committee on Human Services, and the Honorable Robert Bunda, Chairman, House Committee on Health, January 28, 1986, p. 1.

4. U.S., Department of Health and Human Services, Bureau of Community Health Services, *A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide,* DHHS Pub. No. (HSA) 80-5508, Rockville, Md., Public Health Service, 1980, p. 55.

Council (formerly the National Council for Homemaker Services) was established to promote the development of homemaker services and set standards for the field.[5]

Until 1965, most home care services were provided by home nursing agencies. Since 1965, the home care industry has changed dramatically due to a variety of federal initiatives. Today, home nursing agencies constitute only a small segment of the home care industry, and home *health* agencies are the major providers of home care services.

Impact of federal funds. Between 1965 and 1975, a number of federal programs were established which spurred rapid growth in the home care industry. These programs provided health insurance to elderly, disabled, and low-income persons. They also provided funding for the development of community-based services targeted at low-income and elderly persons.

In 1965, the Medicare program was established to provide health insurance to elderly and disabled persons. Medicare covered a variety of medical services, including home health care. In order to qualify for home health benefits, Medicare recipients had to meet certain requirements such as being hospitalized prior to entering a home health program. They also had to be sick enough to require skilled nursing care on a part-time or intermittent basis. Medicare did not cover supportive services unless they were related to a medical need. In 1983, Medicare home health expenditures totaled $1.5 billion.[6]

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5. *Ibid.*

6. U.S., Comptroller General, *Constraining National Health Care Expenditures: Achieving Quality Care At An Affordable Cost,* GAO/HRD-85-105, Washington, D.C., U.S. General Accounting Office, September 30, 1985, p. 135.

Also in 1965, the Medicaid program was established to provide federal matching funds for state medical assistance programs which insured low-income families and individuals. Participating states were required to cover home health services, and they were authorized to cover a number of supportive services such as personal care. In 1983, federal and state expenditures for Medicaid home health care totaled nearly $600 million.[7]

In 1974, Congress amended the Social Security Act to provide funding for the delivery of social services to income-eligible persons. Homemaker-home health aides and personal care services were included under this initiative, which is now known as the "Social Services Block Grant Program." In 1980, federal and state expenditures for community-based long-term care (including home care) were estimated at $1.2 billion.[8]

In 1975, Congress also amended the Older Americans Act to designate home care as a priority area for state and local action. Federal funding for community-based programs, including some home care services, was provided to state and local agencies on aging. In 1980, approximately $724 million was provided for all community-based programs.[9]

Recent developments. During the past five years, federal concerns about the high cost of health care and congressional actions to reduce the budget deficit have prompted a number of changes in the Medicare, Medicaid, block grant, and

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7. *Ibid.*, p. 209.

8. U.S., Congress, House, Select Committee on Aging, *The "Black Box" of Home Care Quality*, p. 19.

9. *Ibid.*, p. 20.

Older Americans Act programs. These reforms introduced competition into the home care marketplace and have forced all providers to develop more cost-effective ways of delivering care. They have also spurred rapid growth by removing barriers to the utilization of home care services by some elderly and disabled persons. Private health insurers have also become more willing to pay for home health services in lieu of more expensive hospital care.

Increased competition. Competition has been introduced by new Medicare policies which encourage the delivery of care by proprietary (investor-owned) home health agencies. Until recently, most home health services were delivered by private, nonprofit organizations. Today, proprietary agencies are the largest single form of home health care providers.

Competition has also been stimulated by new Medicare policies which encourage the delivery of home health care by hospitals. In 1983, Medicare established a prospective payment system for hospital services in an effort to control rising hospital costs. Under this system, Medicare no longer reimburses hospitals for any reasonable cost of care. Instead, it pays hospitals a fixed price for treating each admission in 470 separate diagnostic related groups of patients. This new payment system has forced hospitals to release, earlier than previously, elderly and disabled patients into the community. In an effort to provide continuity of care and retain business, hospitals have begun to establish their own home health care programs.

Medicaid policies have been revised to authorize states to enter into competitive bidding arrangements for the purchase of services and to reduce consumers' freedom to select health care providers. Medicaid has also reduced some home health benefits and authorized states to substitute inexpensive

homemaker services for more expensive home health services. Funding for community-based services under the block grant and Older Americans Act programs has also been cut. All these changes are forcing home care agencies to develop more cost-effective ways of delivering services.

Rapid growth. In an effort to reduce the high cost of hospital and nursing home care, Medicare and Medicaid policies relating to home care services have been liberalized. These changes have spurred rapid growth in the home care industry.

Medicare has eliminated requirements that beneficiaries be hospitalized prior to entering a home health program and reduced requirements that some beneficiaries share in the cost of home health care. It has also begun to cover new "high-tech" home health services such as new methods of feeding and chemotherapy.

The Secretary of Health and Human Services has been authorized to waive certain Medicaid requirements so that states can offer supportive services to recipients who would otherwise require nursing home care. This waiver program has spurred the development of personal care programs targeted at elderly and disabled persons.

Another factor contributing to recent growth in the home care industry has been an increasing willingness on the part of private insurers to pay for home health care. In 1976, only 5 percent of the largest insurers covered home health services. By 1986, more than 80 percent covered these services. Although coverage has increased, it is estimated that private insurers pay for only 10 percent of the national home care bill.[10]

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10. "Staying Home and Feeling Better," *Newsweek*, July 7, 1986, p. 49.

Professional organizations. There are three major professional organizations in the home care field. The National Association for Home Care represents the interests of home care organizations. The National League for Nursing represents the interests of traditional home nursing agencies. And the National HomeCaring Council represents the interests of homemaker–home health aide services. All three organizations conduct educational programs for member agencies and lobby for their interests.

National standards. ***Home care agencies.*** Several public and private programs have established national standards for the certification or accreditation of home care agencies.

Medicare has established minimum standards for the certification of home health agencies. These standards require agencies to provide skilled nursing and one other therapeutic service under the direction of a physician. There are extensive requirements for program operation, including standards for the training and supervision of home health aides. Most home health agencies seek Medicare certification because it enables them to receive reimbursement for services delivered to elderly and disabled patients. In 1986, more than 6000 agencies were Medicare–certified.[11]

The Joint Commission on Accreditation of Hospitals (JCAH) has recently established an accreditation program for hospital–based home health programs which is based on Medicare standards. However, the JCAH program includes more stringent standards including stricter requirements for the training and supervision

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11. National Association for Home Care, "Home Care Fact Sheet," Washington, D.C., April 1986, p. 2.

of personnel. Hospital-based home health programs must conform with JCAH standards. In 1986, approximately 1000 programs were accredited by JCAH.[12] In the near future, the commission also plans to accredit home health agencies which are not affiliated with a hospital.

The National League for Nursing accredits home nursing programs in 30 states.[13] The league's accreditation standards are currently being revised to conform with Medicare certification requirements for home health agencies.

The National HomeCaring Council accredits homemaker-home health aide services in 33 states.[14] The council's accreditation standards cover various aspects of program operation including staffing arrangements.

Home care paraprofessionals. The only nationally recognized paraprofessional occupations are "homemaker-home health aides" and "nurse's aides." Both occupations are entry-level allied health occupations which complement and supplement the work of independent practitioners such as physicians and nurses. The National HomeCaring Council has issued a model curriculum for the training of homemaker-home health aides. However, the council does not certify individuals who have completed training programs based on this curriculum. There are no comparable national standards for the education and training of nurse's aides.

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12. U.S., Congress, House, Select Committee on Aging, *The "Black Box" of Home Care Quality*, p. 33.

13. National League for Nursing, "NLN Accredited Agencies," New York, November 1986.

14. National HomeCaring Council, *Directory of Homemaker-Home Health Aide Services*, New York, June 1985.

State regulation of home care services. No state requires home care paraprofessionals to be licensed or statutorily certified. However, many states have established minimum standards for the training and supervision of homemaker–home health aides and/or nurse's aides. These standards are enforced through state administrative rules or policies.

Thirty–six states and the District of Columbia require home health agencies to be licensed. Most states define a home health agency as one that provides skilled nursing *and* other therapeutic services. However, a few states define home health agencies more broadly to include the provision of only one therapeutic service. Under this broader definition, home nursing agencies must be licensed.

In addition to these licensing programs, Connecticut licenses homemaker–home health aide services and Massachusetts licenses homemaker services.

Regulation of home care services in Hawaii. In Hawaii, Section 321–11(10), HRS, authorizes DOH to license home health agencies. The department has adopted rules which require all public and private home health agencies to be licensed. The rules define a home health agency as follows:

> "A public or proprietary agency, a private nonprofit organization, or a subdivision of such agency or organization which is primarily engaged in providing direct or indirect skilled nursing services and other therapeutic services under a physician's direction to homebound patients on a part–time or intermittent basis (in a place used as the individual's home)."[15]

The rules require home health agencies to submit a "satisfactory" statement of agency policies, including the scope of services and conditions under which they will

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15. Section 11–97–1, Hawaii Administrative Rules.

be offered. These policies must meet current and acceptable standards of professional practice.

The rules also require home health aides to complete a community college training program for nurse's aides or its equivalent.[16] And they require home health aides to provide services in accordance with a physician's written order and treatment plan.

Legislative Proposal to

Regulate Home Care Services

The stated purpose of House Bill No. 1804 is to protect the health and welfare of individuals who receive home care services from unlicensed paraprofessional workers, chore workers, and agencies. In particular, the bill is designed to extend government protection to recipients who are "susceptible to physical and mental harm or abuse of physical assets because of their deteriorated conditions and impaired ability to think and act independently." The bill was prepared by a group of public and private home care providers who were especially concerned about the vulnerability of frail elderly persons.

The bill seeks to provide public protection in three ways: (1) by regulating paraprofessional workers through a Board of Home Care Services, (2) by regulating home care agencies through DOH, and (3) by requiring the Department of Social Services and Housing (DSSH) to conduct criminal history checks on homemakers employed by the department.

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16. The Kapiolani Community College training program is an eight-week course that prepares students to perform basic nursing skills and therapeutic nursing care under the direction of a licensed physician or nurse.

Board of Home Care Services. House Bill No. 1804 would establish an independent board to license home care paraprofessionals (home health aides and personal care aides) and register chore workers. The board would be composed of home care paraprofessionals, health care professionals with experience in home care, and public members. The members would be appointed by the Governor and confirmed by the Senate. They would serve without pay but be reimbursed for their expenses. The board would be placed in the Department of Commerce and Consumer Affairs (DCCA) for administrative purposes only.

The board would be authorized to issue, suspend, revoke, and renew licenses for home care paraprofessionals. It would also be authorized to define the services and duties of licensees, set licensing standards, determine which health professionals are exempt from licensing requirements, conduct criminal history record checks, set fees, and adopt rules. It would be required to register chore workers on a voluntary basis, maintain a registry of licensed home care paraprofessionals and registered chore workers, and conduct a public information campaign to encourage consumers to use the registry.

Home care paraprofessionals. ***Scope of practice.*** Home care paraprofessionals would provide home health aide and personal care services. Home health aide services are defined as:

> "Simple nursing tasks, personal hygiene services, and housekeeping tasks essential to the recipient's health and other related supportive services."

Personal care services are defined as assistance with:

> "Bathing, dressing, feeding, performance of toilet and personal hygiene functions, taking medications which are ordinarily self-administered, and mobility and transfer activities and other household tasks which are related to a medical need."

Home health aides would be authorized to deliver home health aide and personal care services. *Personal care aides* would only be authorized to deliver personal care services.

It would be unlawful for anyone to deliver home health aide or personal care services without a license except for the following persons:

- registered nurses, licensed practical nurses, and other licensed, certified, or registered professionals exempted by the board;
- nurse's aides or other persons who perform simple nursing tasks in a hospital or nursing home;
- operators of licensed adult residential care homes;
- families who care for adults in federally–authorized foster homes;
- public agency employees;
- persons who care for relatives; and
- persons who only provide homemaker or chore services.

It would also be unlawful for unlicensed persons to call themselves a licensed home care paraprofessional, licensed home health aide, or licensed personal care aide.

Licensing standards. In order to qualify for a paraprofessional license, applicants would be required to demonstrate competency in the English language and an ability to make an informed judgment through normal observation of a patient's condition. They would also be required to submit to a criminal history record check and meet other requirements set by the board.

Chore workers. Chore workers are defined as individuals who provide essential housekeeping and related services in the home for persons who are physically disabled, mentally disabled, or facing a crisis. Chore services would

include such activities as assisting with bathing, dressing, and grooming; marketing and shopping; and simple home repairs.

Chore workers would be permitted to apply to the board for registration on a voluntary basis. They would be required to submit to a criminal history record check in order to qualify for registration.

Unregistered persons who use the title "registered chore worker," or who imply that they are registered, would be guilty of a misdemeanor.

Home care services agencies. House Bill No. 1804 would repeal DOH's current authority to license home *health* agencies under Section 321-11(10). It would establish a new statute authorizing the department to issue, suspend, revoke, and renew licenses for the broader area of "home *care services* agencies." The department would also be authorized to set fees, adopt rules, and maintain a registry of licensed home care services agencies.

Scope of regulation. Home care services agencies would include: (1) any licensed paraprofessional who provides home health aide or personal care services as an independent contractor; and (2) any corporation, partnership, or sole proprietorship which provides home health aide services, personal care services, or home health services.

Home health services would include any one of the following: part-time or intermittent nursing care; physical therapy; occupational therapy; speech pathology and audiology services; home health aide services; and medical supplies, equipment, or appliances.

It would be unlawful for anyone to operate a home care services agency without a license, except for state and county agencies which must comply with "equivalent" standards established by DOH.

Licensing standards. The Department of Health would be required to establish minimum standards for the operation of home care services agencies, including:

- supervisory requirements for personnel providing home health aide and personal care services;
- a code of ethics for the delivery of care and handling of personal assets;
- requirements for liability insurance and bonding;
- requirements for recordkeeping and reporting, including a system for receiving and reviewing complaints; and
- a provision stating that home health aide and personal care services may only be provided by licensed home care paraprofessionals or persons licensed, certified, or registered by the State in a profession with a higher level of skills.

Any standards established for agencies providing home health services must enable these agencies to receive reimbursement under the Medicare and Medicaid programs. The Department of Health would be prohibited from establishing standards relating to agency service charges or insurance and bonding requirements for chore workers.

In order to qualify for a license, the principals of an agency (e.g., directors, officers, partners, proprietors, and contractors) would be required to submit to a criminal history record check conducted by the department. In addition, applicants would have to comply with the department's operational standards and pay a fee.

Enforcement. The department would be authorized to periodically monitor home care services agencies and investigate complaints. It would be a misdemeanor to violate the statute or rules.

Homemakers. Homemakers employed by DSSH would be required to submit to a criminal history record check as soon as possible after employment and once every two years. The Department of Social Services and Housing would be authorized to terminate homemakers if their criminal record indicates that they might pose a risk to the health, safety, or well-being of persons receiving their assistance.

Summary of testimony. Hearings were held on House Bill No. 1804 during the 1986 legislative session. Support for the bill was expressed by several public and private home care providers and one consumer. These individuals were concerned about the potential for physical, mental, and financial abuse of home care recipients. Some supporters testified that although there is little evidence of abuse, they wanted to prevent a potentially harmful situation from arising in the future.

Supporters testified that the bill would reduce health care costs by preventing overutilization of home care services and premature institutionalization of patients. They also stated that regulation would increase the likelihood that paraprofessional workers would pay taxes on their earnings.

One supporter testified that the bill would help to alleviate the current shortage of qualified home care paraprofessionals by making the occupation a more attractive opportunity to enter the health care field.

Opponents of the bill testified that it attempted to correct a problem that does not exist. They also stated that it would add an unnecessary and expensive layer of regulation to the present health care system and aggravate the current shortage of paraprofessional workers.

One opponent testified that the bill would affect all consumers rather than just those who are mentally incompetent and in need of supervision. This would take

away the consumer's right to select a personal caregiver by imposing external controls over entry into the occupation.

The bill was opposed by DOH which recommended that a better approach would be to simply amend home health agency licensing rules to "bring about desired changes in paraprofessional training and supervision."[17]

Analysis of the Proposed Legislation

Summary of findings. Our analysis of House Bill No. 1804 is based on criteria in the Sunset Law. We find that there is no need to restructure the current Department of Health licensing program for home health agencies or to regulate home care paraprofessionals.

In summary, our findings are:

1. There is little evidence that consumers have been harmed by the delivery of home care services.

2. Consumers of home health and home nursing care are adequately protected by a variety of laws and legal doctrines governing the delivery of *therapeutic services.* It is neither desirable nor feasible to regulate the delivery of *supportive services.*

3. Licensing of home care paraprofessionals would have numerous adverse consequences such as increasing the cost of health care, reducing providers' flexibility to utilize personnel in a cost-effective manner, restricting entry into the occupations by qualified persons, and limiting consumer choices.

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17. Testimony on House Bill No. 1804 submitted by Leslie Matsubara, Director, Department of Health, to the Honorable Robert Bunda, Chairman, House Committee on Health, January 28, 1986.

4. Voluntary criminal history record checks for chore workers would serve no useful purpose, and the Department of Social Services and Housing is already empowered to conduct record checks on homemaker employees.

5. There may be a need to amend the nursing practice act to specifically authorize unlicensed persons to practice under the direction and supervision of a licensed nurse.

6. The current Department of Health licensing program for home health agencies can be improved in a number of areas to increase its effectiveness and responsiveness.

7. There are numerous deficiencies in the proposed legislation.

Potential for harm. There is little evidence that consumers have been harmed by the delivery of home care services. A recent study of the home care industry by the American Bar Association noted that the home care industry has been relatively free of patient horror stories and found that neglect and abuse are not rampant in the home care field.[18] Federal investigations of the home care industry have also failed to uncover fraud and abuse by home care paraprofessionals.

There have been anecdotal reports about licensed and unlicensed home care workers neglecting patients or absconding with patient assets. However, these reports have been sporadic, and they have not provided details about the level of service provided (e.g., whether care was provided by a home health aide, chore worker, or companion) and the conditions of employment (e.g., whether the worker was employed by a licensed home health agency, a community organization, or the

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18. U.S., Congress, House, Select Committee on Aging, *The "Black Box" of Home Care Quality*, pp. 3 and 36.

consumer). Therefore, they are difficult to evaluate in the context of the present licensing proposal.

Home health and home nursing services. There is no need to increase regulation of home health and home nursing agencies, or to require licensing of home health aides, since a variety of laws and legal doctrines governing the delivery of therapeutic services adequately protect consumers from harm.

Professional practice acts. The delivery of therapeutic services is regulated by state laws governing the practice of medicine, nursing, and other health occupations. These laws require independent practitioners to be licensed in order to practice in any setting, including the home. They also prohibit practice by unlicensed paraprofessionals unless they are directed and supervised by a licensed health professional. The unlicensed and unsupervised practice of a regulated occupation may result in disciplinary action by state licensing boards.

Home health services are provided under the direction of a licensed physician, and home nursing services are provided under the direction of a licensed nurse. Paraprofessionals working for either type of agency are adequately supervised, and there is no evidence that they have harmed consumers.

Doctrine of respondeat superior. Home health and home nursing agencies are generally liable for the actions of their employees under the doctrine of *respondeat superior.* This doctrine holds that an employer is responsible for all damages caused by an employee if it can be demonstrated that the employee acted within the scope of employment, that the employee was negligent, and that this negligence was the proximate cause of injury. In order to protect themselves from lawsuits arising out of the negligent actions of employees, home health and home

nursing agencies must establish standards for the selection, training, and supervision of employees which ensure safe and competent practice.

Additional protection for home health consumers. As noted earlier, DOH currently licenses home health agencies that provide skilled nursing and one other therapeutic service. No complaints have been filed against Hawaii home health agencies in the past five years.

Medicare standards for the operation of participating home health agencies also protect elderly and disabled patients. In addition to requiring medical direction and nursing supervision, the standards address the scope of practice, training, and supervision of home health aides. They also specify the conditions under which agencies may contract with other organizations supplying personnel. Home health agencies must comply with these standards in order to receive reimbursement from the Medicare program.

The Joint Commission on Accreditation of Hospitals has also established standards for the delivery of hospital-based home health care by licensed health professionals, unlicensed paraprofessionals, and volunteers. These standards provide an additional level of protection to many consumers.

Supportive services. It is estimated that more than 5 million Americans need help with normal activities of daily living such as bathing, dressing, grooming, toilet assistance, and housekeeping.[19] Most of this personal and domestic care is provided by family members. Some care is provided by paraprofessionals working

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19. National Center for Health Statistics, Barbara Feller, "Americans Needing Home Care, United States," *Vital and Health Statistics,* Series 10, No. 153, DHHS Pub. No. (PHS) 86-1581, Public Health Service, Washington, D.C., U.S. Government Printing Office, March 1986, p. 2.

for home care agencies and by independent workers hired directly by the consumer. Many consumers receiving supportive services are elderly or disabled, and the need for these services increases with age. Most supportive services are paid for by consumers since health insurance plans do not cover this level of care.

Personal care. There have been anecdotal reports about abuse and neglect of frail elderly persons receiving personal care. However, most elderly abuse and neglect are caused by relatives who are under stress due to the burdens of caregiving. These incidents are often *reported* by home care workers rather than *caused* by them. The bill would not protect the vast majority of elderly persons who are at risk because it would not regulate care provided by relatives. It might also limit the reporting of abuse and neglect by restricting the supply of home care workers.

Providers who support House Bill No. 1804 want to protect frail elderly and disabled persons who are unable to make rational decisions due to physical and mental deterioration. They state that these consumers are vulnerable to abuse and neglect because they are often unwilling or unable to complain about their care. However, consumers who have diminished mental capacity need more protection than a licensing program can provide. This would include protection by relatives and friends who assume responsibility for their care or, in extreme cases, protection by the courts through guardianship and other protective service arrangements.

The bill would also provide a blanket solution covering *all* personal care arrangements rather than a limited solution covering only consumers who are unable to make rational decisions. It would require licensing of friends, neighbors, and volunteers as well as workers deployed by home care agencies. This would restrict

the availability of personal care services and diminish consumers' ability to live independently and make their own decisions.

The bill would also "professionalize" the delivery of personal care services by imposing external standards on the delivery of care. A recent federal report on home health care fraud and abuse discusses the drawbacks of certification and credentialing proposals:

> "Increasing professionalization may limit the utility of the services provided. For example, many individuals are reluctant to accept the help of unknown professionals for such personal needs as bathing and dressing. Members of particular racial and ethnic communities may be uncomfortable with agency personnel who are unaware of the clients' religious beliefs and cultural habits. Moreover, language barriers may prevent individuals from effectively communicating with agency personnel concerning the client's particular needs."[20]

The report recommends that a better approach would be to encourage the development of agencies with strong community ties whose personnel would be more likely to share the cultural norms and traditions of clients. Under this approach, elderly and disabled consumers would be more willing to seek help when they need personal care.

There are alternative approaches which can be taken to protect vulnerable populations. One such approach would be to amend Section 349-12, HRS, to authorize the Executive Office on Aging to represent the interests of home care consumers. Another approach would be to amend Chapter 349C, HRS, to require the reporting of abuse or neglect of *any* adult, rather than just adults who are over the age of 64. A third approach would be to develop administrative agreements for

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20. U.S., Congress, Senate, Committee on Governmental Affairs, *Home Health Care Fraud and Abuse,* 97th Cong., 1st sess., October 14, 1981, pp. 52-53.

the sharing of information on abuse or neglect of home care consumers between agencies receiving complaints (e.g., the Executive Office on Aging and DSSH) and DOH.

Domestic care. House Bill No. 1804 defines "chore workers" as persons who provide "essential" housekeeping and related services in the home for persons who are physically disabled, mentally disabled, or facing a crisis. The bill would authorize the voluntary registration of chore workers who pass criminal history record checks.

This provision is not necessary because there is no evidence that home care consumers are at any greater risk than other consumers. The provision would not serve any useful purpose since individuals with criminal backgrounds would not apply for registration. And it would not be feasible to require all chore workers to pass criminal history record checks since consumers would very likely simply ignore this requirement and make their own arrangements.

The bill would also require DSSH to conduct criminal history record checks on homemaker employees. The department reports that this provision is not necessary since it already conducts background checks on these employees.

Adverse consequences of licensing home care paraprofessionals. Supporters of House Bill No. 1804 testified that licensing will reduce the cost of health care and increase the supply of home care paraprofessionals. These assumptions are incorrect. Licensing *increases* the cost of health care by restricting the supply of health workers. This is of particular concern in the home care field since there is already a shortage of home health aides and personal care workers.

Licensing would reduce the number of paraprofessional workers by increasing standards for entry into the field. It would reduce providers' flexibility to employ

the most qualified workers in a cost-effective manner by prohibiting the hiring of unlicensed workers. And as noted above, it would limit the availability of personal care workers who are sensitive to the cultural habits and religious beliefs of consumers.

None of the national programs which accredit or certify home care programs require home health aides or personal care workers to be licensed. The fact that no other state licenses these workers is a compelling factor against establishing a licensing program since it would reduce geographic mobility for qualified workers.

The federal government has recently loosened requirements that health care personnel be licensed in order to receive reimbursement for their services. In 1982, the U.S. Office of Management and Budget issued a policy stating that the federal government will rely on *voluntary* standards for credentialing health manpower whenever feasible and consistent with the law.[21]

In 1984, the Associate Executive Director of the National Association for Health Certifying Agencies summarized the current trend away from support for state regulation of health occupations as follows:

> "The Commission is inclined to be skeptical about the value of state regulation of health professions. State, or federal, regulation is seen as generally serving the interests of the regulated profession more than the interests of the public. It is also regarded as expensive, inhibitive of mobility, and subjective as a result of political influence."[22]

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21. Sybil Goldman and W. David Helms, *The Regulation of the Health Professions*, Bethesda, Md., Alpha Center, October 1983, p. 18.

22. Neil Weisfeld, "The National Commission for Health Certifying Agencies: An Introduction," *Health Policy*, Volume 4, 1984, p. 70.

Licensing would also be difficult to implement because there is no distinctive scope of practice for home health aides or personal care workers. The scope of practice for home health aides overlaps with that of registered nurses and licensed practical nurses, and the scope of practice for personal care workers overlaps with that of home health aides. Both scope of practice definitions also include activities which may be carried out by unlicensed persons such as chore workers and family members.

Scope of practice definitions are difficult to change once they have been enacted. They must be carefully worded in order to avoid restricting the growth of regulated occupations. This is of particular concern for the personal care field which is new and evolving. Premature categorization of the scope of practice for this evolving field could thwart its development.

Licensing costs may be restrictive. Home health aides and personal care workers would be licensed by DCCA. Act 92, SLH 1980, requires the Director of DCCA to maintain a reasonable relationship between licensing fees and the cost or value of services rendered. These costs include the operational costs of a board and apportioned costs for DCCA staff services, including its Regulated Industries Complaints Office, hearings office, administrative services, and the director's office, central services, and apportioned costs of the Department of the Attorney General.

Licensing fees are generally higher for regulatory programs with fewer licensees. Applicants in some of the smaller regulatory programs pay as much as $100 for the application fee, $100 for the examination fee, another $100 for the original license fee, and $150 for the biennial license renewal. These expenses may

be prohibitive for home health aides and personal care workers who are paid at or near the minimum wage level.

Other concerns expressed by home care providers. House Bill No. 1804 is somewhat unique in that it was drafted by a group of agency representatives rather than members of the occupations which will be regulated. Some home care providers have expressed concerns which have a bearing on the current licensing proposal. *First,* they are concerned that the nursing practice act does not specifically authorize unlicensed persons to provide "basic nursing services" or "administer medications" under the direction and supervision of a licensed nurse. *Second,* they are concerned that DOH's current regulation of home health agencies is inadequate.

Delegation of nursing tasks. There are concerns about the extent to which unlicensed personnel can practice nursing under the direction and supervision of a licensed nurse. Some home care providers are concerned about potential liability if they delegate nursing tasks to unlicensed personnel since the nursing practice act does not specifically authorize this activity. Some providers are also concerned that the nursing practice act does not specifically permit unlicensed personnel to "administer medications" to patients.

These concerns are not universal, and many providers feel comfortable operating within the current statutory framework. One point for consideration is that the medical practice act permits practice by unlicensed persons who are trained to perform only a very limited number of diagnostic or therapeutic procedures under the direction of a physician. This could be interpreted to cover paraprofessionals working for licensed home health agencies. Another point is that community standards have been established which support the delivery of nursing

care by unlicensed persons working under the direction and supervision of licensed nurses. These standards adequately protect consumers.

If the Legislature wants to clarify the circumstances under which unlicensed persons can practice nursing, it might consider amending the nursing practice act to specifically permit unlicensed persons to practice nursing under the direction and supervision of a licensed nurse. This is the approach taken by most states.

Inadequacies in the home health care licensing program. The Department of Health's regulation of home health care can be improved, particularly in the areas of training standards, coverage of home health care agencies, and enforcement. However, it is not necessary to repeal Section 321-11(10) and establish an entirely new licensing statute since changes can be made to the current licensing program by the more expedient route of amending DOH regulations.

Training standards. Some home care providers have expressed concern about the adequacy of DOH's current standards for the training of home care paraprofessionals. The department reports that it is developing a uniform training curriculum for persons acting in the capacity of nursing assistants (whatever their title). It will amend licensing regulations relating to home health care and other programs (e.g., adult residential care homes) when the new training standards are validated.

The department is also exploring the feasibility of requiring a certification examination for individuals who have completed approved training programs. It believes that this approach will have several advantages over individual licensing of home care paraprofessionals, including the establishment of a single group of persons who are qualified to work under supervision in a number of settings (not just

home health care). The department's plan is reasonable, and it should respond to provider concerns when fully implemented.

Ambiguous language. The department's definition of a "home health agency" permits agencies which are not "primarily" engaged in the delivery of skilled nursing and other therapeutic services to operate without a license. The use of the word "primarily" is ambiguous, and providers seeking to evade licensing could argue that they are not "primarily" engaged in these activities. It would be up to the department to prove otherwise in expensive legal proceedings. Since there is no reason to exempt any agency which provides home health services, DOH should consider amending its regulations to remove the ambiguous term.

Some providers have criticized the unlicensed operation of home nursing agencies whose employees provide skilled nursing *and* home health aide services. They state that these agencies should be licensed under current DOH regulations since they provide skilled nursing *and* one other therapeutic service (e.g., home health aide services). They are concerned that the agencies are not required to conform with DOH standards for the training and supervision of home health aides, and therefore consumer health and safety may be jeopardized.

The department's regulations define "home health aides" as persons who have completed a community college training course for "nurse's aides" or its equivalent. There is ambiguity in this definition since the titles "home health aide" and "nurse's aide" are interchangeable. The department should consider clarifying its regulations to remove this ambiguity.

Lack of policies relating to enforcement. When we asked DOH how it would respond to complaints filed against licensed and unlicensed home health agencies, the department responded that it would be difficult to conduct any investigation

without the cooperation of consumers. The department also stated that it would be difficult to enforce current licensing regulations since the statutes and regulations are deficient.

The Department of the Attorney General stated that Chapter 321 contains several provisions relating to the enforcement of DOH regulations. However, since there have been no complaints relating to home health agencies, the effectiveness of current statutes and regulations has not been tested.

In order to respond effectively to any future complaints filed against home health agencies, DOH should consult with the attorney general's office to identify and correct deficiencies in the statutes or regulations which might impede enforcement of the licensing program. It should also consider developing a protocol for the investigation and prosecution of home health cases to ensure fast and effective response to consumer complaints and unlicensed activity. In developing this protocol, the department should consult with the Regulated Industries Complaints Office in the Department of Commerce and Consumer Affairs which has had extensive experience in enforcing licensing statutes and prosecuting unlicensed activity cases.

Deficiencies in the proposed legislation. House Bill No. 1804 contains a number of deficiencies which would increase the costs of regulation and have other adverse impacts on the home care industry.

Organizational and operational problems. The bill would create a new independent board in DCCA to license home health aides and personal care workers. However, home health aides do not practice independently. Since they work under the direction and supervision of a licensed physician or nurse, it would be more reasonable and economical to regulate them through the Board of Medical

Examiners or the Board of Nursing. Personal care workers, who perform many of the same tasks as home health aides, should be regulated by the same board that licenses home health aides.

The bill would give the board the authority to set licensing fees. However, under Act 92, SLH 1980, this authority belongs with DCCA.

The bill also confuses the roles of the board and DOH in conducting criminal history record checks. And it does not synchronize the biennial renewal schedules for licenses and the criminal history record checks. This would greatly increase the costs of regulation.

Scope of regulation. ***Home health agencies.*** The bill would include companies that provide "medical supplies, equipment, or appliances suitable for use in the home" under the definition of a home health agency. These companies rarely provide direct patient services, and they are not currently regulated. It would be unreasonable to require them to be licensed by DOH.

Definitions used in the bill create a conflict. The bill would require all home health agencies to comply with Medicare and Medicaid standards. However, it would use a definition for home health agencies that is different from the federal definition. Under the bill, a home health agency would be defined as an agency that provides "any one" of a number of services. Medicare defines a home health agency as one that provides skilled nursing "and" other therapeutic services. Therefore, the bill would bring single-purpose agencies under regulation but prevent them from obtaining a license since they would not meet Medicare standards.

The bill would require licensed home health aides and personal care workers who practice independently to obtain a *separate* agency license. This would

impose an unreasonable financial burden on paraprofessionals who are paid at or near the minimum wage level.

The bill would also exempt public agencies (and home health aides and personal care workers employed by these agencies) from licensing requirements. However, public agencies are currently regulated, and there is no rational reason for this exemption.

Home care paraprofessionals. The bill would cover uncompensated personal and domestic care provided by friends and volunteers. This is a departure from the scope of regulation set by the nursing practice act which only covers compensated care.[23] The provision would restrict the availability of supportive services, cause numerous problems for community organizations, and be unenforceable. It would serve provider rather than consumer interests.

Licensing standards. The bill would require home health aides and personal care workers to demonstrate competency in the English language and an ability to make informed judgments through normal observation of a patient's condition. It would also require applicants to submit to a criminal history record check and meet other requirements set by the board.

These standards do not adequately delineate the competency requirements for home care paraprofessionals. For example, they do not state what level of English language competency would be required or set any standards for the education, training, and supervision of paraprofessionals. These kinds of requirements need to be set forth *before* any licensing statute is enacted.

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23. Section 457–1, HRS.

Enforcement program. The bill does not establish any grounds for disciplinary action against licensees, and it fails to establish intermediate sanctions for disciplinary action such as restrictions on practice (or agency operations). The bill also does not acknowledge the disciplinary provisions in Section 321–20 which relate to all DOH licensing programs.

Recommendations

We recommend the following:

1. House Bill No. 1804 should not be enacted. However, the Legislature might consider amending Chapter 457, Hawaii Revised Statutes, to specifically permit unlicensed persons to practice nursing under the direction and supervision of a licensed nurse.

2. The Department of Health should consider updating its home health agency regulations to remove ambiguous terms, and it should develop policies for the investigation and prosecution of consumer complaints and unlicensed activity cases.