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RECOMMENDATIONS FOR THE REGULATION OF HOME CARE PROVIDERS

**Report of the Home Care Advisory Task Force to the
Commissioner of Health**



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Minnesota Department of Health
March 15, 1989

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EXECUTIVE SUMMARY

The Minnesota Commissioner of Health convened the Home Care Advisory Task Force in July, 1988, to study the legislation regulating home care providers and recommend licensure standards. The Task Force consisted of 15 members representing providers and consumers, and residing in various parts of the state. Meetings were held monthly between July, 1988, and March, 1989.

The Task Force considered standards in nine subject areas and recommends:

1. That all home care providers be regulated under one of six classes of licensure that include comprehensive home care agencies, paraprofessional agencies, individual paraprofessionals, professional services providers, medical equipment vendors, and hospice programs. This recommendation excludes specific types of providers and defines services subject to licensure.

2. That all licensees, or designated administrative representatives, and employees that interact directly with the recipients of home care services, must complete an orientation program that includes applicable state regulations, the home care patient bill of rights, communicable disease control, and emergency procedures.

3. That health professionals regulated by the state be currently licensed or registered, and those not regulated meet nationally recognized standards.

4. That three categories of paraprofessionals, home health aide, homemaker, and home maintenance worker, be established with specific training and supervision requirements for each category; and the standards for each category be the same for individual providers and employees of licensees. Home health aides may provide specialized tasks, such as assistance with medications, under the direction and supervision of a registered nurse.

5. That hospice programs operate under specific requirements for quality assurance, record keeping, orientation, training, and care conferences, that are unique to hospice programming.

6. That no one be allowed to work in home care who has been convicted of a crime of physical violence, the illegal taking of money or property, or a crime directly related to the kinds of activities undertaken by home care providers or the types of persons likely to be served by home care providers, unless the person has not been convicted of a crime nor been incarcerated for at least two years following the conviction.

7. That the home care rules be enforced through correction orders, a system of discretionary fines, and license revocation.

8. That all home care providers, except individual paraprofessionals, be required to establish specific written policies and procedures related to the management and provision of home care services.

9. That the Department of Health establish an ongoing Home Care Task Force, a registration system for paraprofessionals, a survey mechanism that includes home visits and physician evaluations, and that the Department employ surveyors with home care experience.

TASK FORCE MEMBERSHIP

Pat Adams, Public Health Nursing Director, Dakota County Public Health Nursing Service; St. Paul.

Catherine Baudeck, Vice President and Administrator, Home Health Service of Hibbing; regional nurse consultant of the Veterans Administration; Hibbing.

Harold Berntsen, Volunteer, Minnesota Senior Federation and Metropolitan Senior Federation; St. Paul.

Cal Condon, (Chair) Waseca County Commissioner; State Community Health Services Advisory Committee; Waseca.

Eleanor Conrad, Registered nurse, retired; St. Cloud.

Phyllis King, Administrator, Arrowhead Health Care Center; Chairman of the Board of Arrowhead Alternative Services; Administrator of Arrowhead Health Care Center's home care program; Eveleth.

Karen Lamecker, Director of Rehabilitation Services and supervisor of physical therapists in home care service, Caroline Center; Apple Valley.

Lee Lewis, Director, Wilder Foundation's Alzheimers Family Care Center; Minneapolis.

Sherilyn Moe, Director of Community Services, Catholic Eldercare, Inc., which provides home care, day care and community education; Minneapolis.

Mary Peterson, Staff nurse, St. Joseph's Medical Center; Brainerd.

Lawrence Poston, President, Minnesota Medical Association; family practice, University of Minnesota Medical School; Minneapolis.

Lynette Rauscher, Director, Hospice Duluth; Consultant/surveyor, Joint Commission on Accreditation of Healthcare Organizations; Duluth.

Judith Schultz, Director, Lake Region Hospital Home Care Program; past Chair, Assembly of Home Health Nursing Agencies' Standards Committee; Chair-elect, Assembly of Home Health Nursing Agencies; Fergus Falls.

Mary Silvaroli-Daul, Early Beginnings, Inc.; member, American Occupational Therapy Association, Minnesota Occupational Therapy Association, and the Great Plains Organization for Perinatal Health Care; St. Paul (member, July through September, 1988).

Charlene Stenerson, Family Based Services Supervisor, Region VIII North Welfare Department; Marshall (member since October, 1988).

Susan Taylor, Executive Director, Senior Services and Home Care, Health One Corporation; member, American Association of Homes for the Aging, American Hospital Association, Governing Council on Aging and Long-term Care, and Advisory Council to Division of Ambulatory Care; Minneapolis.

INTRODUCTION

As a result of substantial growth in the home care industry and a recognition of the vulnerability of persons who require services in their residences, the Minnesota Legislature enacted a comprehensive law to license home care providers. The recommendations contained in this report are offered to help implement that legislation.

BACKGROUND

Historically, the care of individuals who needed medically related care or assistance with personal care was provided primarily in the home by family or friends. However, long-term care shifted to nursing homes because of advances in medical technology, changes in family lifestyles that made it impractical to care for family members at home, and the availability of payments from Medicare, Medicaid, and private insurance.

More recently, increasing numbers of individuals have sought to obtain both medical care and general health related assistance in their homes. Several factors account for this shift back to home care. The number of elderly and handicapped individuals who require medical and nursing services is increasing with the aging of the population; the cost of providing services in institutions has increased substantially; access to institutional services has become restricted in many instances by changes in Medicare and state policy intended to control costs; advances in medical technology have made it practical to provide many sophisticated services in a client's home that were previously only available in a hospital or long term care facility; and money for home care services has become increasingly available.

This return of care to the home has created new problems, because people who need home care often have complex needs, the required services are not always available from a single provider, and clients are often isolated from persons who might otherwise provide oversight and assistance. In addition, those in need of help may not know what assistance is available, what services are appropriate, and how to remedy problems encountered with providers. Physicians, no longer accustomed to providing services in their patients' homes, generally have not been involved in the provision of home care to the extent required to develop and implement the most appropriate plans of care.

HISTORY OF HOME CARE REGULATION IN MINNESOTA

Medicare established the first set of governmentally mandated standards for home health care agencies. When benefits for home health care became available through Medicare, Minnesota's health care industry expanded to meet the demand for the services, including skilled nursing and therapies. With benefits from Medicaid (Medical Assistance), and private health insurance, private and public agencies found it financially feasible to provide needed home care services to clients. The number of agencies certified by Medicare increased from 123 in 1983 to more than 200 in 1988.

As early as 1970, the Minnesota Legislature debated the regulation of home care providers. In 1983, the Commissioner of Health, Sr. Mary Madonna Ashton, appointed a Home Health Care Task Force to study home care, identify issues and problems, and recommend solutions that would provide some assurance of protection to consumers of home care services.

In 1984, the Task Force issued its report, Recommendations for the Improvement of Home Health Services in Minnesota. Three issues were addressed in the report: regulatory concerns, financial concerns, and system development. Although the Task Force recommended registration of home care providers, the Commissioner concluded that licensure would more effectively protect the consumer and achieve the goals of the Task Force's recommendations. The Commissioner agreed with the recommendations for a patients' bill of rights, complaint mechanism, and information system about home care providers and services.

The momentum for home care licensure grew in 1985. Consumer organizations and media reports focused attention on the vulnerability of home care consumers to abuse and generated substantial support for the regulation of home care services.

THE HOME CARE LAW

The 1987 Legislature enacted Laws of Minnesota, chapter 378 (Minnesota Statutes, sections 144A.43 to 144A.49) requiring licensure of home care and hospice providers (see appendix 1). The law requires that anyone who provides hospice services, or is regularly engaged in providing home care services in a residence for a fee to a person whose illness, disability, or physical condition creates a need for the service, must register with the Department of Health, and later must be licensed.

The law provides a range of substantive requirements and provides the Commissioner with the authorities necessary to regulate the industry, including:

- A bill of rights, established to secure 17 specified rights to consumers of home care.
- Authority for the Commissioner of Health to adopt licensure rules that meet specified criteria, and to enforce the statute and rules through inspections and imposition of sanctions.
- Licensing procedures and a list of providers exempt from licensure.
- A requirement that the rules not duplicate or conflict with other regulatory standards.
- Persons who have been convicted of crimes relating to home care services may not be licensed to provide home care and may not be employed by a provider, unless they satisfy criteria of rehabilitation; and the Commissioner is to adopt rules defining disqualifying crimes and rehabilitation criteria.
- Authority for the Commissioner to establish an information and referral system relating to home care.
- Licensure of hospice programs under specified requirements, and rulemaking authority.
- Lastly, temporary procedures for registering home care providers and hospices pending the adoption of licensure rules.

The recommendations of this report were formulated under the Commissioner's statutory mandate to include in the rules:

- a. provisions to assure, to the extent possible, the health, safety and well-being, and appropriate treatment of persons who receive home care services;
- b. requirements that home care providers furnish the commissioner with specified information...;
- c. standards of training of home care provider personnel...;
- d. standards of supervision ... of personnel...;
- e. requirements for the involvement of a consumer's physician...;
- f. the establishment of different classes of licenses...; and
- g. operating procedures required to implement the home care bill of rights.

The law also requires that the rules not duplicate or replace standards and requirements imposed by other regulatory programs, nor impose additional training requirements on regulated professions, unless necessary to prevent problems unique to home care.

THE HOME CARE ADVISORY TASK FORCE

As required by the law, the Commissioner of Health established the Home Care Advisory Task Force to identify issues and recommend regulatory standards. The members were selected from among applications submitted through the state open appointments process, administered by the Secretary of State.

The Commissioner appointed Mr. Cal Condon as Chair. Mr. Condon is a Waseca County Commissioner and has been active in health policy matters. Judith Schultz, director of a home care agency was elected Vice-chair by the Task Force.

Charge to the Task Force

The Commissioner charged the Task Force, in part, with the following responsibilities:

This Advisory Task Force is convened to assist the Department in developing the rules establishing standards of licensure of home care providers and hospice programs. Specifically, we ask that you identify relevant issues and concerns, provide information, expert opinion, and the benefit of professional experience, and recommend policy concerning realistic and enforceable standards of training, supervision, and other aspects of home care within various categories of licensure.

Principles For Development of Rules

The Task Force was guided in its deliberations by the following principles established by the Department of Health:

1. The goal is to "regulate" the existing industry, not materially alter it nor design and implement a health care system.
2. The state should focus on service activities rather than managerial and operational responsibilities. Standards must have a proximate relationship to patient care and protection, i.e., they must be tied closely to behavior that directly affects patients. Minimize interference with management structure, avoiding rules that are detached from service quality.
3. Distinguish licensure standards from certification standards (e.g., Medicare conditions of participation) and private accreditation standards.
4. Focus on staff qualifications, training, and supervision.

5. Avoid forcing providers into rigid, license slots, but allow all types of providers (not all providers) to operate without radically altering their structures or going out of business; maintain flexibility for new forms and methods of services.
6. Avoid anti-competitive trade restrictions that have marginal utility in reaching goals of licensure; avoid impeding alternative paths into the industry. The goal is to protect the consumer, not providers or segments of the industry.
7. Avoid disincentives to do business, such as requiring the hiring of personnel who may not be readily available or affordable, or imposing requirements that are costly, but tenuously related to patient care.
8. Standards must be uniformly enforceable, i.e., understandable, measurable, rational, and common-sensical.
9. Perhaps, implement a few set of rules at a time.
10. Be cognizant of potential costs of the rules to providers, consumers, and the state.

Procedure

The Task Force began deliberating in July, 1988, and met monthly through January, 1989, with a final meeting in March, 1989.

The Chair appointed two subcommittees to study specific issues and report to the Task Force. The Paraprofessional Subcommittee recommended standards for the training and supervision of home health aides, homemakers, and home maintenance workers. The Assisted Living Services Subcommittee made recommendations for the regulation of "assisted living" programs offered in residential environments. An additional subcommittee was appointed to prepare a draft of this report for consideration by the full Task Force.

Throughout the meetings, visitors freely offered information and comments. In addition, individuals and organizations communicated views directly to members of the Task Force and Department of Health staff.

RECOMMENDATIONS

RECOMMENDATION 1

Classes of Licenses

It is recommended that all home care providers be regulated under one of six classes of licensure.

The Task Force recognizes that the licensure law applies to a diverse group of providers offering a wide range of services. Regulation of a "full service" skilled nursing care agency necessarily must be different than regulation of an individual homemaker. It would be impractical, if not impossible, to adopt rules that universally apply to all. To solve this problem, the Task Force defined the following six generic license classes, at least one of which would be appropriate for every type of provider:

1. **Class A**, the holder of which may provide nursing services, other professional home care services, home health aide services, homemaker services, and home maintenance services (that is, a class A licensee may provide all home care services, including all services that may be provided by someone licensed under class B, C, D, or E, and hospice services if endorsed as meeting the requirements of a hospice program; to be known as a **"comprehensive home care agency"**);

2. **Class B**, the holder of which may provide homemaker and home maintenance services (to be known as a **"paraprofessional agency"**);

3. **Class C**, the holder of which is an individual who may provide services of a home health aide, homemaker, and home maintenance worker (to be known as an **"individual paraprofessional"**);

4. **Class D**, the holder of which may provide one or more professional services, such as: professional nursing, occupational therapy, speech therapy, physical therapy, nutritional services, medical social services, or other professional services subject to the home care law (to be known as a **"professional services provider"**). [Note: This license would not be required of a person exempt under Minnesota Statutes, section 144A.46, subdivision 2];

5. **Class E**, the holder of which may provide home care services related to the sale or

rental of durable medical equipment (to be known as a "medical equipment vendor"); and

6. **Class F**, the holder of which may provide hospice services, as provided by Minnesota Statutes, section 144A.48 (to be known as a "hospice program").

Discussion of Licensure Classes

The Task Force addressed several specific types of services that may be subject to home care licensure.

Public school services:

The Task Force discussed the inclusion of those therapy services provided by public schools through early intervention programs that are not otherwise exempt or excluded from licensure. The Task Force agrees with recommendations of professionals and others that **early intervention services be regulated under one of the recommended classes of license.**

Case management:

Case management services, whether provided independently or within an organization, significantly affect access to and quality of services received by individuals who are dependent on the recommendations and resources of a case manager. **The Task Force recommends that case management services be licensed under the professional services category as a direct service.**

Assisted living:

The Task Force considered the nature of **residential centers** that provide some type of assistance in activities of daily living for those who require such services. **The Task Force concludes that "assisted living" services would be covered by the license category appropriate to the specific services provided, if such services are otherwise subject to licensure.** For example, if an apartment building manager provides case management services along with skilled nursing or paraprofessional services, the services would be subject to a Class A or B license. Providers of case management services, independent of other home care services, should be subject to professional services licensing.

Sick child care:

The Task Force recommended that sick child care, meaning home care of children who have short-term, non-chronic illnesses, is baby-sitting and should not be regulated as home care, unless the service consists of more than traditional child care.

Medical equipment dealers:

Medical equipment dealers that provide home care services along with the provision of medical equipment must be licensed. However, it is recognized that the sale or lease of medical equipment is not itself home care, nor is the incidental provision of technical services required to set up equipment.

RECOMMENDATION 2

Provider Orientation

The Task Force recommends that all license holders, their designated administrative representatives, and employees who provide or directly affect the provision of home care services, be required to complete an orientation program.

Home care is unique in that a client's residence is usually not designed for the performance of many of the services required to meet the client's needs. Home care providers should know what other resources are available in its clients' communities to meet their continuing needs. The Task Force recommends that administrative and direct care personnel be required to complete an orientation to the provision of home care services that includes the following:

1. State home care law and rules;
2. The home care bill of rights;
3. Reporting of abuse and neglect under the vulnerable adults act and child protection act;
4. Communicable disease control in the home;
and
5. Emergency response.

RECOMMENDATION 3

Professional Services

The Task Force recommends that practitioners of state regulated professions must only satisfy those regulatory requirements. It is recommended that practitioners of professions not currently regulated be required to meet nationally recognized private certification standards, except for respiratory therapists who are appropriately supervised.

The Task Force considered the various professional health services that may be provided to persons in their residences, and recommended conditions under which practitioners could provide services as independent licensed providers or as employees of licensed providers.

The following is a list of each professional service with the minimum standard. Note that all licensees and employees of licensees are subject to the orientation requirement described in Recommendation 2, above.

Nothing in the following standards is intended to preclude the provision of any service within the scope of a professional license.

Professional nursing

Persons providing professional nursing services must be currently licensed and registered in Minnesota as registered nurses by the Board of Nursing.

A provider of professional nursing services must designate a registered nurse to be responsible for the development and implementation of nursing policies and procedures and the supervision of nursing services.

Practical nursing

Persons providing practical nursing services must be currently licensed in Minnesota as licensed practical nurses by the Board of Nursing.

Physical therapy

Persons who provide physical therapy must currently be registered as physical therapists by the State Board of Medical Examiners.

Speech therapy

Persons who provide speech therapy must hold a Certificate of Clinical Competency (CCC) in Speech Pathology from the American Speech and Hearing Association, or have a baccalaureate degree in speech therapy with clinical consultation available from a speech pathologist who holds a CCC.

Respiratory therapy

Persons who provide respiratory therapy must be certified or eligible for certification by the National Board of Respiratory Care, or be supervised by a registered nurse or physician.

Occupational therapy

Persons who provide occupational therapy services must have graduated from a course of study in occupational therapy accredited by the occupational therapy professional organization.

Nutritional and dietitian services

Persons who provide the services of a nutritionist/dietitian must be currently registered by the American Dietetic Association as a dietitian.

Medical social services

Persons who provide social work services as part of home care must be in compliance with Minnesota Statutes, chapter 148B.

RECOMMENDATION 4

Paraprofessionals

The Task Force recommends that all individuals working in each paraprofessional category be subject to the same training and supervision requirements, regardless whether they are employed by an agency or work independently.

The Task Force studied the nature of paraprofessional services offered in the home, and the categories of service defined by other law and programs. It was concluded that three categories of paraprofessionals be defined for purposes of training and supervision: home health aide, homemaker/companion, and home maintenance worker. Each category would be subject to different training and supervision requirements.

In 1981, the Minnesota Department of Health, Section of Public Health Nursing, developed a model curriculum for the training of home health aides/homemakers, with revisions made in 1987. This curriculum was based on recommendations of the Home Caring Council, a national organization of paraprofessional agencies. Courses have been offered regularly by the Technical Institutes and several junior colleges around the state. The curriculum is intended to provide students with a beginning knowledge of home care services, the roles of the home health aide and homemaker in home health care, skills for communicating and working with people, and skills in personal care and home management. The Task Force concluded that the training recommended to be required of home health aides and homemakers be based on the existing curriculum and delivery system.

Home health aide

Home health aides may perform all allowable duties of homemakers and home maintenance workers, and may perform nursing tasks delegated by a registered nurse or rehabilitation tasks delegated by a physical therapist.

Each home health aide must successfully complete a **training course** of at least 66 hours, that is approved by the Minnesota Department of Health, and includes a standard written and practical test administered by a technical institute. The training and testing program must be directed by an instructor who is qualified under State Board of Vocational Technical Education rules and may be offered at any location.

An individual may **test out of any distinct** component of the approved training course, but must pass the written and practical test required at the completion of the course.

A person who has not completed the training and testing requirements may be **grandparented** and therefore work as a home health aide if:

- a. at the time the rules are adopted, the person is employed as a home health aide;
- b. at the time the rules are adopted, the person has had at least 1,000 hours of experience as a home health aide within the previous two years;
- c. the person's employer recommends that the person be certified to work as a home health aide; and
- d. the person holds a nursing assistant certificate.

In addition to the pre-service training, for each year of employment, a home health aide must complete at least **8 hours of inservice** training and must demonstrate to a registered nurse the aide's competence in at least two skills in a home setting.

At least the first home health aide assigned to a client must be oriented at the client's residence when home health aide services are initiated. Aides assigned to serve a client after the initial visit may be oriented other than at the client's residence.

A registered nurse must supervise and observe home health aide services at least every three months and also evaluate the care plan at the client's residence at least every three months. A physical therapist must evaluate a client care plan that involves physical therapy rehabilitation services at the same time intervals.

Home health aides may be assigned by registered nurses or physical therapists to perform **specialized tasks**, such as:

1. nursing tasks;
2. assistance with medication (oral, suppository, eye drops, or topical); and
3. rehabilitation tasks.

The procedures or medications must be regularly scheduled, and planned and prepared by registered nurses or physical therapists. Aides must be individually trained by a registered nurse or physical therapist to perform the designated task or procedure.

Homemakers

A homemaker/companion may provide transportation, general housekeeping, well child care and supervision, companion care, grocery shopping, regular meal planning and preparation, laundry, and similar services, but may not perform personal care.

A homemaker may assist with household budgeting, including paying bills, but must provide a receipt to the client for all

transactions and purchases. The homemaker may not assume the "power of attorney" for the client.

A homemaker must complete a **training course of at least 24 hours**, approved by the Department of Health. The training program must be directed by an instructor who is qualified under the rules of the State Board of Vocational Technical Education. Successful completion of the course must include a **written and practical test** completed at a designated educational setting.

A person who has not completed the training and testing requirements may be **grandparented** and therefore work as a homemaker if:

a. at the time the rules are adopted, the person is employed as a homemaker or home health aide;

b. at the time the rules are adopted, the person has had at least 1,000 hours of experience as a homemaker or home health aide within the previous two years; and

c. the person's employer recommends that the person be certified to work as a homemaker.

In addition to the pre-service training, homemakers must complete at least **6 hours of inservice training** per year of employment.

Home maintenance workers

Home maintenance workers may provide regular and heavy laundry services; wash walls; prepare light and simple meals and snacks, and provide kitchen cleanup; wash windows; dust and vacuum; and perform other similar services. Home maintenance services are generally offered to perform work that is heavier than that performed by homemakers and less directly related to the immediate personal comfort of the client than homemaker services.

Home maintenance workers need not be supervised (although they may be, of course).

Home maintenance workers must complete the orientation required of all home care providers and employees. Home maintenance workers are required to attend an inservice to review the orientation topics at least once per year of employment.

RECOMMENDATION 5

Hospice Programs

The Task Force recommends the following definitions and requirements to implement the licensing of hospices.

Much of the regulation of hospices is specified in the statute. The Task Force recommends the following definitions and requirements:

Medical social services

A person who provides social work services must be in compliance with Minnesota Statutes, chapter 148B. The person may assist the hospice team in providing psychological and financial assessment and assistance, and may assist in providing community resource coordination. This person must participate in the development, implementation and evaluation of client care plans.

Identifiable hospice administration

"Identifiable hospice administration", as used in the statute (section 144A.48, subdivision 1, clause (4)), shall be defined as "a person or persons with defined lines of responsibility and authority who are responsible for the overall general and fiscal management of a hospice program".

Central coordination

"Centrally coordinated," as used in the statute (section 144A.48, subdivision 1, clause (4)), means that one person must be designated by the hospice administration as the coordinator of client care to assure continuity in developing and implementing interdisciplinary care plans across service settings, including home care and inpatient care, and bereavement services.

Interdisciplinary team

All core service personnel and others involved in direct client or family care must be oriented to the physical, spiritual and psychosocial aspects of hospice care.

Volunteers

Volunteer training must include at least:

1. the hospice program's goals and services;
2. confidentiality and protection of the clients' and families' rights;
3. procedures for responding to medical emergencies and deaths;
4. distinction between administrative and clinical authority and responsibility;
5. physiological and psychological aspects of terminal disease;

6. family dynamics, coping mechanisms, and psychosocial issues surrounding terminal disease, death and bereavement;
7. safety policies and procedures;
8. general communication skills; and
9. infection control.

Charts and records

The hospice must maintain a centralized composite medical record for each client that must include documentation of services provided directly and at least a current summary of each service provided by arrangement with other providers.

Quality assurance plan

Each hospice program must have a quality assurance plan, described in writing, that includes plans to monitor, over time, all aspects of hospice care including nursing, medical, volunteers, bereavement, psychosocial and spiritual care, and other therapies as appropriate. The hospice must:

1. Document the collection and analysis of data and the action taken as a result; and
2. Monitor and evaluate various aspects of its direct care services at least four times a year, including both the home and inpatient settings. The quality assurance plan should show evidence of follow-through on findings and evaluation of the effectiveness of the changes made.

Hospice home health aides

Hospices that employ home health aides must supervise them as follows:

1. Initially, a registered nurse must orient the aides at a client's residence; and
2. Thereafter, supervise each aide, in person or by telephone, at least monthly or when any changes in the plan of care affect the home health aide services.

Care conferences

An interdisciplinary care conference must be held to review each plan of care as follows:

1. A registered nurse must develop each client's plan of care in consultation with the physician within 48 hours after admission of the client to the program;
2. The core team must meet within one week after admission of the client to review and finalize the plan of care; and
3. The core team must meet periodically to review and update each plan of care. The meetings must be held at least monthly, and more often if required by the client's condition.

RECOMMENDATION 6

Criminal Disqualification

The Task Force recommends the following with respect to disqualification criteria, rehabilitation criteria, and criminal record searches.

The statute prohibits persons who have been convicted of certain crimes from holding a home care license or from working for a licensee. The Department is required to establish criteria for determining what crimes should bar a person from working in home care, and under what conditions the person should be considered rehabilitated.

It is recommended that:

Disclosure of convictions

All applicants for employment with home care providers must disclose all previous criminal convictions in writing.

Releases

All applicants for employment must sign releases to authorize the employer to investigate their criminal histories.

False disclosure

Employees who intentionally fail to accurately disclose their conviction histories must be discharged or denied employment.

Rehabilitation criteria

Two years following a conviction or incarceration in jail or prison, whichever is later, without further conviction or incarceration, is sufficient to indicate rehabilitation. Compliance with probation or parole can be used as evidence of rehabilitation.

Scope of disqualification

Individuals who do not provide client care services should not be subject to the disqualification requirements.

Disqualifying crimes

The crimes that should be considered disqualifying because of their relevance to home care are those in which:

1. the crime is one of physical violence or compulsion directed to a victim; or
2. the crime is one involving the intentional taking of another's money or property through some illegal means; or
3. the crime is directly related to the kinds of activities undertaken by home care providers or the types of persons likely to be served by home care providers.

RECOMMENDATION 7

Remedies and Fines

Enforcement

When it is determined that a violation of the rules has occurred, The Task Force recommends that enforcement remedies be asserted in the following order:

1. a correction order be issued;
2. a fine be assessed, if the provider fails to comply with the correction order within a reasonable time; and
3. the license be revoked for repeated violations, as determined necessary.

Fines

The Task Force recommends a discretionary system of fines that take into consideration the severity of infractions, rather than a detailed, preset fine schedule.

RECOMMENDATION 8

Administrative Policies & Procedures

The Task Force recommends that all providers, except Class C licensees (individual paraprofessionals), be required to establish the following POLICIES AND PROCEDURES; Class C licensees must establish a policy and procedure for emergencies and back-up care:

1. Identification and scope of each service offered;
2. Training required of staff members prior to their providing service;
3. Inservice training requirements;
4. Supervision of personnel;
5. Documentation and record-keeping;
6. Personnel policies;

7. Orientation to:
 - a. clients
 - b. the provider
 - c. policies and procedures,
8. Emergencies and back-up care;
9. Privacy and confidentiality;
10. Contract services;
11. Criminal disqualification;
12. Client care policies;
13. Coordination of services;
14. Acceptance, non-acceptance, admission, and discharge of clients;
15. Discontinuation of client services; a class A or class B provider must designate a person to assist clients in transitions to other providers or away from home services;
16. Coordination with other community resources; and
17. Clinical record requirements.
18. Involvement and coordination of physician and other medical services.

Class C licensees (individual paraprofessionals) must only establish a policy and procedure for emergencies and back-up care (item 8, above), although they must comply with all substantive requirements that may be required by the rules.

RECOMMENDATION 9

Enforcement

The Task Force considered the nature of the enforcement process and recommends:

1. Surveyors. Health Department surveyors who evaluate home care providers should have had previous direct home care experience;

2. Survey Process. Surveys should be conducted using various methods that include, but are not limited to:

a. Home visits arranged with client permission;

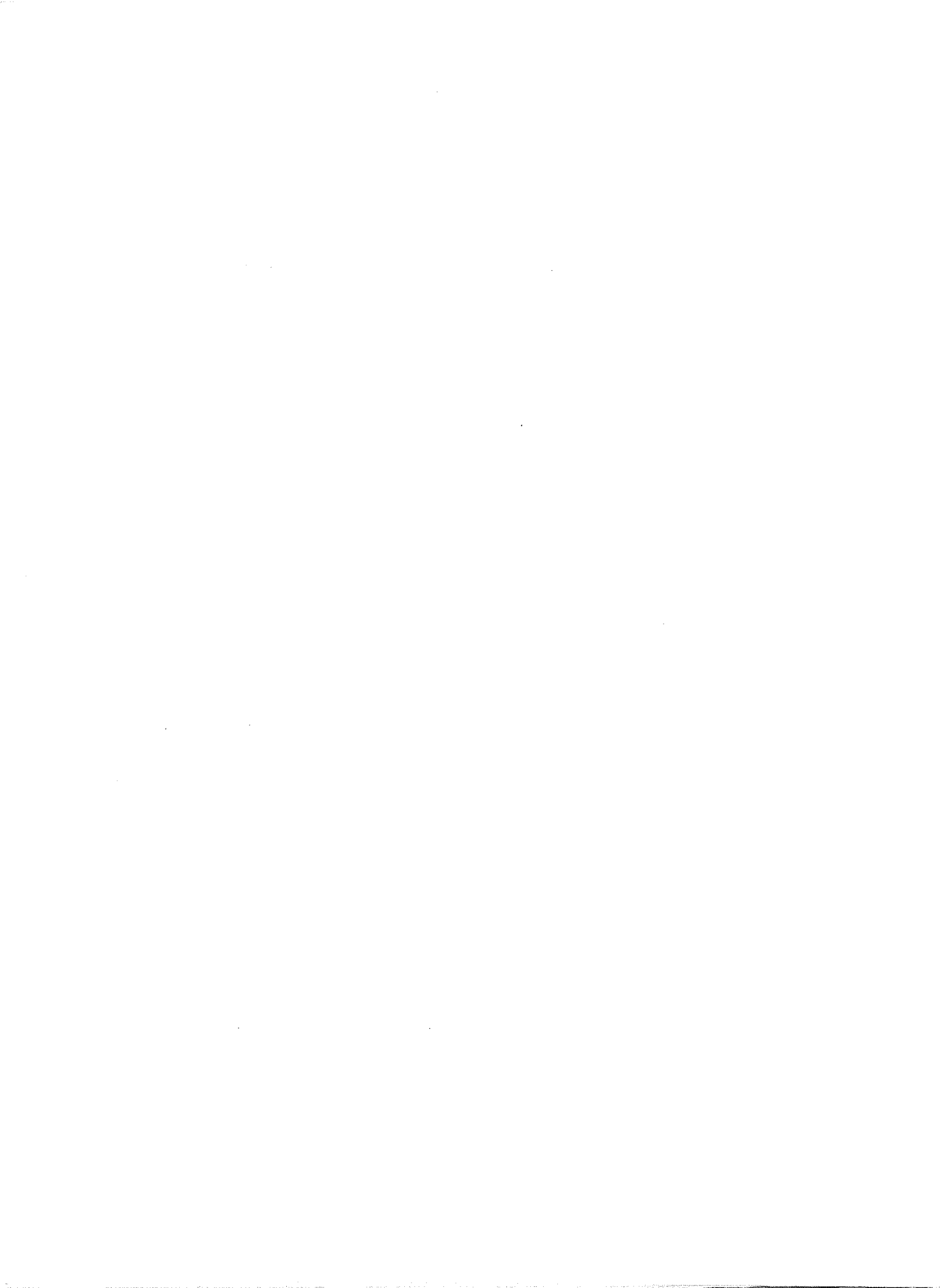
b. Client evaluations, solicited during home visits or by some other method;

c. evaluations of the services by physicians who have had experience with the providers, when appropriate; and

d. Review of policies and records.

3. Advisory Committee. The Commissioner should appoint an advisory committee to provide continuing advice on the rules, survey process, and long-term planning.

4. State Registry. The Department of Health should establish a registry for all home care paraprofessionals similar to that being established for nurse aides employed by Medicare and Medicaid certified facilities.



APPENDIX 1

HOME CARE HOSPICE PROGRAM

144A.43 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 144.699, subdivision 2, and 144A.43 to 144A.48.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Home care service.** "Home care service" means any of the following services when delivered in a place of residence to a person whose illness, disability, or physical condition creates a need for the service:

- (1) nursing services, including the services of a home health aide;
- (2) personal care services not included under sections 148.171 to 148.299;
- (3) physical therapy;
- (4) speech therapy;
- (5) respiratory therapy;
- (6) occupational therapy;
- (7) nutritional services;
- (8) home management services when provided to a person who is unable to perform these activities due to illness, disability, or physical condition. Home management services include at least two of the following services: housekeeping, meal preparation, laundry, shopping, and other similar services;
- (9) medical social services;
- (10) the provision of medical supplies and equipment when accompanied by the provision of a home care service;
- (11) the provision of a hospice program as specified in section 144A.48; and
- (12) other similar medical services and health-related support services identified by the commissioner in rule.

Subd. 4. **Home care provider.** "Home care provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of home care services for a fee. At least one home care service must be provided directly, although additional home care services may be provided by contractual arrangements. "Home care provider" includes a hospice program defined in section 144A.48. "Home care provider" does not include:

- (1) any home care or nursing services conducted by and for the adherents of any recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing;
- (2) an individual who only provides services to a relative;
- (3) an individual not connected with a home care provider who provides assistance with home management services or personal care needs if the assistance is provided primarily as a contribution and not as a business;
- (4) an individual not connected with a home care provider who shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;
- (5) an individual or agency providing home-delivered meal services;
- (6) an agency providing senior companion services and other older American volunteer programs established under the Domestic Volunteer Service Act of 1973, Public Law Number 98-288;
- (7) an individual or agency that only provides chore, housekeeping, or child care services which do not involve the provision of home care services;
- (8) an employee of a nursing home licensed under this chapter who provides emergency services to individuals residing in an apartment unit attached to the nursing home;
- (9) a member of a professional corporation organized under sections 319A.01 to 319A.22 that does not regularly offer or provide home care services as defined in subdivision 3;
- (10) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit corporation organized under chapter 317, a partnership organized under chapter 323, or any other entity determined by the commissioner;
- (11) an individual or agency that provides medical supplies or durable medical equipment, except when the provision of supplies or equipment is accompanied by a home care service; or
- (12) an individual licensed under chapter 147.

History: 1987 c 378 s 3

144A.44 HOME CARE BILL OF RIGHTS.

Subdivision 1. **Statement of rights.** A person who receives home care services has these rights:

- (1) the right to receive written information about rights, including what to do if rights are violated;
- (2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services;
- (3) the right to be told about the services that are being provided or suggested, about other choices that are available, and about the consequences of these choices including the consequences of refusing these services;
- (4) the right to refuse services or treatment;
- (5) the right to know, in advance, any limits to the services available from a provider, whether the services are covered by health insurance, medical assistance, or other health programs, and the provider's grounds for a termination of services;
- (6) the right to know what the charges are for services, no matter who will be paying the bill;
- (7) the right to know that there may be other services available in the community, including other home care services and providers, and to know where to go for information about these services;

- (8) the right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, medical assistance, or other health programs;
- (9) the right to have personal, financial, and medical information kept private;
- (10) the right to be allowed access to records and written information from records in accordance with section 144.335;
- (11) the right to be served by people who are properly trained and competent to perform their duties;
- (12) the right to be treated with courtesy and respect;
- (13) the right to be free from physical and verbal abuse;
- (14) the right to reasonable notice of changes in services or charges;
- (15) the right to a coordinated transfer when there will be a change in the provider of services;
- (16) the right to know how to contact an individual associated with the provider who is responsible for handling problems and the name and address of the state or county agency to contact for additional information or assistance; and
- (17) the right to assert these rights without retaliation.

Subd. 2. **Interpretation and enforcement of rights.** These rights are established for the benefit of persons who receive home care services. "Home care services" means home care services as defined in section 144A.43, subdivision 3. A home care provider may not require a person to surrender these rights as a condition of receiving services. A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights. This statement of rights does not replace or diminish other rights and liberties that may exist relative to persons receiving home care services, persons providing home care services, or providers licensed under Laws 1987, chapter 378. A copy of these rights must be provided to an individual at the time home care services are initiated. The copy shall also contain the address and phone number of the office of health facility complaints and a brief statement describing how to file a complaint with that office.

History: 1987 c 378 s 4

144A.45 REGULATION OF HOME CARE SERVICES.

Subdivision 1. **Rules.** The commissioner shall adopt rules for the regulation of home care providers pursuant to sections 144A.43 to 144A.49. The rules shall include the following:

- (a) provisions to assure, to the extent possible, the health, safety and well-being, and appropriate treatment of persons who receive home care services;
- (b) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to 144A.49;
- (c) standards of training of home care provider personnel, which may vary according to the nature of the services provided or the health status of the consumer;
- (d) standards of supervision by a registered nurse or other appropriate health care professionals of personnel providing home care services, which may vary according to the nature of the services provided or the health status of the consumer;
- (e) requirements for the involvement of a consumer's physician, the documentation of physicians' orders, if required, and the consumer's treatment plan, and the maintenance of accurate, current clinical records;
- (f) the establishment of different classes of licenses for different types of providers and different standards and requirements for different kinds of home care services; and
- (g) operating procedures required to implement the home care bill of rights.

Subd. 2. **Regulatory functions.** (a) The commissioner shall:

- (1) evaluate, monitor, and license home care providers in accordance with sections 144A.45 to 144A.49;

(2) inspect the office and records of a provider during regular business hours, provided that when conducting routine office visits or inspections, the commissioner shall provide at least 48 hours advance notice to the home care provider;

(3) with the consent of the consumer, visit the home where services are being provided;

(4) issue correction orders and assess civil penalties in accordance with section 144.653, subdivisions 5 to 8; and

(5) take other action reasonably required to accomplish the purposes of sections 144A.43 to 144A.49.

(b) In the exercise of the authority granted in sections 144A.43 to 144A.49, the commissioner shall comply with the applicable requirements of section 144.122, the government data practices act, and the administrative procedure act.

Subd. 3. Advisory task force. The commissioner of health shall establish and appoint a home care advisory task force consisting of 15 members representing the various kinds of home care providers, including a hospice program, health care professionals, community health services agencies, and consumers. The appointment, removal, and compensation of members is as provided in section 15.059, subdivision 6. The task force shall provide advice and recommendations to the commissioner regarding the development of rules required by subdivision 1.

History: 1987 c 378 s 5

144A.46 LICENSURE.

Subdivision 1. License required. (a) A home care provider may not operate in the state without a current license issued by the commissioner of health.

(b) Within ten days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete. Within 90 days after receiving a complete application, the commissioner shall either grant or deny the license. If an applicant is not granted or denied a license within 90 days after submitting a complete application, the license must be deemed granted. An applicant whose license has been deemed granted must provide written notice to the commissioner before providing a home care service.

Subd. 2. Exemptions. The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) a person who is licensed under sections 148.171 to 148.285 and who independently provides nursing services in the home without any contractual or employment relationship to a home care provider or other organization;

(2) a personal care assistant who provides services under the medical assistance program as authorized under section 256B.0625, subdivision 19, and section 256B.04, subdivision 16;

(3) a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under section 256B.0625, subdivision 19, and section 256B.04, subdivision 16;

(4) a person who is registered under sections 148.65 to 148.78 and who independently provides physical therapy services in the home without any contractual or employment relationship to a home care provider or other organization;

(5) a person who provides services to a person with mental retardation under a program of semi-independent living services regulated by Minnesota Rules, parts 9525.0500 to 9525.0660; or

(6) a person who provides services to a person with mental retardation under contract with a county to provide home and community-based services that are reimbursed under the medical assistance program, chapter 256B, and regulated by Minnesota Rules, parts 9525.1800 to 9525.1930.

An exemption under this subdivision does not excuse the individual from complying with applicable provisions of the home care bill of rights.

Subd. 3. Enforcement. The commissioner may refuse to grant or renew a license, or may suspend or revoke a license, for violation of statutes or rules relating to home care services or for conduct detrimental to the welfare of the consumer. Prior to any suspension, revocation, or refusal to renew a license, the home care provider shall be entitled to notice and a hearing as provided by sections 14.57 to 14.70. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 60 days if the commissioner determines that the health or safety of a consumer is in imminent danger, provided (1) advance notice is given to the provider; (2) after notice, the provider fails to correct the problem; (3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and (4) there is an opportunity for a contested case hearing within the 60 days. The process of suspending or revoking a license must include a plan for transferring affected clients to other providers.

Subd. 4. Relation to other regulatory programs. In the exercise of the authority granted under sections 144A.43 to 144A.49, the commissioner shall not duplicate or replace standards and requirements imposed under another state regulatory program. The commissioner shall not impose additional training or education requirements upon members of a licensed or registered occupation or profession, except as necessary to address or prevent problems that are unique to the delivery of services in the home or to enforce and protect the rights of consumers listed in section 144A.44. For home care providers certified under the Medicare program, the state standards must not be inconsistent with the Medicare standards for Medicare services. To the extent possible, the commissioner shall coordinate the inspections required under sections 144A.45 to 144A.48 with the health facility licensure inspections required under sections 144.50 to 144.58 or 144A.10 when the health care facility is also licensed under the provisions of Laws 1987, chapter 378.

Subd. 5. Prior criminal convictions. An applicant for a home care provider license shall disclose to the commissioner all criminal convictions of persons involved in the management, operation, or control of the provider. A home care provider shall require employees of the provider and applicants for employment to disclose all criminal convictions. No person may be employed by a home care provider or involved in the management, operation, or control of a provider, if the person has been convicted of a crime that relates to the provision of home care services or to the position, duties, or responsibilities undertaken by that person in the operation of the home care provider, unless the person can provide sufficient evidence of rehabilitation. The commissioner shall adopt rules for determining whether a crime relates to home care services and what constitutes sufficient evidence of rehabilitation. The rules must require consideration of the nature and seriousness of the crime; the relationship of the crime to the purposes of home care licensure and regulation; the relationship of the crime to the ability, capacity, and fitness required to perform the duties and discharge the responsibilities of the person's position; mitigating circumstances or social conditions surrounding the commission of the crime; the length of time elapsed since the crime was committed; the seriousness of the risk to the home care client's person or property; and other factors the commissioner considers appropriate. Data collected under this subdivision shall be classified as private data under section 13.02, subdivision 12.

History: 1987 c 378 s 6; 1988 c 689 art 2 s 268

144A.47 INFORMATION AND REFERRAL SERVICES.

The commissioner shall ensure that information and referral services relating to home care are available in all regions of the state. The commissioner shall collect and make available information about available home care services, sources of payment, providers, and the rights of consumers. The commissioner may require home care

providers to provide information requested for the purposes of this section, including price information, as a condition of registration or licensure. Specific price information furnished by providers under this section is not public data and must not be released without the written permission of the agency. The commissioner may publish and make available:

- (1) general information and a summary of the range of prices of home care services in the state;
- (2) limitations on hours, availability of services, and eligibility for third-party payments, applicable to individual providers; and
- (3) other information the commissioner determines to be appropriate.

History: 1987 c 378 s 7

144A.48 HOSPICE PROGRAMS.

Subdivision 1. Definitions. For the purposes of this section, the following terms have the meanings given to them:

(1) "Core services" means physician services, registered nursing services, medical social services, pastoral care or other counseling services, and volunteer services that are provided either directly by the hospice program or through a service contract or other arrangement;

(2) "Hospice patient" means an individual who has been diagnosed as terminally ill with a probable life expectancy of under one year, as documented by the individual's attending physician, and who alone or, when unable, through the hospice patient's family has voluntarily consented to and received admission to a hospice program;

(3) "Hospice patient's family" means relatives of the hospice patient, the hospice patient's guardian, primary caregivers, or persons identified by the hospice patient as having significant personal ties;

(4) "Hospice program" means palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to terminally ill hospice patients and their families to meet the physical, nutritional, emotional, social, spiritual, and special needs experienced during the final stages of illness, dying, and bereavement, through a centrally coordinated program that ensures continuity and consistency of home and inpatient care provided directly or through an agreement;

(5) "Interdisciplinary team" means a group of qualified individuals with expertise in meeting the special needs of hospice patients and their families, including, at a minimum, those individuals who are providers of core services;

(6) "Palliative care" means care directed at managing the symptoms experienced by the hospice patient and intended to enhance the quality of life for the hospice patient and the patient's family, but not directed at curing the illness; and

(7) "Volunteer services" means services by volunteers who provide a personal presence that augments a variety of professional and nonprofessional services available to the hospice patient, the patient's family, and the hospice program.

Subd. 2. License requirements. A hospice program may not operate in the state or use the words "hospice" or "hospice program" without a current license issued by the commissioner of health. The commissioner shall license hospice programs using the powers and authorities contained in sections 144A.43 to 144A.47 and 144A.49. In addition a hospice program must provide:

(1) centrally coordinated hospice core services in the home and inpatient settings;

(2) that the medical components of the hospice program are under the direction of a licensed physician who serves as medical director;

(3) that the palliative medical care provided to a hospice patient is under the direction of the attending physician;

(4) an interdisciplinary team that meets regularly to develop, implement, and evaluate the hospice program's plan of care for each hospice patient and the patient's family;

- (5) accessible hospice care, 24 hours a day, seven days a week;
- (6) an ongoing system of quality assurance;
- (7) that volunteer services are provided by individuals who have completed a hospice training program and are qualified to provide the services;
- (8) a planned program of supportive services available to patients' families during the bereavement period; and
- (9) that inpatient services are provided directly or by arrangement in a licensed hospital or nursing home.

Subd. 3. **Required inspections.** The commissioner shall inspect the hospice program, the home care and the inpatient care provided by the hospice program to determine if the requirements of sections 144A.45 to 144A.48 are met.

Subd. 4. **Rule authority.** The commissioner shall promulgate rules to implement the provisions of this section.

Subd. 5. **License designation.** A license issued to a home care provider meeting the requirements contained in this section shall indicate that the provider is qualified to offer hospice care.

History: 1987 c 378 s 8

144A.49 TEMPORARY PROCEDURES.

For purposes of this section, "home care providers" shall mean the providers described in section 144A.43, subdivision 4, including hospice programs described in section 144A.48. Home care providers are exempt from the licensure requirement in section 144A.46, subdivision 1, until 90 days after the effective date of the licensure rules. Beginning July 1, 1987, no home care provider, as defined in section 144A.43, subdivision 4, except a provider exempt from licensure under section 144A.46, subdivision 2, may provide home care services in this state without registering with the commissioner. A home care provider is registered with the commissioner when the commissioner has received in writing the provider's name; the name of its parent corporation or sponsoring organization, if any; the street address and telephone number of its principal place of business; the street address and telephone number of its principal place of business in Minnesota; the counties in Minnesota in which it may render services; the street address and telephone number of all other offices in Minnesota; and the name, educational background, and ten-year employment history of the person responsible for the management of the agency. A registration fee must be submitted with the application for registration. The fee must be established pursuant to section 144.122 and must be based on a consideration of the following factors: the number of clients served by the home care provider, the number of employees, the number of services offered, and annual revenues of the provider. The registration is effective until 90 days after licensure rules are effective. In order to maintain its registration and provide services in Minnesota, a home care provider must comply with section 144A.44 and comply with requests for information under section 144A.47. A registered home care provider is subject to sections 144A.51 to 144A.54. Registration under this section does not exempt a home care provider from the licensure and other requirements later adopted by the commissioner.

Within 90 days after the effective date of the licensure rules under section 144A.45, the commissioner of health shall issue provisional licenses to all home care providers registered with the department as of that date. The provisional license shall be valid until superseded by a license issued under section 144A.46 or for a period of one year, whichever is shorter. Applications for licensure as a home care provider received on or after the effective date of the home care licensure rules, shall be issued under section 144A.46, subdivision 1.

History: 1987 c 378 s 14



Appendix 2

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Appendix 3

WORKING DOCUMENTS

Following is a list of documents that were prepared for the Home Care Advisory Task Force to assist in its deliberations.

CHARGE TO THE TASK FORCE

Provides the purpose and goals of the Advisory Task Force.

CLASSES OF HOME CARE LICENSES

A list of proposed classes of licensure for home care providers including class A, B, Independent, Professional services and therapies, Non-professional sick child care, Durable Medical, and Hospice.

CLINICAL RECORD REQUIREMENTS

Suggestions for clinical record requirements for home care providers.

CRIMINAL DISQUALIFICATION AND REHABILITATION

Discussion about the requirements and procedures for implementing the prohibition against licensing or employing persons who have been convicted of certain crimes.

DEFINITIONS

Suggested definitions of home health aide, homemaker, and home maintenance worker.

DISCUSSION GUIDELINE FOR PROFESSIONAL SERVICES

Selected topics about professional service providers such as registered nurse, registered physical therapist, occupational therapist, respiratory therapist, etc., including education, experience, continuing education, and supervision requirements.

DISCUSSION OUTLINE FOR HOSPICE

Questions relating to the regulation of hospice.

DISEASE PREVENTION AND CONTROL REQUIREMENTS

Recommendations for disease prevention and control requirements.

FLOW CHART FOR LICENSURE

Decision tree for determining which home care providers are subject to licensure, which are exempt, and which are excluded.

TECHNICALLY SOPHISTICATED SERVICES

Recommendations for the regulation of technically sophisticated treatments and procedures.

HOME CARE PROVIDERS

A list of potential licensure categories based on service definitions developed by home care staff.

ISSUES FOR TASK FORCE MEMBERSHIP DISCUSSION

Presents suggested schedule for discussion topics.

FORMS OF REGULATION

Discussion of various types of civil and criminal law that regulate providers of home care services in addition to the licensure law.

NON-ACCEPTANCE OR TERMINATION OF CLIENT CARE

Recommendations for requirements of acceptance, rejection, and termination of client care.

OUTLINE OF DISCUSSION

Outline of the recommendations of the Advisory Task Force.

OUTLINE OF HOME CARE ISSUES

Issues discussed by the Advisory Task Force presented in outline form for purposes of further discussion.

PRINCIPLES OF RULEMAKING

Establishes criteria for the development of licensure rules.

STATEMENT OF INTENT

Presents the Department's goals and objectives for home care regulation and a statement of need and purpose.

TIMELINES FOR TASK FORCE DISCUSSION

Suggested schedule for discussion topics from August to January, 1989.

TIMETABLE FOR DEVELOPMENT AND PROMULGATION OF HOME CARE RULE

Presents the projected schedule for developing and promulgating the home care rule.

REGULATION OF HEALTH CARE PROFESSIONS

Summary of health care professions and the status of their regulation by the state.