

# **SOME ASPECTS OF QUALITY ASSURANCE IN HOME CARE FOR HAWAII'S ELDERLY**

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## FOREWORD

House Concurrent Resolution No. 309 and House Resolution No. 333, adopted by the Fifteenth State Legislature, Regular Session of 1989, requested the Legislative Reference Bureau to undertake an examination of the issues involved in home care quality assurance, including discussion of findings concerning the following questions:

- (1) Given the broad scope of home care services, can a single entity be responsible for assuring their quality and appropriateness and by what criteria should quality be measured?
- (2) Is it possible to design incentives to improve accountability and reward the delivery of quality care at home?
- (3) How can the recruitment, training, and supervision of home health workers be improved to enhance the quality of care provided?
- (4) Can quality care, particularly in personal care and chore services, be assured without pricing services out of the reach of the lower-income elderly?

This report responds to the resolutions.

The Legislative Reference Bureau thanks the many individuals who participated in the study, including professionals who work daily in the home care industry and citizens who are recipients of home care. Special mahalos go to the following individuals in Hilo: June T. Kunimoto, Public Health Nursing Supervisor and Project Director-Case Management Program, Department of Health; Molly Pruyn, Case Management Coordination Project; and Jane H. Testa, Program Specialist in the Hawaii County Office of Aging.

Samuel B. K. Chang  
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## Chapter 1

### INTRODUCTION

House Concurrent Resolution No. 309 and House Resolution No. 333, which is identical in substance to H.C.R. No. 309 (see Appendix A), both adopted by the 1989 regular session of the Hawaii State Legislature, requested the Legislative Reference Bureau (Bureau) to examine the issues involved in home care quality assurance and determine the most appropriate course for the State of Hawaii to follow in this area. The thrust of the testimony presented at a hearing on H.C.R. No. 309 and H.R. No. 333 was that there must be a way to assure quality care of elderly who receive home care because there is no direct supervision of the care provider and because the person receiving the care is often frail, vulnerable, and afraid to complain for fear of losing the services of the caregiver.

#### Conduct of the Study

Background information for this study began with a review of the literature. Most of the literature on home care concerns the care of the elderly, but home care issues also affect children and adults who are not elderly, are incapacitated, and receiving care at home. Examples include the handicapped such as paraplegics and developmentally disabled children. In keeping with the mandate of the resolutions, the focus of this study is primarily on the elderly over 65 years of age, but the reader should keep in mind that one out of four people currently receiving home care is under age 65.<sup>1</sup> Recommendations presented in this report are equally applicable to the disabled and those under 65 years old.

Following a literature review, the researcher interviewed several professionals affiliated with agencies which provide home care services. These interviews provided an overview of the issues and concerns surrounding home care.

#### Organization of the Report

The report is presented as follows:

Chapter 1 provides an introduction to the report and describes the elderly population in Hawaii.

Chapter 2 provides a working definition of home care, describes the scope of home care service providers, and funding mechanisms.

Chapter 3 discusses the issue of quality assurance in home care as addressed by the American Bar Association's 1986 report and the Legislative Auditor's 1987 "sunrise" study. This chapter also examines the nature of elderly abuse in Hawaii and the impact of new federal rules under the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) requiring the training and registration of health care aides.

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1. Janet Zhun Nassif, The Home Health Care Solution. A Complete Consumer Guide (New York: Harper and Row, 1985), p. 7.

Chapter 4 examines the data in terms of the issues raised by the resolutions.

Chapter 5 contains conclusions and recommendations.

### Other Studies About the Elderly

The Bureau has studied and reported on several related issues affecting the health of the elderly in Hawaii. Some of the most recent studies were:

- (1) "Health Care Benefit Costs for Retired Public Employees: Issues and Funding Options" (S. Claveria, 1987).
- (2) "Assuring Dignity in Long-Term Care for the Elderly" (S. Claveria, 1987).
- (3) "Pharmaceutical Assistance for the Elderly" (S. Claveria, 1988).
- (4) "Feasibility of Establishing a State Veterans Facility for Veterans as a Distinct Group of the Elderly" (P. Pan, 1988).

In addition, the Legislative Auditor of the State of Hawaii issued its "Sunrise Analysis of a Proposal to Regulate Home Care Services" in February 1987.

This study on quality assurance in home care of the elderly is but one of a series of studies requested by the Legislature and one which must be read as part of an integrated whole in order to develop an understanding of the policy considerations relating to elderly care in Hawaii.

### Characteristics of the Elderly Population in Hawaii

#### The Number of Elderly in Hawaii

A popular magazine in Hawaii recently reported that: "In Hawaii, those over 60 represent 14 per cent of the population, and that age group is growing. There will soon be more people over 65 than under 25.... The 65-plus group in Hawaii is increasing 2-1/2 times faster than the national average."<sup>2</sup> The April 1980 census showed 76,000 residents 65 years and over in Hawaii. The July 1, 1987 estimates for the same age group was 109,000 residents, or a 33 percent increase over six years.<sup>3</sup>

The rapid growth of the elderly population can be readily seen from Figure 1 showing the growth of the elderly population 65 years and older by percent for each decade from 1900 through 2000. In 1900 the over 65 group constituted only 1.7 percent of the population and remained at nearly the same level until 1930. Between 1940 and 1980 this age group

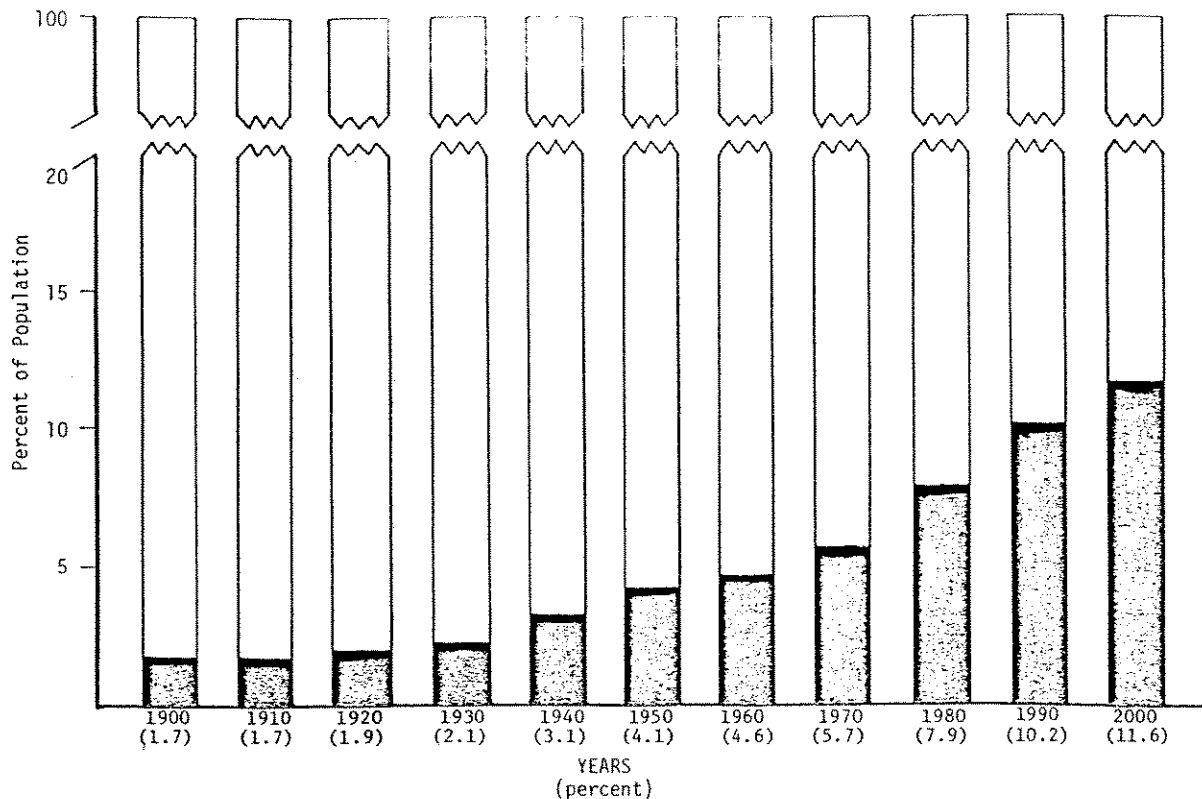
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2. Diana Lomont, "The Unhealthy Bottom Line," Honolulu Magazine, July 1989, pp. 66, 70.

3. Hawaii, Department of Business and Economic Development, The State of Hawaii Data Book 1988, (Honolulu: 1988), Table 19, p. 37.

Figure 1

**GROWTH OF THE ELDERLY POPULATION  
65 YEARS AND OLDER BY PERCENT: 1900-2000**



Source: Reprinted from Hawaii, Executive Office on Aging, The Elderly in Hawaii: A Data Digest of Persons 60 and Over (Honolulu: 1982), p. 46.

increased by about one percent each decade until it reached 7.9 percent of the population in 1980. Estimates for the year 2000 indicate that nearly 12 percent of the population of Hawaii will be the over 65 year olds. The Department of Business and Economic Development (DBED) has further estimated the elderly population (65 years and over) in the year 2010 to be a little more than 13 percent of the population.<sup>4</sup>

According to the Department of Labor and Industrial Relations (DLIR), "[b]y 2005, there will be more seniors 65 years or older than between the ages of 55 and 64. The 75 years and over group will realize the most growth between 1980 and 2005, and will become the most populous older subgroup. They will be followed by those 55 to 59 years of age." Furthermore, DLIR reports that the proportion of older individuals in the State who have chosen to live in the Honolulu Metropolitan Statistical Area (Honolulu MSA) has increased from 67.9 percent in 1960 to nearly 75 percent in 1984. Among the islands, the ratio of

4. Ibid., Table 21, p. 39.

seniors to total population in decreasing order was: Kauai County, Hawaii County, Maui County, and Honolulu MSA.<sup>5</sup>

### The Health of the Elderly in Hawaii

While the number of elderly in the population is a figure which can be arrived at with some precision, a description of the health characteristics of this demographic group is less precise. Generalizing about the health of the elderly is difficult because people age at different rates and acquire disabilities from different sources: environment, genetics, accident, etc. According to professionals who study the aged, about 80 percent of persons over 65 have at least one chronic illness, but most of the elderly are healthy enough to require minimal help in daily living.<sup>6</sup>

An elder person's need for help in daily living is influenced by three main factors: age, sex, and socioeconomic status. The elderly population is sometimes divided into three age groups: the "young-old", between 65 and 74; the "older-old", between 75 and 84; and the "oldest-old", anyone over 85. Generally, the older the person, the greater is the need for care. While the young-old may need help only during acute illness or injury, the older-old may need help with yardwork and housework. The oldest-old usually require personal care and more supervision. It has been estimated that about one in three in the over-85 age group requires some kind of personal assistance.<sup>7</sup>

Since women tend to live longer than men, they are more likely to reach the oldest-old category with its attendant levels of disabilities. Finally, those who occupy the lower socioeconomic levels suffer from more illnesses and disabilities than the general population.<sup>8</sup> The sex distribution in Hawaii of older (over 55) persons, after several decades of a majority of males over females, equalized in 1980 and in 1984 revealed a male-female ratio of 48.7 percent to 51.3 percent. The longer average female life expectancy of 80.9 years to the male life expectancy of 75.4 years will probably assure a higher proportion of older females to older males in future years.<sup>9</sup> In general the elderly in Hawaii enjoy a healthy life and this fact was reflected in a comparative study in 1983, of elderly in Hawaii, Kentucky, Ohio, and Oregon conducted by the United States General Accounting Office (GAO). This study examined the health situation, the economic situation, and the social situation of older persons living in these four states. In the health area, sampled persons were asked how well they could perform instrumental activities of daily living (IADLs such as shopping, preparing own meals, doing own housework, taking own medicine, handling own money) and basic activities of daily living (ADLs such as feeding oneself, grooming, walking, taking a bath or shower, getting in and out of bed, etc.). The sample group was also asked if one or more of 29 illnesses such

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5. Hawaii. Department of Labor and Industrial Relations. Research and Statistics Office. Hawaii's Seniors: Their Vast Potential (Honolulu: 1988), p. 3. hereafter cited as Hawaii's Seniors: Their Vast Potential.

6. Marjorie H. Cantor. "Social Care: Family and Community Support Systems." Annals of the American Academy of Social Sciences, May 1989, p. 100.

7. Nassif, p. 25.

8. Cantor, p. 101.

9. Hawaii's Seniors: Their Vast Potential, p. 4.



## INTRODUCTION

as arthritis, cancer, circulatory trouble, diabetes, Parkinsons' disease, etc., interfered with activities a great deal. The study also determined whether those elderly unable to perform IALs and ADLs without help received compensatory services, and whether those with interfering illness got treatment.

The findings indicated that the elderly in Hawaii were "generally healthy and healthier, had less interfering illnesses, and [had] health problems more fully being cared for than sampled older persons living in Kentucky , Ohio, or Oregon."<sup>10</sup>

As expected, and following national trends, sampled older persons in Hawaii gained health problems with age. Interestingly, high blood pressure, mental (emotional health) and arthritis/rheumatism were reported more frequently in Hawaii than in the other locations. Many of the elderly in Hawaii who needed help with ADLs were able to get help to compensate for lack in capabilities, but if help is provided by agencies, not all of their needs for help were being met so the assumption was that these unmet needs were being compensated for by family and friends.<sup>11</sup>

Another study prepared by the State Executive Office on Aging (EOA) published in May 1983 confirmed that, in general, the elderly in Hawaii enjoy good health. This survey to establish a statewide needs assessment of individuals age 60 and over found that:

Approximately three-quarters [of the population surveyed] rate their own health as good or excellent while 4% rate their health as poor. Nearly 10% report that they need more medical care and are affected a great deal by their problems. However, an estimated 15% rate their health as better than it was five years ago.<sup>12</sup>

While the overall picture of the elderly in Hawaii indicates good health and long life, there remains a group of people "at-risk" who, with assistance, can remain at home and avoid premature institutionalization. This is the group which utilizes and benefits from home care services.

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10. U.S., General Accounting Office. Statement of Facts: Data About Sampled Older Persons Living in Hawaii, Kentucky, Ohio, Oregon (Washington: 1984), p. 1.

11. Ibid., pp. 11, 15.

12. Hawaii, Executive Office on Aging, A Statewide Needs Assessment of Individuals Age 60 and Over (Honolulu: 1983), p. 42.

## Chapter 2

### HOME CARE

This chapter defines home care, and describes the at-risk population in Hawaii who require home care. It concludes with a description of the various home care service providers in Hawaii.

#### What is Home Care?

"Home care" is often used interchangeably with "home health care" which is a term with a narrower focus for services covered under the medicare home health benefit. Medicare's home health benefit is health care prescribed by a physician and is oriented toward skilled care intermittently provided by a registered nurse, and physical, occupational, or speech therapist. Because of its focus on medical care, as a general rule, the person's well-being in the social, economic, and psychological arenas is not considered in home health care. However, the kinds of services needed by the elderly, disabled, and chronically ill actually varies along a continuum from unskilled, non-medical services to highly skilled, continuous (around-the-clock) nursing services.

For purposes of this report, "home care" means those services provided to patients in their own homes or a home-like setting in the community on an intermittent or continuous basis ranging from non-medical and social services such as chore and homemaker services, hospice, legal aid, or personal care, to highly technical medical, therapeutic, and professional health services such as post-acute skilled nursing, physical therapy, and the like.<sup>1</sup>

Home care services can also benefit the caregiver instead of the patient, by providing respite, escort, counseling, and other supportive services. The "home" need not be the elder's home, but could be the home of a relative, or, as in the foster care situation, the home of an unrelated family. Because the emphasis is on retaining the client in the community, this type of care is sometimes referred to as "community-based" care programs. Home care, therefore, is a continuum of services provided in the home, not in an institution, to individuals who need assistance in daily living. Home care is not the kind of care provided by an adult residential care home (ARCH) or adult boarding home, which are institutions licensed by the state Department of Health. Home care is not a licensed activity except insofar as services are provided by a medicare-licensed provider for home health services. The variety of home care services available to the elderly (and to the disabled, as necessary) is readily apparent from Appendix B which is a glossary of services from the United States General Accounting Office.<sup>2</sup>

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1. This definition is derived from a composite of definitions in: Keith B. Anderson and David I. Kass, Certificate of Need Regulation of Entry Into Home Health Care (Washington: Bureau of Economics Staff Report to the Federal Trade Commission, Jan. 1986), p. 20; State Health Notes, "Regulation of In-home Care: An Overview of State Activity," April 1989, p. 2; and Charlene Harrington and Leslie Grant, The Delivery, Regulation, and Politics of Home Care: A California Case Study (San Francisco: Institute for Health and Aging, 1988), p. 1.
  2. U.S., General Accounting Office, The Elderly Should Benefit from Expanded Home Health Care but Increasing these Services Will Not Insure Cost Reductions (Washington: 1982), pp. 47-48.

## The Growing Demand for Home Care

Home care is a type of long-term care. After hospitalization for acute illness or injury, a patient may require daily medical and nursing care at the skilled nursing level in a skilled nursing facility (SNF). At a later stage the patient may require only intermediate care with continued physician monitoring but less intensive treatment provided in an intermediate care facility (ICF). After the patient stabilizes and recovers, the patient may still need maintenance, support service, or assistance (physical, social, or psychological) because of the chronic nature of the patient's disabilities. This type of person may require custodial care or less intensive attention such as monitoring of medications, meal preparation, or grooming. Patients at the skilled care, intermediate care, and custodial care levels can all benefit from home care.<sup>3</sup> Because the client who requires home care has a variety of needs, the services provided can vary in intensity.

The usual combination in addition to medical supervision, includes home nursing visits, access to social services, and the services of homemaker-home health aides. Basic services may adequately maintain individuals in their homes at effective levels of health and function over long periods of time or permanently without recourse to more concentrated care or to institutionalization.

Such services are most effective when chronic disease limits but does not totally disable, when mobility has been affected so that full physical functioning in the essential activities of daily living is not possible for short or long periods of time. Individuals with multiple diagnostic problems who might, on paper, appear to require institutional care, are very frequently able to continue to live normally in their own homes, to participate in community life, to continue to work, when such basic services are available to them.

Home care programs serve the patient who is already in his own home and needs care, but does not require hospital or other institutional care; they also serve the institutional patient who is ready for discharge and now needs only services of the sort that can feasibly be provided at home. They are diverse and flexible. They are not restricted to any one group of patients, but are community wide in their reach. All age groups, all disease entities and states of illness, all economic levels are accepted when indications dictate care at home as the treatment of choice. (Citations omitted.)<sup>4</sup>

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3. For a detailed explanation of the different levels of long-term care the reader will find a review of the Bureau's 1987 long-term care report instructive. See: Susan K. Claveria, Assuring Dignity in the Long-term Care for the Elderly, Legislative Reference Bureau Report No. 2 (Honolulu: 1987), hereafter cited as Assuring Dignity in the Long-term Care for the Elderly.
  4. U.S., Congress. Senate. Special Committee on Aging, Home Health Services in the United States, 92d Cong. 2d Sess., 1972, pp. 7-8.

Home care has been shown to be preferred by the elderly (and others recuperating from illness and injury). In contrast to institutionalization, home care is less stressful to the patient, more humane, maintains the elder in the elder's original social network, and contributes to a longer lifespan of higher quality and dignity.<sup>5</sup> Besides the recuperative benefits of returning home, home care as an alternative to institutionalization may be preferred by the patient's family because it is less costly than institutionalization.

Home care also may be the only alternative for some elders because there may be no available nursing home bed in the community. In Hawaii, for example, there are 2,769 long-term care beds in the State which will increase to only 3,383 when all approved beds are in operation.<sup>6</sup> In 1980, Hawaii's nursing home bed ratio per 1,000 elderly over 65 was 26.1 beds per 1,000 elderly, while the national average was 57.5 beds.<sup>7</sup> In 1985 Hawaii's nursing home bed ratio rose fractionally to only 27.8 and the State Health Planning and Development Agency (SHPDA)<sup>8</sup> decided in 1986 to limit nursing home bed growth to no more than 40 beds per 1,000 elderly in each county.<sup>9</sup>

The cost of nursing home care can also be outside the reach of the average family. Nursing home care can average \$3,000 per month in this State while home care can be provided at less cost.<sup>10</sup>

There are many other reasons for the increase in the need for home care, including the increase in two-career families, the lower incidence of extended families living in the same household, and the desire of many elders to live independently for as long as possible. All of these factors together or in combination result in an increasing number of elderly persons who continue to live in the community and require support systems ranging from social services to medical assistance.

### Utilization of Home Care in Hawaii

The EOA has provided data regarding home care users, but an accurate count is not possible because clients often receive more than one service (which results in double counts); there are also individuals who find caregivers without the aid of agencies (which results in an

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5. Janet Zhun Nassif, The Home Health Care Solution. A Complete Consumer Guide (New York: Harper and Row, 1985), pp. 2-15.
  6. Assuring Dignity in the Long-term Care for the Elderly, p. 6.
  7. Hawaii, Department of Human Services, Adult Day Care, Adult Day Health, and Day Hospital Services (Honolulu: 1987), pp. III-5 to III-7, hereafter cited as Adult Day Care, Adult Day Health, and Day Hospital Services.
  8. Hawaii Rev. Stat., chapter 323D.
  9. Adult Day Care, Adult Day Health, and Day Hospital Services, pp. III-5 to III-7.
  10. See Assuring Dignity in the Long-term Care for the Elderly, p. 1; and Kathryn L. Braun, et al., "Geriatric Patient Outcomes and Costs in Three Settings: Nursing Home, Foster Family and Own Home," Journal of the American Geriatrics Society, May 1987, pp. 387-397.

## HOME CARE

undercount); and finally there are many individuals whose care is provided for by family or close friends, whose numbers are also unknown.

Table 1 lists 13 categories of programs or services available to elders and the number served, the estimated target population, and the unmet need which is the difference of the number served from the target group. The total number of elders served by all 13 programs in 1989 was nearly 21,000 elders. The top four programs with the largest percentage of unmet need in descending order were: (1) senior companion (87 percent unmet), (2) telephone reassurance (77 percent unmet), (3) shopping assistance (54 percent unmet), followed closely by (4) case management (51 percent unmet). The programs which closely met their target groups were: (1) home health services (5 percent unmet), (2) congregate meals (6 percent unmet), (3) home delivered meals (10 percent unmet), and (4) personal care (13 percent unmet).

The figures in Table 1 represent programs funded by the Older Americans Act<sup>11</sup> and collected by the EOA from the four state Area Agencies on Aging: the City and County of Honolulu, and the counties of Kauai, Maui, and Hawaii.

### Future Demand for Home Care

In 1987 the state Department of Human Services (DHS) issued a report on adult day care, adult day health, and day hospital services.<sup>12</sup> This report included need and demand projections for long-term care and adult day center services. Assuming that the people over 65 who have a limitation due to chronic illness or injury will also require some kind of home care, the figures may provide a basis for approximating the upper limit of the number of people over 65 who may need some type of home care service. Table 2 indicates that in 1980 a total of 12,895 individuals had some kind of ADL limitation and by 1985 the number increased by more than 4,000, to 17,154. By the year 2000 the total number of individuals requiring some help with ADLs could number close to 27,000. Using these forecast figures and the estimated elderly population for the respective years, it is estimated that 14 to 15 percent of the resident population over 65 will need some kind of home care service in the next decade.

By as early as 1990, there may be more than 15 percent of the elderly population who need some kind of help in daily living in order to live comfortably at home.

### Home Care Providers in Hawaii

Home care is provided most often by family, friends, or neighbors. It has been estimated that between 70 to 90 percent of all care for the frail elderly comes from natural (informal) caregivers.<sup>13</sup> Figure 2 depicts the percentage distribution at the national level of primary and secondary caregivers and use of outside help. National data for this chart were

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11. 42 U.S.C. §§3001-3037a (1982).

12. Adult Day Care, Adult Day Health, and Day Hospital Services.

13. Tun-Mei Y. Chang, and others, Impact of Major Public Policies and Programs on Natural Caregiving: An Appraisal (Wisconsin: Department of Health and Social Services, March 1984), p. 3.

Table 1

**UNMET NEEDS FOR SUPPORTIVE SERVICES  
FOR ELDERLY IN HAWAII  
1989**

<u>Programs/Services</u>	<u>No. Served</u>	<u>Target</u>	<u>Unmet Need</u>	<u>Percent* Unmet</u>
Case Management	933	1,895	962	51
Chore Services	1,449	1,807	358	20
Day Health Care	35	51	16	31
Escort	1,997	2,528	531	21
Friendly Visiting	1,161	2,067	906	44
Home Health Services	510	535	25	5
Personal Assistance	3,592	4,134	542	13
Personal Care	920	1,491	571	38
Senior Companion	123	1,010	887	87
Shopping Assistance	103	224	121	54
Telephone Reassurance	107	476	369	77
<u>Nutrition Services</u>				
Congregate Meals	7,254	7,696	442	6
Home Delivered Meals	2,665	2,970	305	10
<b>GRAND TOTALS*</b>	20,849	26,884	6,035	22%

\*Percentages and grand totals were calculated by the Legislative Reference Bureau. All other data provided by the Executive Office on Aging.

Source: Executive Office on Aging.

**EVALUATION OF UNMET NEEDS FOR SUPPORTIVE SERVICES  
NUTRITION SERVICES, AND MULTIPURPOSE  
SENIOR CENTERS IN THE STATE OF HAWAII**

The Hawaii State Executive Office on Aging, through its four planning service areas, conducted a statewide evaluation of unmet needs for supportive services, nutrition services, and multipurpose senior centers as directed in the Administration on Aging's PI-89-05 memorandum dated January 19, 1989. The information, based on existing data, was summarized and is hereby reported in a 4-column format:

**Column 1 - Programs/Services**

The entries in this column are generally categorized according to the three areas designated in the directive: supportive services, multipurpose senior centers, and nutrition services. Because the first category--Supportive Services--covers a wide array of programs, it was further broken down into subheadings as designated in Section 321(a) of the Older Americans Act of 1965, as amended.

**Column 2 - No. Served**

Data in this column represent numbers of elders (or others as indicated) who are currently being served or who have been served over the past year. Reports submitted by service providers were used as the primary source of information. Other sources include service provider contracts, on-site visitations, senior registration forms, telephone logs, and other agency reports.

**Column 3 - Target**

This column shows total numbers of elders (or others as indicated) who should be receiving the service or who should be participating in the program. Methods used to determine this include one-year projections based on expected increases in segments of the elderly and/or other relevant populations, projections based on current use patterns and current demand, wait lists, key informant and other survey results, and reports from other agencies.

**Column 4 - Unmet Need**

Figures in this column indicate numbers of elders (or others as specified) who currently desire the respective service but are not being served as well as those for whom services will be required in the coming year, as anticipated by the planning service areas.

Table 2

NUMBER OF PEOPLE OVER 65 YEARS OLD WHO  
NEED HELP WITH ACTIVITIES OF DAILY LIVING

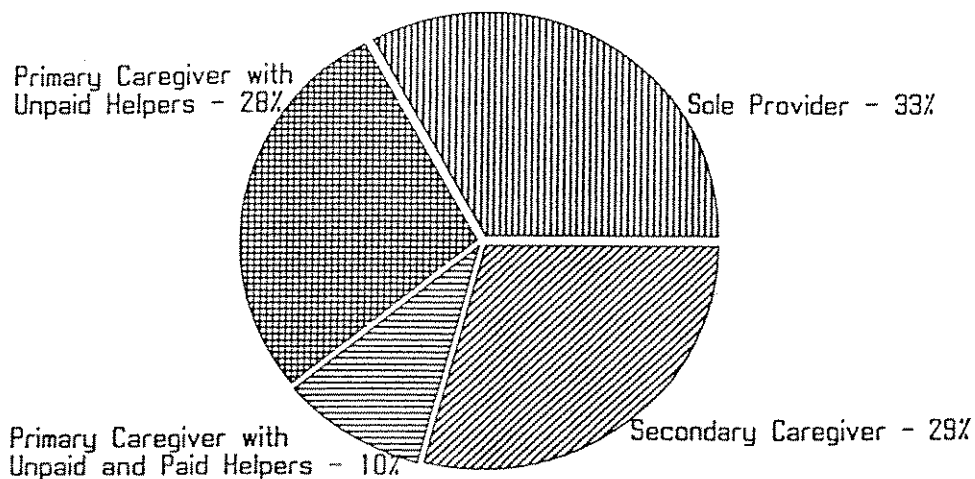
	<u>1980</u>	<u>1985</u>	<u>1990</u>	<u>1995</u>	<u>2000</u>
Need Population	12,895	17,154	20,973	24,116	26,855
Estimated Population 65 yrs. +	76,000	109,00*	125,300	160,800	188,000
% over 65 needing help	16.9%	15.7%	16.7%	14.9%	14.2%

\*Estimated population over 65 years on July 1, 1987.

Source: Calculations based on data from Table 21, Hawaii State Databook 1988 (Hawaii, Department of Business and Economic Development); and Adult Day Care, Adult Day Health, and Day Hospital Services (Hawaii, Department of Human Services), Table III-3.

Figure 2

DISTRIBUTION OF PRIMARY AND SECONDARY  
CAREGIVERS AND USE OF OUTSIDE HELP



Source: Reprinted from U.S. Congress, House, Subcommittee on Human Services of the Select Committee on Aging, Exploding the Myths: Caregiving in America, 100th Cong., 2nd sess., 1988, p.21.

derived from the Informal Caregivers Survey, a component of the 1982 Long-term Care Survey conducted by the United States Department of Health and Human Services. "Approximately 70 percent of the population are primary caregivers with the remainder assuming a secondary role. One-third of the caregivers are sole providers, 28 percent are primary caregivers with one or more unpaid helpers and only 10 percent receive paid and unpaid assistance."<sup>14</sup> This distribution is shown in chart form in Figure 2. The figures for Hawaii are probably similar, although there has been no confirmation of this through a similar survey in Hawaii.

After family and friends, home care providers come from many different formal sources depending upon the elder's needs. If the event which triggered the need was medical, such as hospitalization for injury or illness, the elder usually receives assistance in locating home care service providers through a hospital-based home health care program. This type of home "health care" is often reimbursed through medicare when the treatment plan requires physician involvement, nursing care, and therapy.

Other elders may enter the home care system when they lose all or part of the services of their informal caregiver such as a spouse or child, and then must seek help through a social service agency, church group, public health nurse, or other similar source. Little is known about service utilization, but "[t]he little information which is available on service utilization indicates that families tend to purchase services only when the responsibility of elder care becomes too difficult for them to handle alone or with additional unpaid help. Further, when they do approach formal service providers, they are modest in their service demands, often requesting far less assistance than professionals would have recommended."<sup>15</sup> The kind of help needed may be minimal, such as assistance with grocery shopping, or more intensive such as personal care, feeding, or grooming.

Payment for home care services can come from private, out-of-pocket payments to the caregiver, free or partially funded services through a publicly funded social service program, or payment through medicare or medicaid programs. Funding sources have different eligibility requirements which can affect who gets service and what kind. Figure 3 provides a summary of the amount of money allocated to elderly programs of one kind or another from federal, state, and county funds for the State of Hawaii in fiscal year 1987-1988. It was not possible to further separate funds allocated to only home care services. For comparative purposes it is instructive to see that Oahu, where most of the elderly reside is allocated the bulk of funds from other than county sources, and Kauai the least. When county appropriations are included, however, Maui has the least amount of funds available for elderly programs.

Not only are there a variety of service providers, there are different kinds of services available to the client, and the client may find some services unavailable because of age, income, geographic location, or other reasons. Thus, the average consumer is unlikely to know where to begin searching for a home care provider. One author described home care as

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14. U.S.. Congress, House. Subcommittee on Human Services of the Select Committee on Aging. Exploding the Myths: Caregiving in America. 100th Cong., 2d sess., 1988. p. 21.

15. Ibid., p. 53.



Figure 3

**MONEYS ALLOCATED TO THE ELDERLY  
IN THE STATE OF HAWAII\*  
1987-1988**

			KAUAI	OAHU	MAUI	HAWAII
From Older American Act (Federal), FY Oct. 87-Sept. 88	Total Authorized: for EOA administration: For EOA ombudsman:	\$3,622,905 280,000 30,000	\$ 383,419	\$1,826,780	\$ 492,649	\$ 609,857
From State of Hawaii Legislative Appropriation FY Jul. 87-Jun. 88	Total appropriated: Minus restrictions: Plus collective bargaining increases:	\$4,393,241 132,106 10,392				
	Net allocated	\$4,271,530**	384,453	2,237,237	336,554	421,023
From county appropriations FY Oct. 87-Sept. 88			411,375	430,823	273,242	753,962
	County Totals		\$1,177,364	\$4,629,840	\$1,096,302	\$1,814,842

\*These figures do not include donations, gifts, AWH grants, and certain federal funds targeted for elderly programs in UMTA, Economic Opportunity funds, etc.

\*\*In addition to amounts allocated to the four counties, the following amounts were allocated from this net total:

\$ 244,318 for tuition exemption  
\$3,514,267 for purchase of service  
\$ 348,486 for other current operating expenses and payroll of EOA  
\$ 12,169 for equipment  
\$ 152,290 for other purchase of service

Source: Rene Zubiri, Accountant, Executive Office on Aging, July 14, 1989.

a "tri-animal combination" (see Figure 4) and wrote "...you can flip each of the three parts separately to make endless, fanciful combinations of homecare hybrids" from these three categories.<sup>16</sup>

Figure 4

### HEMOCARE "TRI-ANIMAL" COMBINATION

*Head*

(*Who* the provider is)

- Nonprofit
- Proprietary
- Free-standing
- Hospital-based
- Health Department
- Veterans Administration
- HMO
- Subsidiary
- Independent contractor
- Individual
- Referral agency

*Body*

(*What* the provider does)

- "Low-tech" care, e.g., homemaker, personal care, supportive services, companion, chore service
- Skilled nursing
- Physical therapy
- Speech therapy
- Occupational therapy
- Medical social services
- Home health aids
- "Hi-tech" care, e.g., infusion therapies, respiratory therapy, dialysis, enteral & parenteral nutrition, interactive monitoring system

*Legs*

(*How* the service is funded)

- Medicare
- Medicare HMOs
- Medicaid
- Medicaid waiver
- Social Services
- Older Americans Act
- Veterans' benefits
- State/Local appropriation
- Private insurance
- Charitable giving
- Out-of-pocket

Source: Charles Sabatino, "Homecare Quality", Generations, Winter 1989, p. 12.

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16. Charles Sabatino, "Homecare Quality," Generations, Winter 1989, p. 13.

## HOME CARE

The yellow pages of the telephone directory for Oahu lists 23 home health services as of February 1, 1989 (see Appendix C). Some of these services are hospital-based programs while others are operated by for-profit agencies. The Bureau interviewed a number of service providers in order to gain insight into the issues involved in assuring quality home care. The following findings are presented to provide the reader with a survey of the variety of home care service providers in the community. It is not intended to be a comprehensive inventory of every service provider in the State.

### **Access to Home Care Services Through Private Agencies**

Examples of this group of agencies are Medical Personnel Pool and Kokua Nurses. These agencies provide the client with personal care attendants, nurses, and other personnel as needed. In some cases these agencies are contracted by the State or a county to provide certain kinds of care through elderly programs funded by an Area Agency on Aging. The agency interviews and hires caregivers, trains, supervises, and monitors these employees, coordinates assignments, manages workers' compensation fees, liability insurance, and other tax or payroll matters relating to their employees. Some of these agencies are medicare-certified home health agencies, and some are accredited by the Joint Commission on Accreditation of Healthcare Organizations. If medicare certified, the agency qualifies for medicare reimbursement. However, certification and accreditation is not a necessary condition to becoming a home care service provider.

### **Access Through Case Management Programs**

Case management and channeling is an administrative service that links the client and the providers of long-term care. Examples of the type of programs which provide case management services include Project Malama in the Department of Human Services, the Case Management Coordination Program (CMCP) under the Public Health Nursing Branch of the Department of Health, and the Nursing Home Without Walls program in the Department of Human Services, Community Long Term Care Branch. A case manager, usually a registered nurse, social worker, or a combination of these professionals, will assess the client's problems (and provide periodic reassessment as needs change) including medical, environmental, financial, and other conditions in order to tailor an appropriate care plan for the individual client. Based on this care plan, the case manager arranges for services such as meal delivery, chore service, personal care, and so on with service providers. Because an elder person's living conditions, support group, and physical needs can vary and change, case managers or their aides schedule follow-up and monitoring visits to keep up with clients' current needs. Because the case manager does the "legwork" for locating help for specific needs, the client need not be familiar with the variety of services in the community, the eligibility requirements, or the mechanisms for locating them.

### **Hospital Based Programs**

Since 1983 medicare pays hospitals a fixed amount for a patient's care in specific diagnostics related groups (DRGs). This practice has resulted in sending patients home after hospitalization for acute conditions but who may still require care until they are fully recovered. Hospital based programs are designed to assist the patient in recovering at home. Patient care in these cases is medically prescribed and supervised. The phrase "home health

care" is the common term in these programs, because the health care component is essential to receipt of services and often, for medicare reimbursement.

### Information and Referral Programs

The purpose of information and referral (I & R) programs is to provide information to the client about who to call for certain services that would enhance an elder's ability to live at home and to help a caregiver cope with problems in providing care. Referral includes contacting a service provider and putting the provider in touch with the client. Some support groups for specific diseases (such as cancer or Alzheimer's disease) provide this type of service, and case management organizations also will refer any caller to sources in the community providing the kind of help needed by an elder or an elder's caregiver.

County area agencies on aging often provide information and referral services. Information and referral differs from case management in that the client (or natural caregiver) must follow through with service providers to see that services are actually received. Some I & R programs may be labeled "registries" or "brokers" but operate in similar fashion in that the worker who goes to the client's home is not an employee of the referring organization, and the responsibility of supervision, payment for services, and so forth rest with the client.

### Other Programs

There are many social service and community organizations which provide help with certain activities including providing transportation for the elderly to keep medical appointments, go shopping, provide respite to the informal caregiver, among other services. Some of these organizations utilize volunteers and have a small paid staff. Eligibility criteria vary, as do payment requirements.

### Summary

For a quick review of the variety of services and the multitudinous service providers, refer to Appendix D, which is a copy of the contents pages of a handbook prepared by the City and County of Honolulu.<sup>17</sup> From this single source it is possible to see that there are many different kinds of services provided to the elderly from many providers. The same kind of arrangement, with slight variations, exists on the neighbor islands.

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17. City and County of Honolulu, Elderly Affairs Division. Helping Hands Resource Handbook, Services for the Frail, Homebound Elderly (Honolulu: 1988).

## Chapter 3

### THE ISSUE OF QUALITY ASSURANCE IN HOME CARE

The previous chapter defined home care and described generally how the home care industry is organized in Hawaii. This chapter examines the concerns surrounding quality assurance in home care beginning with the American Bar Association's "Black box" report. It then examines how various home care service providers in Hawaii approach the quality issue, whether abuse exists in Hawaii's home care system, and the Legislative Auditor's sunrise evaluation of a 1986 legislative proposal to regulate caregivers in Hawaii.

#### Quality Assurance

The issue of providing quality care is not new to the home care industry. Hospitals, funding agents, social workers, and case managers, among others, have been examining this issue for many years.<sup>1</sup> The difficulties of assuring quality in home care is part of the nature of the service. Clients are scattered throughout the community; they are often socially isolated and living alone and are served by several different providers.<sup>2</sup> Under these conditions, it is difficult to monitor care without expending additional costs for personnel and time. One study has shown that providing quality assurance in home care increases costs from 25 cents to \$3.00 per hour.<sup>3</sup>

#### The "Black Box"

In 1986 the American Bar Association (ABA) issued its report on quality in home care which examined the national home care system and the problems surrounding quality assurance. The "black box" referred to by the ABA are the unknown conditions under which home care services occur: generally without supervision, and for individuals who were frail, vulnerable, and at the mercy of the service provider.

According to the ABA report, even if the present number of known home care problems or abuses is small, there is a risk that more problems can develop in this area with the growth of the home care industry. Drawing on the parallel of abuses which developed as a result of rapid growth in the nursing home industry, the ABA report opined that now is the time to prepare for regulation of the home care industry before its potential growth rate prevents development of adequate quality assurance measures.

The utilization of home care services nationwide will continue to grow because of various demographic and legislative factors, such as the increase in the number of elderly and the push by hospitals toward returning patients home earlier, as discussed in previous chapters of this report. The ABA reported that, "The [home care] industry is growing and changing rapidly; there is little uniformity in definitions of services and providers;

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1. See "Assuring Quality of Care." in Generations, Winter 1989.
  2. Iris Freeman. "The Consumer's Role." Generations, Winter 1989. p. 33.
  3. Sheila J. Atchley, "The Ohio Quality Assurance Project," Generations, Winter 1989, p. 59.

## ABA Recommendations

The ABA recommended that:

- (1) Standards for home care services should be made to apply to the widest possible spectrum of agency types and funding sources. "On the state level, an option would be to establish or extend a licensure system to all home care services intended to maintain sick or functionally impaired persons in their homes. Presently, most state licensure is limited to traditionally medically oriented home health agencies."<sup>14</sup>
- (2) The content of standards must be strengthened to cover the actual care given which focuses on patient-worker interactions and quantifiable outcomes of care rather than in completing paperwork correctly.
- (3) Consumers must be protected by a minimum bonding and liability insurance requirement.
- (4) Providers must be required to be more accountable to the consumer by (a) providing a patient bill-of-rights, (b) educating the patient to allow the patient to make informed decisions about care and treatment, (c) developing a grievance mechanism, (d) providing consumer input into program evaluation, and (e) including consumer participation in advisory groups.
- (5) Quality assurance should be monitored both periodically and through a complaint process.
- (6) Sanctions should include denial, revocation or suspension of an agency's status, fines, injunctive relief, public disclosure of agencies out of compliance, and granting consumers a "private right of action" enabling them to sue providers that do not meet minimum required standards.
- (7) There should be development of minimum training by an entity like a community college leading to certification or licensure for all homemaker-home health aides and personal care attendants.
- (8) There should be continued research and data collection about home care services.<sup>15</sup>

## Quality Assurance in Hawaii

The current quality assurance procedures in Hawaii follow the pattern documented by the ABA report. Home health care agencies which are licensed for medicare reimbursement (see Appendix E for a list of licensed home health agencies in Hawaii) must comply with federal rules and meet federal guidelines for certification. In this way clients receive a

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14. Ibid., p. 43.

15. Ibid., pp. 43-49.

## THE ISSUE OF QUALITY ASSURANCE IN HOME CARE

measure of quality assurance from the compliance process of the state and federal governments.

Hospitals are monitored by hospital accreditation groups. Therefore, a hospital based home care program is assured quality from another kind of professional monitoring group. If a private insurer reimburses for home care services, the insurer will usually require a review of services and care. Finally, elders who receive services from a case manager in any of the social services agencies, are monitored by the agency's case manager. The Department of Health's public health nurses for example, made 34,405 visits statewide to elders over 60 years old in fiscal year 1987.<sup>16</sup>

It has been argued that current monitoring systems to meet federal or state guidelines are inadequate because the reviews concentrate more on structure and process, and less on outcomes. Furthermore, medicare standards are usually the minimum level a state licensing scheme attempts to meet.<sup>17</sup> The type of quality checks made by licensing agencies are usually paper reviews, that is, review standards which look at the structural organization that provides the care, staff qualifications, review of case records, and similar criteria. A paper review is time efficient, but seldom examines closely, if at all, the individual elder's unique lifestyle needs and social conditions. On the other hand, on-site review which is provided by a case manager, social worker, or public health nurse, is time consuming and labor intensive, but does look beyond the physical environment to the client's support groups, emotional, social, and other needs. A more valuable kind of check on quality which can occur is the observation during visits by family or friends, or the more frequent observation of the natural caregiver, if one is available on site who can observe the condition of the elder and the work habits of the caregiver.

The elders who are at greatest risk of unreported neglect and abuse are probably elders who live alone and those who personally hire caregivers, and who are without the benefit of a case manager or agency to oversee the work of the caregiver (the "do-it-yourselfers"). Another factor often ignored in the abuse/neglect situation is the extent of stress on the family or informal caretaker and its effects on the elder's overall quality of life. To determine the extent of ill treatment of home care recipients, the Bureau turned to data collected about abuse, neglect, and exploitation of the elderly.

### Incidence of Elderly Abuse

In Hawaii, the Department of Human Services (DHS) is required by law to collect information about abuse and neglect among the elderly population.<sup>18</sup> Abuse can be physical injury or psychological abuse while neglect can be neglecting medical needs, resulting in physical deterioration, malnutrition, and the like. The total number of complaints about alleged abuse and/or neglect of the elderly received by Elder Protective Services for calendar year 1988 was 373 reports. Over 60 percent of the victims lived in their own homes or the

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16. Hawaii, Department of Health. Statistical Supplement, 1987, p. 172.

17. Leslie A. Grant and Charlene Harrington. Quality of Care in Licensed and Unlicensed Home Care Agencies: A California Case Study (San Francisco: Institute for Health and Aging, 1988) p. 3.

18. See Hawaii Rev. Stat., chapter 346, as amended by 1989 Haw. Sess. Laws, Act 381, which repealed chapter 349C, Hawaii Rev. Stat.

home of an adult offspring. Nearly 25 percent of the victims were 85 years of age or older. Nearly 20 percent of the complaints were made by a social agency, followed closely by a nurse (16.6 percent), and hospital (15 percent). Response to the complaint was made within 24 hours in 80 percent of the cases reported. Abuse was confirmed in about 19 percent of the reports while 34 percent were confirmed cases of neglect. The perpetrator of the abuse was found to be the caretaker in nearly 41 percent of the reports. Appendix F provides more detail of the 1988 statistics.

The Ombudsman of the Executive Office on Aging reported a total of 80 complaints during the calendar year 1988. Of this total, 73 percent of the complaints were resolved or partially resolved, 74 percent concerned conditions or problems in skilled or intermediate care nursing facilities (SNFs or INFs). Twenty of the complaints dealt with resident care while eleven complaints dealt with financial matters.

The EOA's Ombudsman is required to resolve complaints about abuse or neglect only in the institutional setting, but the Ombudsman works closely with other offices such as the Department of Health and Department of Human Services as deemed necessary for proper follow through on all sources of complaints which can affect the elderly.<sup>19</sup> The Department of Health reported no complaints about Home Health Care agencies.<sup>20</sup> Area Agencies on Aging for all counties reported no data of abuse. There is a general feeling that abuse exists, but is simply not reported.

The Bureau's interviews with agencies which provide home care services indicated that the number of actual abuse, neglect, financial exploitation, and similar cases in Hawaii by agency-provided caregivers is very, very small and reports are anecdotal, not documented. This does not mean that abuse does not and could not occur. Except for the data provided by Elder Protective Services and EOA, there are very little hard data about exploitation, injury (physical and psychological), or non-performance of caregiver duties. It is possible that the number of abuse cases might be underreported. As a survey of Home Health Agencies in California and Missouri reported:

Surveyors considered that problems in home health care were underreported for a number of reasons. The surveyors noted that many home care patients were alone, dependent, and vulnerable and therefore afraid to complain about poor quality because they would lose the services they are receiving. Patients frequently were reported by surveyors not to understand what services they were supposed to be receiving in the home and were unaware of how much and what was being billed to Medicare or Medicaid. In other situations, the patients did not know where or how to make complaints.<sup>21</sup>

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19. Interview with EOA Ombudsman, Sandy Rongitsch, July 25, 1989.

20. Telephone interview with Helen Yoshimi, Hospitals and Medical Facilities Branch, Medicare Section, Department of Health, August 5, 1989.

21. Charlene Harrington and others, The Study of Regulation of Home Health Care Agencies in Two States: California and Missouri (San Francisco: Institute for Health and Aging, 1988), p. 18.



The question of whether or not underreporting of elder abuse and neglect occurs in Hawaii was examined in an elder abuse and neglect survey in 1987.<sup>22</sup> Among the key findings of this survey it was suspected that underreporting is a problem. "Among those who had seen abused or neglected elderly victims in the past six months, almost half (48%) had not reported the incidents." There are many barriers to reporting abuse, among which are: (a) victim's fear or shame (51 percent); (b) limited mental capacity (43 percent); (c) lack of awareness of reporting procedures (46 percent); (d) the reporter's fear of retaliation (26 percent) and unwillingness to get involved (35 percent); and (e) perceived lack of appropriate services for victims (34 percent).<sup>23</sup> Suggestions for encouraging reporting included: public education, clear definitions of reportable situations, a hotline, and publicizing reporting requirements. Other key findings are reprinted in Appendix G.

Service providers are concerned about assuring quality in elder home care. The Bureau found that in addition to the compliance procedures for medicare licensing, accreditation, and other voluntary procedures, home care agencies make every effort to check frequently on the more frail individuals and to adjust services to fit the special needs of an elder who requires more attention than others.

In general, infractions by agency employees appear to be relatively infrequent in Hawaii. Where an agency's employee is not performing to the agency's standards, several different actions can be taken ranging from counseling, re-training, and termination. But the severe shortage of employees in the health care industry generally means that a terminated employee could go on to be hired by another agency or as an independent contractor to an unsuspecting elder.

#### **County Area Agencies on Aging (AAA)**

In an effort to pinpoint specific reports of abuse, neglect, and caregiver exploitation of the elderly who receive home care from formal or informal sources, the Bureau interviewed each county's AAA. The question put to the AAA representative was: "Have you heard of any abuse, injury, or neglect of any elder receiving homecare services?" No county AAA maintains specific data on this problem. In general the conclusions were that Hawaii has been fortunate in not having had any serious instance of elder abuse in the home care setting and it is possible that some problems exist but elders may be afraid to complain. (See underreporting problem addressed earlier.)

The more common problem appears to be that AAAs find it difficult to locate enough workers for chore and homemaker services, and personal care attendants, and workers who are reliable and dependable. However, this problem is probably a symptom of the State's condition of "full employment", and is not directly an "abusive" situation. It was also generally agreed that it is difficult if not impossible to identify elders who are being abused by family members or other informal caregivers until the elder is seen by a doctor, or a complaint is filed on the elder's behalf by an interested bystander (for example, a neighbor or friend) to the Department of Human Services' Elder Protective Services office.

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22. SMS Research & Marketing Services, Inc., Elder Abuse and Neglect Survey, 1988 (Honolulu: 1988).

23. Ibid., p. 1.

There is also some evidence that citizens do not understand how home care services differ among providers, depending on whether direct care or simple referral is involved. An I & R or registry service, for example, requires more monitoring of the elder and the worker by the informal caregiver. If a worker does not appear on the day and the time promised, or does not perform the tasks described, the family member must act assertively to receive the proper care for the elder. If a case worker is assigned to the elder, some of these "supervisory" tasks might be assumed by the professional, but it is still unlikely that the case worker will be present at all times when a service is being provided. Thus consumer responsibility remains an important function of quality assurance in home care.

### The Privately Hired Caregiver

The consumer who bypasses the agency hire route by locating and hiring a caregiver, aide, or companion through the classified ads or by word-of-mouth must assume more of the quality assurance aspects by carefully interviewing the worker and watching the worker perform caregiving tasks. Other factors which the private hire consumer must consider are the requirements of the State's labor laws as to private employers. The average consumer, however, is not informed about what to look for when hiring a caregiver, unless already involved in healthcare or elderly care activities as a nurse or social worker. Furthermore, the typical consumer is often unprepared for the event which triggers the need for finding a caregiver so that a caregiver might be hired with very little advance planning or evaluation.

### Caregiver Stress

The informal caregiver (family, neighbor, or friend) is often ignored in the quality of care equation. Social, economic, and respite support for the natural caregiver are vital to maintaining the continued maintenance of the elder in a family setting.<sup>24</sup>

Providing care on a continuing basis to a helpless, frail elder can be stressful on the caregiver. In fact, studies have indicated that caregivers "perceived themselves to be in poorer health" than their age peers in the United States population as a whole.<sup>25</sup> Furthermore, the greatest predictor of an elder entering an institution is the health and availability of a caretaker, not the health of the elder.<sup>26</sup> Most elders are cared for by family members, by a spouse (usually the wife), or by a child (usually a daughter). The effects of providing elder care by women who also care for their family and children, or who give up full-time jobs to care for an elder, can be destructive to the woman, her family life, as well as to

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24. Tun-Mei Y. Chang and others, Impact of Major Public Policies and Programs on Natural Caregiving: An Appraisal (Wisconsin, Department of Health and Social Services: March 1984), p. 33 and Bobby Heagerty and others, "They Are Not Alone: Lending Support to Family Care Givers," Health Progress, December 1988, pp. 55-58, 75.

25. See U.S., Congress, House, Subcommittee on Human Services of the Select Committee on Aging, Exploding the Myths: Caregiving in America, 100th Cong., 2d sess., 1988, p. 20, hereafter cited as Exploding the Myths: Caregiving in America, and Chai R. Feldblum, "Home Health Care for the Elderly: Programs, Problems, and Potentials," 22 Harvard Journal on Legislation, 1985, pp. 193-254.

26. U.S., Dept. of Health, Education, and Welfare, Home Health Care Benefits Under Medicare and Medicaid (Washington, D.C.: July 1974), p. 11 and Exploding the Myths: Caregiving in America, pp. 18-28.

the woman's future earning potential and pension level.<sup>27</sup> Researchers who have studied the negative effects of caregiving report that caregivers who are daughters "comprise a substantial proportion of elder abusers" with financial dependency of the caregiver being a "major correlate of elder abuse."<sup>28</sup> The effects on the workforce of employees having to provide elder care in general have also been documented.<sup>29</sup>

In 1986 a proposal in the Hawaii State Legislature attempting to regulate services delivered by home care providers was thoroughly reviewed by the State's Legislative Auditor.

#### Auditor's Sunrise Report of 1987

In 1987 the Legislative Auditor issued a sunrise analysis of a proposal to regulate home care services and to examine the provisions of House Bill No. 1804 (1986). The bill was 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.<sup>30</sup> The proposed bill had three mechanisms by which the public would be protected. Protection would have been provided by:

- (1) Regulating paraprofessional workers (home health aides, personal care aides, choreworkers, and housekeepers) through a Board of Home Care Services;
- (2) Regulating home care agencies through the Department of Health; and
- (3) Requiring the Department of Human Services to conduct criminal history checks on homemakers employed by the Department.

The Auditor found:

- (1) Little evidence that consumers have been harmed by the delivery of home care services; and
- (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. These include professional practice acts, the doctrine of respondeat superior, and other licensing and accreditation procedures.

The Auditor also found it neither desirable nor feasible to regulate the delivery of supportive services. Supportive services would include the kind of services

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27. Exploding the Myths: Caregiving in America, p. 28.

28. Ibid., p. 33.

29. Roy S. Azarnoff and Andrew E. Scharlach, "Can Employees Carry the Eldercare Burden?", Personnel Journal, Sept. 1988, pp. 60-65.

30. Hawaii, Legislative Auditor, Sunrise Analysis of a Proposal to Regulate Home Care Services (Honolulu: 1987), p. 13.

provided for personal care and chore or housework. The Auditor reported that most elderly abuse and neglect are caused by relatives who are under stress due to the burdens of caregiving and the proposed bill would not protect the at-risk population for care provided by relatives.

The Auditor suggested that instead of requiring certification of support staff, one approach would be to "encourage the development of agencies with strong community ties whose personnel would be most likely to share the cultural norms and traditions of clients."<sup>31</sup> Several other alternatives were suggested, including:

- (a) To amend section 349-12, Hawaii Revised Statutes, to authorize the EOA to represent the interests of home care consumers,
  - (b) To amend chapter 349C, Hawaii Revised Statutes, to require the reporting of abuse or neglect of any adult, rather than just adults who are over age 64, and
  - (c) To develop administrative agreements for the sharing of information on abuse or neglect of home care consumers between agencies receiving complaints.
- (3) Licensing of home care paraprofessionals would have numerous adverse consequences such as increasing the cost of health care by restricting the supply and mobility of workers, reducing providers' flexibility to utilize personnel in a cost-effective manner, restricting entry into the occupations by qualified persons, and limiting consumer choices.
  - (4) Voluntary criminal history record checks for choreworkers would serve no useful purpose, and the Department of Human Services 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 (such as training standards) to increase its effectiveness and responsiveness. The Auditor found that in the five years prior to 1987 there had been no complaints relating to home health agencies.
  - (7) There were numerous deficiencies in the proposed legislation including organizational and operational problems. Furthermore, the bill's proposed coverage of unpaid personal and domestic caregivers was viewed as unenforceable and causing problems for community organizations.<sup>32</sup>

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31. Ibid., p. 24.

32. Ibid., pp. 19-33.

### **Impact of Omnibus Budget Reconciliation Act of 1987 on Home Care**

Stricter requirements for certified home health care agencies will apply soon to home health aides with the enactment of the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203 (OBRA 1987).

Under OBRA 1987 beginning January 1, 1990, a person from a home health agency who gives care to a patient in a home who is not otherwise licensed (i.e., registered nurse, physician, etc.) must pass a state approved nurse aide training course and competency testing within four months of hiring. The state must establish a nurse aide registry which a nursing facility is expected to check before hiring. Any substantiated incidents of abuse or mismanagement of funds would be put on the nurse aide's record on the registry.

The effect of establishing a registry and training requirements means that home health care patients who are served by a home health agency can expect a level of competence and screening from home health aides. A related benefit for the family or elder who wants to employ a home health aide on private contract is to first verify whether or not that private hire appears on the nurse aide registry and whether there have been any problems reported about that person.

The requirements of certification and registration would not apply to other care providers such as homemakers, choreworkers, and personal care aides. These workers also enter the elder's home to provide home care services. Family members and other volunteers, friends, neighbors, and other informal caregivers also would not be required to be trained or evaluated under these requirements. Thus although the requirements of OBRA 1987 will affect a part of the estimated 500<sup>33</sup> paraprofessionals in the local home care industry, it is not expected to solve the problem surrounding potential abuse or exploitation of elders by informal caregivers and home care providers who are not nurse aides.

### **Summary**

In summary, despite the concerns raised by H.C.R. No. 309 and H.R. No. 333 (1989), there is little or no evidence of widespread abuse of the elderly in home care settings in any of the counties. The only statistical evidence would be the elderly abuse data maintained by EPS and the EOA Ombudsman, and it has already been shown that home care situations do not account for all reported incidents reported to these agencies.

Problems with worker non-appearance or poor work habits cannot be considered "abuse" or "exploitation" which require legislative action. A certain amount of consumer responsibility and initiative are required under those circumstances. In addition, if the worker is sent by an agency, consumer complaints to the agency should result in corrective action by the agency's management or supervisors.

The ABA's finding that standards for quality care must apply to the "widest possible spectrum" of agency types and funding sources is confirmed in Hawaii by the wide range of

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33. Franklin Sunn, testimony on Jan. 28, 1986 on H.B. No. 1804, relating to home care services, before the House Committee on Human Services and the House Committee on Health.

## QUALITY ASSURANCE IN HOME CARE FOR HAWAII'S ELDERLY

home care service levels which must be monitored if quality care is to be assured for all persons receiving home care. However, it is this very spectrum that makes it difficult to develop standards applicable to all types of caregivers.

The 1987 Legislative Auditor's analysis of a 1986 legislative proposal to regulate home care workers identified a major deficiency--how to monitor informal caregivers who do not normally come under anyone's scrutiny except that of the isolated elder. This group could make up about 80 percent of caregivers of the elderly. Agencies which provide home care services and the professionals involved in this industry are and have been concerned about quality assurance in the home care setting. The regulation of these formal agencies and professional caregivers can be accomplished through established governmental bodies but such regulation would not address the observation that only 20 percent of the caregivers would be required to meet regulatory scrutiny. Ultimately, quality assurance is a responsibility to be shared by all caregivers--formal and informal alike.

## Chapter 4

### ANALYSIS OF DATA

House Concurrent Resolution No. 309 (1989) and House Resolution No. 333 (1989) requested the Bureau to examine the issues involved in home care quality assurance to protect the elderly who receive care at home from exploitation and abuse. The resolutions asked that the following kinds of issues be examined:

- (1) Given the broad scope of home care services, can a single entity be responsible for assuring their quality and appropriateness and by what criteria should quality be measured?
- (2) Is it possible to design incentives to improve accountability and reward the delivery of quality care at home?
- (3) How can the recruitment, training, and supervision of home health workers be improved to enhance the quality of care provided?
- (4) Can quality care, particularly in personal care and chore services, be assured without pricing services out of the reach of the lower-income elderly?

The Bureau's study included a literature review and interviews of home care professionals. The following issues of quality assurance in home care in Hawaii were raised during this study.

#### Defining Home Care

Home care is a term which includes medicare's reimbursable home "health" care which consists of medically oriented therapeutic services. Providers of home health care are licensed by the Department of Health and must comply with federal rules and standards. There are about fifteen home health care agencies licensed by the Department of Health statewide. In addition to home health care, home care in the broadest sense provides for the needs of the elderly in many non-health areas and includes an array of non-medical supportive services. Home care services which provide supportive assistance (including personal care, respite, chore services, transportation, and legal assistance) do not require a license from the health department. Providers of these services are usually family members, friends, and neighbors, but also community organizations, social service agencies, for-profit companies, and private hires.

#### Identifying the Elderly Population in Need of Home Care

A high percent of the elderly (perhaps as high as 80 percent if Hawaii follows the national pattern) who need help in housekeeping, transportation, food preparation, grocery shopping, bathing, eating, grooming, walking, dressing, and other activities of daily living are probably receiving help from informal caregivers such as relatives or friends. The exact number of elderly in Hawaii who are receiving help from family and other informal sources has not been documented.

The state Department of Health does not maintain data about the number of elders receiving home health care reimbursed by medicare. Medicaid-eligible programs such as the Nursing Home Without Walls and the foster family community care programs served about 450 persons in fiscal year 1987. This figure could include individuals younger than 65 because the elderly are not the only age group requiring home care. Supportive services for the elderly in Hawaii funded by the Older Americans Act reached nearly 21,000 individuals as of January 1989 through the four counties' Area Agencies on Aging. This figure includes some double counts for persons receiving more than one service. The public health nurses of the Department of Health made more than 34,000 visits to persons over 60 years old statewide, in fiscal year 1987.

### **Fragmentation of Services and Funding Sources**

Hawaii is no different from other jurisdictions in having a variety of service providers and many different ways to pay for these services because the sources of funding, whether medicare, medicaid, Older Americans Act, state or county legislative appropriation, Aloha United Way, or private donations direct the kind of services provided, determine eligibility requirements and geographical coverage. Fragmentation of services is due to fragmentation of sources of funding, a finding that has been made in other states.<sup>1</sup>

### **Data on Abuse of the Elderly in the Home Care Setting**

To determine whether quality of care in home care is a problem for the elderly in Hawaii, the Bureau obtained data on complaints by and on behalf of elders from the Elder Protective Services office of the Department of Human Services and the Executive Office on Aging's Ombudsman. A breakdown of only home care complaints was not available. Data reflect all types of elderly abuse, including self-inflicted abuse or neglect.

The combined total of EPS and EOA complaints for 1988 was 453 complaints. Given the number of elderly in the state population (estimated in 1987 to be 109,000 persons 65 and older), the number of complaints is very low. Underreporting is suspected to be a problem with these statistics but not all of these complaints involved abuse, neglect, or exploitation of an elder in a home care setting. The Department of Health has received no complaints about licensed home health care providers. However, this may only mean that a licensed home health care provider could have handled any complaints internally if a complaint was made by a client to the manager of the agency.

There is no single agency mandated to receive complaints about home care providers. Licensed professionals such as nurses and doctors are monitored by their respective professional licensing boards, and complaints go to the Regulated Industries Complaints Office (RICO) in the Department of Commerce and Consumer Affairs. Complaints about medicare home health care providers can be made to Department of Health. Complaints about institutions which care for the elderly can be made to the EOA's Ombudsman. Complaints about the employee of a home care agency can be made to the director of the agency. In the case of a private hire, the elder or the family of the elder can terminate the services of the employee whose work may be unsatisfactory.

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1. Charlene Harrington and Leslie A. Grant. The Delivery, Regulation, and Politics of Home Care: A California Case Study (San Francisco: Institute for Health and Aging, 1988), p. 4.



### Current Research on Elder Abuse

Two research projects on elder abuse were announced as this report was being prepared. Both of these studies should generate needed information about elderly abuse.

The first study, The Hawaii Older Abuse and Neglect Research and Demonstration Project, will allow the University of Hawaii and the State to jointly train students to provide protective services for the elderly and participate in a national research project on elderly abuse and neglect. The project will be directed by the University of Hawaii School of Social Work and the Adult Services Program of the Department of Human Services.<sup>2</sup>

The second study, to be conducted by the University of Hawaii's Center on Aging and funded by state funds will be a state-wide needs assessment in the area of elder abuse and neglect. It is expected that this study will help to identify factors in the family, in the older person, or in other situations which can predict where and when abuse is likely to occur.<sup>3</sup>

### Quality Assurance is Not a New Concern

Assuring quality in home care has been a concern of home care agencies and service providers for many years. Quality assurance is an issue which has received considerable study and discussion in the literature and among professionals.<sup>4</sup> Thus quality assurance is not a new concern, as mechanisms have been in place for assuring quality. For example, medicare standards must be met by home health agencies; hospitals must meet accreditation guidelines; case managers, social workers, public health nurses, periodically assess client needs and living conditions to determine if care is appropriate. Understandably, the area of greatest difficulty is how to assess quality care where the elder is not seen in the home by any outsider because care is provided by a family member or a private hire. These individuals may come to the attention of the State only after a complaint is filed with the Elder Protective Services of the Department of Human Services.

### What is Quality?

It is generally agreed that quality assurance is necessary because home care is provided in an isolated setting, in scattered locations throughout the community, and for frail, vulnerable elders who rely on these services in order to continue to live in the community. Most quality assurance efforts concentrate on the factors which are easily verified, such as structural and process standards of the physical environment, the records maintained by the service provider, and compliance reports. However, less quantifiable factors such as interactions with live-in relatives, cultural compatibility with caregivers, or language barriers with caregivers also affect the quality of life at home. These outcome standards are less easily measured.

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2. Telephone interview with Patricia Snyder, Program Administrator, Adult Services Program, September 11, 1989, Department of Human Services and "Researchers from State and University of Hawaii will Study Elder Abuse" Honolulu Advertiser and Star Bulletin, Sept. 10, 1989, p. A-35.

3. Telephone interview with Dr. Anthony Lenzer, Interim Director, Center on Aging, September 11, 1989

4. For e.g., see references cited in Charles Sabatino, "Homecare Quality," Generations, Winter 1989, p. 16.

One example is that home delivered meals which are "nutritionally sound" (a standard similar to school lunches) may be unpalatable to older individuals of some ethnic backgrounds. What should quality assurance measure--the fact that the meal delivered to the elder met all dietary guidelines, hence was of good quality, or that it is tossed out by the elder who chose to go hungry because to that person the food was inedible?

### Consumer Responsibility

Whether home care is delivered by a paid caregiver or a volunteer, the family member, friend, or elder as a consumer must take an active, responsible role in evaluating the quality of care received. In many cases this means the family or friend of the elder must be able to express the needs of the elder and check on the quality of care provided if the elder is unable to do it for himself or herself. The State's taking a greater role in consumer education and in establishing a complaint registration system, would appear to be more valuable than trying to regulate these informal care systems.

A legislative proposal to regulate home care providers in 1986 was examined by the Legislative Auditor and found to be unworkable and costly. The Auditor determined that the intervention of government into these aspects of home care through licensing or other regulatory schemes would increase costs and make it more difficult to locate workers in this field. In addition, since much of home care is being provided by family members or friends who voluntarily provide services, it is questionable whether the government should discourage these otherwise humanitarian gestures by formalizing the care through regulation.

Despite the Legislative Auditor's 1987 findings that regulation of supportive services was not feasible, many professionals in the home care industry still felt some kind of certification and minimum training was called for to assure a minimum level of quality especially for homemaker and personal care attendants. However even professionals admit that certification and training can realistically be required only through regulation of agencies, not of those individuals who privately contract to provide services to elders. Furthermore no state presently requires certification of homemaker or personal care attendants.<sup>5</sup> Clients who hire workers who are not employees of an agency, or who may merely be referred by a registry or friend, must continue to assume major responsibility of supervision and verification of worker experience and performance.

### Legislative Policy and Commitment

It was generally agreed by professionals in the home care industry that incentives which would improve accountability in home care delivery include: (1) higher pay for paid caregivers, especially at the lower levels such as for the chore, homemaker, and personal care attendants; (2) greater outlays of funds for counselling and respite services to reduce caregiver stress; (3) increased funding to add to the number of case managers in public service agencies; and (4) increased funding for more quality assurance personnel to step up monitoring efforts. Each of these suggestions would mean a policy commitment by the Legislature to spend more public dollars to assure quality of care.

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5. The National Association for Home Care. Toward a National Home Care Policy, 1986, p. 28 and Hawaii, Legislative Auditor, Sunrise Analysis of a Proposal to Regulate Home Care Services (Honolulu: 1987), p. 26. hereafter cited as Sunrise Analysis.

## ANALYSIS OF DATA

The Hawaii State Legislature has expressed its concern for Hawaii's elders by appropriating funds for elder care programs in the past. In 1988 two enactments helped expand home care to people who are not eligible for medicaid. Act 208 extended the Nursing Home Without Walls (NHWW) services to the non-medicaid eligible population on a sliding fee basis to assist persons in the gap group. An appropriation of \$599,360 was made for fiscal year 1988-1989. Act 209 extended personal care services to the non-medicaid eligible population on a sliding fee basis until June 30, 1991. These efforts help to assure that lower income elderly who would not qualify for medicaid would still be able to benefit from personal care services and participate in NHWW programs. It is too early to know how many people benefited from these appropriations but the Bureau's interviews with Area Agency on Aging representatives indicated that these funding programs are needed and are being utilized.

In 1989 Act 154 amended the definition of non-medicaid recipient in the NHWW program and among other things appropriated more than \$1.6 million for fiscal year 1989-1990 and nearly \$2 million for 1990-1991 for the services provided by these programs.

Additionally, Act 380 also established a long term care service development fund and required the EOA, in consultation with the Department of Business and Economic Development to study the methods by which the private sector can more effectively participate in providing community-based services (similar to home care). A report is required for the 1990 legislative session. An appropriation of \$800,000 was made for deposit into the long-term care services development fund, \$100,000 for training and assistance in business plan development, \$50,000 for a study to recommend business development methods and an analysis of the community-based long-term care industry, and \$50,000 for staffing and operating expenses. These legislative actions indicate a general policy commitment to help the elderly in Hawaii maintain an active life in their homes for as long as possible.

### Consumer Education

The EOA presents public information to the elderly at places such as senior centers. The EOA should sponsor seminars, workshops, and publish and disseminate home care information directed to educating consumers in detail about what to look for in a home care situation. Many consumers do not know what to expect from a home care service provider, including what skills should be expected of a personal care aide, who to ask for an explanation of services, how to recognize poor work performance, and where to complain about poor service, tardy, disrespectful workers, or other problems. If the elder or family decides to "do it themselves", information should include how to interview and screen potential employees, how to protect valuables in the home, and the obligations of the consumer as an employer for liability insurance, social security and income tax withholding, unemployment compensation and workers' compensation, and so forth.<sup>6</sup> Some of these kinds of information could be disseminated through newsletters produced by the Area Agencies on Aging listed in Appendix H. An example of the kinds of concerns which a client should consider is listed in Appendix I, which was developed on Kauai for home sharing, a program that is now defunct.

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6. Janet Zhun Nassif, The Home Health Care Solution, A Complete Consumer Guide (New York: Harper and Row, 1985), pp. 126-136.

### **Additional Aspects of Consumer Education**

Another aspect of consumer education is the education of informal caregivers who wish to learn how to provide care for an elder at home. Informal caregivers, though not required to be licensed, might be better able to cope with caregiving after receiving basic instruction on how to care for an elderly person at home. The Legislature should look favorably to any demonstration project that is created (perhaps through the Older Americans Act) which would teach unpaid caregivers how to feed, bathe, or move a patient. Both classroom and hands-on sessions for a small fee would probably benefit the caregiver and the elder in better understanding the aspects of home care. An educated consumer would also be a better judge of whether or not an independently contracted caregiver was doing a poor, fair, or good job.

One example of consumer education is a class provided by Straub Clinic and Hospital on caregiving. Approximately 50 people attended a noon time program on caregiving which covered the topics of Straub's Senior Plan, Home Health Services, and safety hints to prevent falls by the elderly (see Appendix J).

### **Attracting More Workers to the Home Care Field**

A major finding from the Bureau's interviews was the severe shortage of workers in the home care industry. When an elder or natural caregiver is desperate to find help, there is a greater tendency to ignore quality control measures such as conducting a thorough interview and background check of a worker. *Under these conditions there would be less likelihood that a client would complain if service is poor because it would be difficult to find another caregiver.*

In view of the shortage of workers in the home care field, innovative demonstration projects that propose ways to utilize previously underutilized age groups must be considered. One suggestion received from Maui's Area Agency on Aging was the development of employment projects which hire healthy senior citizens and high school students with proper training and supervision for caregiving tasks.

### **Mechanisms for Registering and Investigating Home Care Complaints**

In order to collect accurate data about the extent of elderly abuse, neglect, exploitation, and similar complaints in the home care setting, there should be a single telephone number which the public can call to register any complaint about an elder's home care.

The Auditor's suggestion that section 349-12, Hawaii Revised Statutes, be amended to authorize the EOA to represent the interests of home care consumers should be implemented to include expansion of ombudsman duties for investigating complaints by and for home care recipients.<sup>7</sup> Sabatino pointed out that the long-term care ombudsman model under the Older Americans Act is a grievance mechanism which already exists, is known, accessible, and

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7. Sunrise Analysis, p. 24.

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responsive to clients.<sup>8</sup> The next logical step would be to test whether with sufficient publicity, the expansion of the EOA's Ombudsman's duties into home care complaint investigation would be utilized by the elderly population.

The expansion of the duties of the EOA's Ombudsman to include investigation of home care complaints would utilize an existing program in the EOA. A bill (H.B. No. 66) which would have appropriated funds to expand the EOA's Ombudsman program by one position did not pass in the 1989 session and remained in the Ways and Means Committee as of this writing.

The Omnibus Budget Reconciliation Act of 1987 requires the establishment of a hotline, but this hotline is one which is designed for complaints regarding home health agencies and nursing home care, and therefore disregards non-institutionalized home care beneficiaries. An expansion of the hotline function would be useful to home care beneficiaries. According to Sabatino:

The most significant recent development strengthening the role of grievance systems springs again from OBRA, which mandates the establishment of state toll-free hotlines and investigative units to receive and respond to complaints involving Medicare-certified providers. The cost of these systems if seriously implemented will be significant. So, to the extent that states utilize them to monitor more than just Medicare home healthcare, they may be able to achieve some economies of scale and benefit a wider range of home care consumers than just Medicare beneficiaries. (Emphasis added.)<sup>9</sup>

The Department of Health has not established the hotline but expects the OBRA 1987 mandate will result in the creation of the hotline in a few years. When it is established, advertising could expand its use to non-medicare home care complaints.

A generic information and referral (I & R) telephone number for any type of human services information is in the process of being established through cooperative efforts of Aloha United Way (AUW), the Health and Community Services Council (HCSC), the Volunteers Information and Referral Service (VIRS), and the state departments of Health, Labor and Industrial Relations, and Human Services (see newsclip copy in Appendix K). The single access telephone service will eventually be a statewide service for which complaints regarding home care service could be only one of many components which receive attention. Assuming that the I & R number received a complaint about home care, the complaint would be referred to the proper office for investigation and followup. According to a HCSC representative, the I & R line is not intended as a hotline, which implies a crisis intervention kind of service but will be instead a single access information number for social service assistance.<sup>10</sup>

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8. Sabatino. pp. 15-16.

9. Ibid., p. 16.

10. Telephone interview with Peggy Misset, Computer Assistance Manager. Health and Community Services Council, Aug. 23, 1989.

The Legislature should support the creation of an information and referral or "hotline" number for home care complaints of any kind, regardless of who provides the service. This complaint hotline should be well publicized in buses, radio and television spots, as well as through senior citizen centers, and hospitals.

### **Consumer's Bill of Rights**

The education of consumers also involves the concept of a consumer's bill of rights--a written statement that clearly describes the rights of the recipient of home care services to know what is being done and why. A sample of a typical "bill of rights" is reproduced in Appendix L. During the Bureau's interviews, a consumer bill of rights received mixed reviews, some detractors claiming that many home care recipients and families would not bother to read "another piece of paper". However, the Bureau feels that as part of the education process, the consumer and the provider should be put on notice in writing that specific minimum levels of service can be expected by the consumer and that a specified grievance mechanism is available to the consumer who is dissatisfied with service.

The active participation of the client with the care provider would help the client understand what kind of care will be provided and why. Client involvement can result in client freedom of choice, knowledge, control over care, and similar benefits. Sabatino refers to this as "client empowerment" and an essential requirement in any quality assurance program.<sup>11</sup> Several service providers already provide a consumer bill of rights and before beginning service receive a signed consent form which indicates that the elder (or family) understands the kinds of care that will be provided. For example, see Appendix M, Project Malama's Agreement to Participate (in its case management program).

### **Followup on Legislative Auditor's Suggestions**

Of the ten or so findings made by the Auditor, only the suggestion to broaden elder abuse to adult abuse has since been acted upon. The Auditor's recommendation that chapter 349C, Hawaii Revised Statutes, be amended to broaden the requirement that abuse or neglect be reported for any adult (between age 18 and 64) and not only for those 65 and older, was enacted as Act 381, Session Laws of Hawaii 1989. This means that there will no longer be a group (between 18 to 64) that cannot be protected from incidents of reports of abuse and neglect. The definition of "abuse" and the listing of specific instances or circumstances in which abuse occurs, along with the definition of "dependent adult" will help in the identification and collection of data in this area. A copy of Act 381 is reproduced in Appendix N for the benefit of the reader. Act 381 is a temporary act which takes effect on July 1, 1991, and is automatically repealed on June 30, 1993.

### **Increased Funding to Support Quality Assurance Monitoring Efforts and Higher Wages for Caregivers**

Many existing home health or home care programs are monitored and must comply with federal and state guidelines on quality. The Legislature can support these programs by

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11. Sabatino, pp. 15-16.

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increasing funding to staff oversight efforts which are designed to check on quality assurance. For example, increased funding in the quality assurance efforts of NHWW would help to increase the current 10 percent samples monitored in the Community Long-Term Care Medicaid Waiver programs to a higher percentage.

There is no formal requirement for quality assurance standards in the Older Americans Act or Title XX of the Social Services Block Grant, but if the Legislature places a high priority on assuring quality in these programs, then future funding can be tied to the establishment of quality assurance guidelines. Of course, this will require additional funds to staff monitoring and enforcement programs.

Increased funding to pay a higher wage rate for chore, homemakers, and personal care aides, would help in recruitment and retention in these hard-to-fill categories. It is expected that these and similar issues will be addressed by the study requested by Act 380 (1989) and funded by the long-term care service development fund.

### The Role of Case Managers

The assurance of excellent quality care in the home requires supervision and monitoring of the caregivers. Some elders are able to assert themselves sufficiently to assure the receipt of competent services. If the elder is unable to do so, the family must provide the supervision and monitoring, but even then not all family members have the interest or ability to do this. Often the quality assurance aspects of home care are left to formal agents such as a case manager, because the case manager has more experience with service providers and knowledge of appropriate care levels. With proper case management, the assessment of care and advocacy of the elder's needs receives professional, but more expensive, attention. Project Malama, the NHWW, and the Department of Health's Community Long-Term Care Program all provide case managers. Not all service providers have case managers, however, because of the way service is provided in a fragmented fashion by a variety of social service and community organizations.

Increased support to case management services is required if quality assurance is a major goal in home care. This would mean not only increases to the number of case managers to accommodate reasonable caseloads, but also higher salaries to attract more workers into this profession. A commitment to case management might follow the example of New York State's Expanded In-home Services for the Elderly Program (EISEP) which requires each EISEP program to provide case management and in-home services.<sup>12</sup>

In New York State, "[c]ase management is the most important component of EISEP in that it is the key to helping clients and their families assess their long term care needs, develop an appropriate plan of care, and initiate service delivery.... The case manager in consultation with the family and other informal caregivers develops a plan of care that provides appropriate services and helps the client find and use available services."<sup>13</sup>

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12. New York State Office for the Aging. EISEP, the First Year, 1987-88 (Albany: 1989). p.8

13. Ibid., p. 11.

### Case Management in the County of Hawaii

A local case management approach which deserves mention is the Senior Case Management Coordination Project (CMCP) in the County of Hawaii. This project is funded by the State of Hawaii and the Older Americans Act through the Hawaii County Office of Aging and the State EOA. The objective of this developmental model is to use an interdisciplinary approach to serve frail, vulnerable elderly (60 years and older) by using two levels of interdisciplinary teams to maximize services needed by the elder and to provide services in an efficient and effective manner through shared information.

The first team is the mid-management team which consists of administrators (or their representatives) of agencies in the aging network, including Department of Health, Department of Human Services, the Legal Aid Society of Hawaii, the county Police Department, and the Hawaii County Office on Aging. This team serves as the planning, advisory, and evaluation group. The second team is made up of actual service providers, the client (or relative), the coordinating public health nurse, and others, who meet to develop the care plan.

The advantages of the CMCP are many, including top level support, in-service training and regular followup by the public health nurse, counseling, patient involvement, and ability to maximize the services available from many different agencies. The team case-management model was initiated in Hawaii County in 1982 and was subsequently developed for Maui, Kauai, and Oahu in the mid-1980s.<sup>14</sup>

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14. Interviews with June Kunimoto, Public Health Nursing Supervisor, Project Director-Case Management Program, Department of Health, Jane Testa, Program Specialist, Hawaii County Office of Aging, Molly Pruyn, Case Management Coordination Project. See also: Laura Jean C. Armstrong and Constance M. L. Chock, "An Alternative Approach to Care for the Frail, Vulnerable Elderly in Hawaii," Hawaii Medical Journal, November 1987.



## Chapter 5

### CONCLUSIONS AND RECOMMENDATIONS

#### Conclusions

1. Home care includes not only medically oriented skilled care (which may be reimbursed by medicare, or funded through medicaid), but also includes a variety of non-medical services which enhance the ability of the elderly to accomplish activities of daily living. With these services, the elderly are able to live at home for a longer period of time and in some cases, in a more frail, vulnerable condition than was possible in the past.

2. There is no accurate count to indicate how many elderly in Hawaii receive help from informal sources such as family and friends, but it is estimated that 20 percent of elders cared for at home receive assistance from formal sources and informal sources provide services to about 80 percent of all elders being cared for at home. These informal sources provide transportation, grocery shopping, help monitor medication, provide personal care such as bathing and feeding, as well as companionship and social support.

3. Formal sources of home care help include home health care services from a hospital based agency, case management through Department of Health public health nurses or social service programs attached to the Department of Human Services. Community organizations, church groups, social agencies, and support groups of different diseases also provide meals, transportation, telephone reassurance, personal care attendants, information and referral, and other services to the elderly, often through programs funded by the Older Americans Act through county Area Agencies on Aging. Proprietary agencies can also provide caregivers for a fee.

4. There are as many different service alternatives as there are sources of funding--federal funds, state funds, county appropriations, and private donations. Hawaii is no different from other states in this regard.

5. Quality is an elusive concept that has received considerable study by professionals. Adherence to standards of care, provision of necessary and appropriate services, and monitoring of patient outcomes, are all aspects of "quality". Quality assurance may be monitored by meeting federal medicare guidelines and state licensure for medicare reimbursement; by seeking hospital accreditation; by insurers for third party payments; and by social workers, nurses, case managers, agency personnel, and others who might see an elder in the home setting. The elder who is least likely to receive quality assurance control is one whose care is solely the responsibility of a family member, or a privately contracted companion and who is not seen by an outside party such as a case manager or social worker.

6. There are no definitive statistics about abuse by caregivers (either formal or informal) in the home care setting in Hawaii. While there might be a problem with underreporting of exploitation and abuse of the elderly in Hawaii, the general consensus among home care professionals is that formal providers of home care are less likely to be the cause of abuse than family members who are under stress from having to provide daily care without respite. This is because formal providers have mechanisms for periodic checking on the elder's condition and supervisory controls over employees. Therefore the Resolutions' questions asking whether recruitment, training, and supervision of home care workers can be improved to enhance quality of care and whether incentives can be designed to deliver quality

care at home generally do not apply to the great majority of caregivers--the informal caregivers who provide care by themselves--except to the extent that they may hire individuals to provide services.

7. There is a shortage of workers in home care agencies such as nurses, home care aides, personal care attendants, and chore workers, which reflects the general statewide shortage of workers in many other fields as well, i.e., the low unemployment situation. Even if salaries for these groups were increased, workers might still be difficult to find. Thus, it appears that home care provided by family or neighbors and friends will continue to be the best available and financially affordable alternative.

8. Certification, licensing, and regulation of home care workers might be reasonable only at the agency level, not for individuals who independently contract their services to an elder. Yet it is the "independent" who is least subject to outside scrutiny. It also appears infeasible to regulate informal caregivers who constitute such a high percentage of care providers. In 1987 the Legislative Auditor analyzed a legislative proposal to regulate home care providers and concluded that the proposal was unworkable.

9. The Legislature has had a history of commitment to helping the elderly of Hawaii through legislative enactments in the past few years. Examples include the expansion of Nursing Home Without Walls services to those elderly who are not eligible for medicaid by providing services on a sliding fee basis and establishing a long-term care service development fund. Thus it does not appear that services are being priced out of reach of the the low-income elderly. The more relevant issue is how to encourage more workers to enter the home care field when the number of elderly who need home care services is growing and will continue to grow in the coming years.

10. Professionals concerned with quality assurance who feel that licensing, certifying, or otherwise regulating home care providers is the best way to assure quality must address the following issues as well as those raised by the Legislative Auditor in its sunrise report.

- a. While regulation of agencies (not individuals who contract their services independently) is recognized by the professionals themselves as the most reasonable way to control worker quality, this solution affects only 20 percent of caregivers, not the family member or other kinds of caregivers who may be just as likely to abuse or exploit an elder. The monitoring of the remaining 80 percent of unregulated caregivers must be addressed if quality of care is to be assured for all home care recipients. Realistically, consumer education and mechanisms for reporting abusive situations might be the best methods for assuring quality for elders cared for by informal caregivers.
- b. Given the low unemployment rate and the difficulty in locating workers for home care services, the costs of regulation currently appear to outweigh the benefits. There are existing methods of monitoring quality care provided by medicare rules, state licensing of home health agencies, insurers, and other service providers. Recruitment, training, and supervision of home care workers associated with agencies already follow established procedures to assure that the clients receive appropriate care. If any regulation of home care agencies is proposed, the Department of Health must include not only licensed home health care agencies, but unlicensed providers of home care within the scope of regulatory coverage. Only in this way can all organizations and agencies who

## CONCLUSIONS AND RECOMMENDATIONS

send individuals into the home to provide care to clients of all ages be adequately monitored.

Informal caregivers and independently contracted caregivers while not regulated, can still provide good care. Here again, consumer education can enhance the quality of care provided so that recipients and families can learn to identify the factors associated with good care. It would behoove the State to identify alternatives to formal regulation which could still assure quality in the home care setting.

### Recommendations

1. Consumer education ranks high in assuring quality care of elders. Although the Resolutions ask whether a single entity should be responsible for assuring quality in home care service, this is not the true issue. Service providers vary because funding sources and rules for spending these funds vary. This does not mean that quality is thereby diminished. The State can intervene to bring the consumer closer to the issues of quality care through education.

Education begins with teaching the general public about where to seek basic information about community services for home care of the elderly. A series of informational programs presented at senior citizen centers would be a good start. The Executive Office on Aging through its county Area Agencies on Aging already has mechanisms for funding, organizing, and disseminating information about care of the elderly. Cooperative efforts with community colleges can bring this kind of information to every island.

Education about the frequency and occurrence of abuse of the elderly would bring a "hidden" topic out into the public arena. A more accurate indication of the extent of elderly abuse can be possible only if the incidents are recorded and investigated. The general population must learn how to recognize abusive situations and where to report these complaints. This might take the form of a "hotline" or an ombudsman to investigate and mediate problems between the elder and the caregiver. The expansion of duties of the Executive Office on Aging's ombudsman to include receiving home care complaints and referral of the complaints to the appropriate agency for investigation would be an appropriate way to provide a mechanism for investigating abuse of the elderly in home care settings. The results of two current studies being conducted by agencies of the University of Hawaii on elder abuse and neglect should provide additional information about this phenomenon.

Because the informal caregiver remains the largest group of potential abusers, educating consumers on how to properly care for elders and where to seek help when caregiving tasks become too burdensome are also part of the education process. Other educational needs include pointing out the importance of careful interviews of potential caregivers and what skills to look for in a worker when a consumer chooses to hire a caregiver without the aid of an agency or professional. The Executive Office on Aging and the county Area Agencies on Aging, with the cooperation of community colleges, senior citizen groups, and perhaps hospitals, case managers, and the like can put together demonstrations, hands-on seminars, and workshops to teach caregivers the simpler procedures of caregiving tasks. A class for "do-it-yourselfers" must also include the Department of Labor and Industrial Relations to point out employer-employee regulations which must be fulfilled, such as workers' compensation fees, social security taxes, and similar obligations.

## QUALITY ASSURANCE IN HOME CARE FOR HAWAII'S ELDERLY

2. The Legislature historically has been supportive of programs for the elderly. In addition to supporting consumer education programs described above, many of the existing social services for home care can be supported with additional funding. Assuming that the Legislature determines further support of programs for the elderly is warranted, funds would be well spent to assure quality in home care by supporting programs which utilize case management because case managers, whether nurses, social workers, or others provide a vital linkage service between the client and the array of service providers.

Other programs which deserve funding include programs which help the informal caregiver cope with the problems of continual caregiving, such as respite workers, chore workers, and personal care attendants. Assisting the informal caregiver lessens the likelihood of burnout and subsequent neglect of the elder. Finally, programs which facilitate the registering of consumer complaints such as a home care ombudsman would be valuable because there is no single agency which is currently responsible for collecting and acting upon home care complaints.

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## HOUSE CONCURRENT RESOLUTION

REQUESTING A STUDY OF THE PROBLEMS INVOLVED IN ASSURING QUALITY  
OF CARE BY IN-HOME PROVIDERS.

WHEREAS, most frail elderly people prefer to live in their own homes and to maintain their independence, even if they require help to do so; and home care services, which can range from high-tech medical services to housekeeping services, can make this goal possible for a great number of these individuals; and

WHEREAS, in a comparison with care in an institutional setting, home care is more likely to: (1) result in consumer satisfaction; (2) provide for a higher quality of life and a greater degree of functional independence; and (3) be more cost effective for individuals without intensive medical care needs; and

WHEREAS, even the most strident critics of institutional care and the most ardent advocates of home care express discomfort at the lack of oversight to assure appropriateness, quality, coordination, and continuity of care in the home and admit that anything that can go wrong in a nursing home can go wrong in a residence but that it will be more difficult to discover and correct deficiencies in the relatively unregulated world of home care; and

WHEREAS, unlike many states, Hawaii's licensure requirement leaves only the skilled intermittent care of licensed home health agencies to ensure that home health care providers adhere to standards of quality and appropriateness of care; however, even these do not apply to all types of services, and a growing number of providers are electing to forgo licensure to avoid the constraints imposed by licensure; and

WHEREAS, in assessing appropriateness, management, and quality of services the following questions arise:

- (1) Given the broad scope of home care services, can a single entity be responsible for assuring their quality and appropriateness and by what criteria should quality be measured?

- (2) Is it possible to design incentives to improve accountability and reward the delivery of quality care at home?
- (3) How can the recruitment, training, and supervision of home health workers be improved to enhance the quality of care provided?
- (4) Can quality care, particularly in personal care and chore services, be assured without pricing services out of the reach of the lower-income elderly?

and

WHEREAS, the steadily increasing number of elderly in Hawaii, both in absolute terms and as a proportion of the general population, necessitates the expansion of home care services to provide the elderly with the type of care they prefer and to avoid placing on the State the unbearable burden of providing institutional care for this large and growing segment of the population, but with an expansion of home care services must come assurances that such services are appropriate and of high quality; now, therefore,

BE IT RESOLVED by the House of Representatives of the Fifteenth Legislature of the State of Hawaii, Regular Session of 1989, the Senate concurring, that the Legislative Reference Bureau conduct a study to examine the issues involved in home health care quality assurance, including, but not limited to, those discussed above and determine the most appropriate course for the State of Hawaii to follow in this area; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau report its findings to the Legislature not less than twenty days prior to the convening of the Regular Session of 1990; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of the Legislative Reference Bureau.

OFFERED BY:

Joan Hayes  
Larry Spier

Mrs. Anna J.  
 Leanni A. Croteau

Joseph P. Leong  
Luis A. Sandoval  
Khan K. Khan

APR 05 1989

W. Marshall  
HCR HMS 6248  
J. M. Smith

## APPENDIX B

### GLOSSARY OF SERVICES

The items in this glossary define nursing home care and a variety of services that may be provided through an expanded home care program. We have adapted these definitions from P. A. Steiner and J. Needleman, "Expanding Long-Term Care Efforts: Options and Issues in State Program Design," Lewin Associates, Inc., March 1981, pp. 11-13.

Adult day care. A wide variety of day care services exist. Two major models are

Medical model. An out-patient center for people in need of limited yet regular physical rehabilitation or other health services. Frequently providing meals and limited social activity as well, this approach to day care has a strong health care orientation.

Multipurpose model. An out-patient center that provides social interaction and some social and medical services to elderly people in a fixed location for a limited number of hours.

Case management and channeling. An administrative service that links the client and the providers of long-term care. Often case management and channeling programs provide client assessment, service plan development, and follow-up monitoring.

Chore and homemaker services. Household services such as shopping, cooking, and cleaning.

Congregate housing. A group living environment that promotes independent living by supplying supportive medical and social services, either directly or through referral, to elderly people who are in good health despite financial or social impairments.

Domiciliary facility. A residential institution for people in need not of health-related services but of personal assistance in bathing, grooming, dressing, eating, and the like.

Friendly visiting. A service designed to decrease the social isolation of the elderly through regular in-home visits by professionals or volunteers.

Home health care. Medically oriented care for people who are acutely or chronically ill that is provided in a patient's home and that includes services like cleaning wounds, changing bandages, giving injections, and inserting catheters.

Intermediate-care facility. Health-related services that can be offered only in an institutional setting and that are less than those offered in a hospital or skilled-nursing facility but more than room and board. Several levels of this care have been established in many States.

Legal assistance. Free or partially subsidized assistance with legal matters such as wills and tenants' rights.

Meals on wheels. The delivery of inexpensive, nutritionally sound meals in a participant's home. As well as providing meals to people who are unable or unlikely to cook for themselves, the program provides social contact for isolated people.

Nutrition services. Services designed to provide inexpensive, nutritionally sound meals to elderly people in congregate settings.

Personal care services. Personal care includes such services as bathing, dressing, and grooming and is provided in a participant's home.

Respite care. Short-term in-patient or out-patient care delivered to an elderly person in lieu of a regular source of support. The service is normally designed to provide regular relief to relatives and friends who care for the elderly.

Senior centers and recreation services. Services that increase the vigor and social interactions of elderly people by providing formal social activities and a central meeting place. In addition, senior centers act as clearing houses for elderly people in need of information or services.

Skilled-nursing facility. Continuous skilled nursing care or other skilled rehabilitative care provided in a residential facility 24 hours a day and requiring the care of a skilled nurse or other skilled rehabilitation provider.

Telephone reassurance. A service designed to decrease social isolation by providing regular telephone contact to elderly people living alone.

Transportation services. Services designed to increase an elderly person's mobility by improving financial or physical access to transportation. Programs range from the provision of subsidies or public transit systems to the operation of special mini-buses for the exclusive use of senior citizens.



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## APPENDIX D

### HELPING HANDS RESOURCE HANDBOOK

#### Services for the Frail, Homebound Elderly

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# APPENDIX E

## STATE OF HAWAII DEPARTMENT OF HEALTH MEDICARE ADMINISTRATION HOSPITAL & MEDICAL FACILITIES BRANCH

### HOME HEALTH CARE AGENCIES

<u>NAME</u>	<u>ADDRESS</u>	<u>DIRECTOR(S)</u>
OAHU		
CASTLE HOME CARE	640 Ulukahiki Place Kailua, Hawaii 96734	Mrs. Linda Woertz
COMPREHENSIVE HOME SERVICES, INC.	222 North School Street Honolulu, Hawaii 96817	Connie Wiletsky
HOSPICE HAWAII, IIIA	310 Paokalani Ave., Ste.204 Honolulu, Hawaii 96815	Robert Luck
KOKUA HOME HEALTH AGENCY	1210 Auahi St., Suite 223 Honolulu, Hawaii 96814	William J. Daniels
KAHUKU HOSPITAL, IIIA	P. O. Box 218 Kahuku, Hawaii 96731	Rikio Tanji
KUAKINI-AT-HOME	347 North Kuakini Street Honolulu, Hawaii 96817	Judith Walden
MEDICAL PERSONNEL POOL	1441 Kapiolani Blvd. Suite 1320 Honolulu, Hawaii 96814	Carol Kikkawa-Ward
STRAUB CLINIC & HOSPITAL, INC. IIIA	888 South King Street Honolulu, Hawaii 96813	Linda Henning, R.N.
ST. FRANCIS HOME CARE	2230 Liliha Street Honolulu, Hawaii 96817	Charlotte Dennis, R.N.
Family Home Care	1319 Punahou Street Honolulu, Hawaii 96826	Doreen Naito

# HOME HEALTH CARE AGENCIES (CONT.)

<u>NAME</u>	<u>ADDRESS</u>	<u>DIRECTOR(S)</u>
<u>OAHU (CONT.)</u>		
WAIANAEO COMPREHENSIVE HEALTH CENTER	86-260 Farrington Highway Waianae, Hawaii 96792	Michael D. Tweedel, MPH
<u>HAWAII</u>		
HILO HOSPITAL HOME HEALTH	1190 Waiuanue Avenue Hilo, Hawaii 96720	
MEDICAL PERSONNEL POOL (SUB-UNIT HILO BRANCH)	312 Haili Street Hilo, Hawaii 96720	Emma Lau
MEDICAL PERSONNEL POOL (SUB-UNIT KONA BRANCH)	P.O. Box 694 Captain Cook, Hawaii 96704	Emma Lau
WEST HAWAII, KONA SUBUNIT	P. O. Box 69 Kealahou, Hawaii 96750	Helen Ozaki, RN
<u>KAUAI</u>		
ST. FRANCIS HOME	3224 B Elua Street Lihue, Kauai 96766	Claire Alfiler, R.N.
<u>LANAI</u>		
LANAI HOME HEALTH AGENCY	628 7th Street Lanai City, Lanai 96763	Laura Armstrong

HOME HEALTH CARE AGENCIES (CONT.)

<u>NAME</u>	<u>ADDRESS</u>	<u>DIREC</u>
<u>MAUI</u>		
HALE MAKUA HOME HEALTH CARE SERVICE	472 Kaulana Street	Martha Turner
<u>MOLOKAI</u>		
MOLOKAI HOME HEALTH AGENCY	P. O. Box 230 Kaunakakai, Molokai 96748	Laura Armstrong, R.N.



STATE OF HAWAII  
DEPARTMENT OF HEALTH  
MEDICARE ADMINISTRATION  
HOSPITAL, & MEDICAL FACILITIES BRANCH

<u>NAME</u>	<u>ADDRESS</u>	<u>HOSPICES</u>	<u>DIRECTOR(S)</u>	<u>MEDICARE CERTIFICATION NO.</u>
<u>OAHU</u>				
HOSPICE HAWAII	310 Paoakalani Ave., Suite 204 Honolulu, Hawaii		Robert Luck	
ST. FRANCIS HOSPITAL HOSPICE	2230 Liliha Street Honolulu, Hawaii 96817		Sister Francine Gries	
<u>KAUAI</u>				
SAMUEL MAHELONA MEMORIAL HOSPITAL	4800 Kawaihau Road Kapaa, Kauai, Hawaii 96746		John English	

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Title 11

Department of Health

Chapter 97

Home Health Agencies

Sec. 11-97-1 Definitions

Sec. 11-97-2 Legal authorization to operate

Sec. 11-97-3 License

Sec. 11-97-4 License revocation

Sec. 11-97-5 Policies

Sec. 11-97-6 Administration and standards

Sec. 11-97-7 Penalty

Sec. 11-97-8 Validity

Historical Note: Chapter 97 of Title 11, Administrative Rules is based substantially upon Chapter 12D of the Public Health Regulations, Department of Health. [Eff. 11/4/69]

R FEB 01 1982

Sec. 11-97-1 Definitions as used in the chapter:

"Administrator" means the person responsible for the administration of the organization of which the home health agency is a part.

"Department" means the department of health, State of Hawaii.

"Director" means the director of health for the department of health, State of Hawaii, or a duly authorized agent.

✓ "Homebound patient" means a person who because of a condition due to illness or injury is restricted in his ability to leave his place of residence except with the aid of supportive devices such as, crutches, canes, wheelchairs, walkers, use of special transportation, or the assistance of another person; or a person who has a condition which is such that leaving his home is medically contraindicated.

"Home health agency" means 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.)

"Home health agency coordinator" means the person responsible and accountable for the functioning of the agency and the services provided. Preferably, the coordinator shall be a qualified public health nurse.

"Home health aide" means a person who has successfully completed the basic prescribed nurse aide course in the community college system; or an equivalent course, with additional training and supervision to prepare the person for this role.

"Licensed practical nurse" means an individual who has successfully completed a prescribed course as established for licensure as a licensed practical nurse in the State with a current valid license to practice in the State.

"Medical social worker" means a person who is a graduate of a school of social work accredited by the Council on Social Work Education and has had social work experience in either a hospital, outpatient medical rehabilitation, medical care, or mental health program.

"Occupational therapist" means an occupational therapist currently registered by the American Occupational Therapy Association.

"Occupational therapy assistant" means an occupational therapy assistant who has successfully completed a training course approved by the American Occupational Therapy Association and is certified by that body as a certified occupational therapy assistant.

"Physical therapist" means any physical therapist currently licensed to practice in the State as a physical therapist.

"Physical therapy assistant" means a person who has successfully completed a curriculum of study approved by the American Physical Therapy Association leading to an associate of arts degree.

"Physician" means any physician or surgeon having a valid, unrevoked license from the State.

"Proprietary agency or organization" means a private agency or organization not exempt from income taxation under Section 501C of Internal Revenue Code of 1954.

"Public agency or private non-profit agency" means an agency exempt from income taxation under Section 501C of the Internal Revenue Code of 1954.

"Public health nurse" means any nurse licensed to practice professional nursing in the State who has completed a baccalaureate degree program approved by the National League for Nursing or graduated with a diploma from an accredited three-year nursing program supplemented by completion of an accredited university curriculum in public health nursing for which a certificate was awarded.

"Registered professional nurse" means a professional nurse currently licensed by the State as a registered professional nurse and has had at least one year's experience as a professional nurse.

"Speech therapist" means a person who has been granted a certificate of clinical competence in the appropriate area-speech pathology or audiology by the American Speech and Hearing Association; or meets the equivalent educational requirements and work experience necessary for such certificate; or has completed the academic and practicum requirements for certification and is in the process of accumulating the necessary supervised work experience required for certification. [Eff. FEB 01 1982 ]  
(Auth: HRS Sec. 321-11) (Imp: HRS Sec. 321-11)

Sec. 11-97-2 Legal authorization to operate. A home health agency and, in cases where the home health agency is a part of a larger organization, shall at all times comply with the laws of the State and shall, whenever required by the director, submit to the director evidence of compliance therewith. Such evidence shall include but not be limited to, copies of licenses, certificates, permits, or other authorizations required by the laws of the State of Hawaii. [Eff. Feb. 01, 1982 ] (Auth: HRS Sec. 321-11) (Imp: HRS Sec. 321-11)

Sec. 11-97-3 License (a) It is unlawful for any person, to conduct, maintain, operate, or permit to be maintained or operated, or to participate in conducting, maintaining or operating a home health agency, unless the home health agency is licensed by the director.

(b) Any person, organization or corporation desiring to operate a home health agency shall make application to the director for a license on forms provided by the department. The director shall issue a license if the proposed home health agency meets the requirements under this chapter.

(c) A license, unless sooner suspended or revoked, shall be renewed every two years on date, or within 30 days thereafter. Application for renewal of license shall be made by the home health agency thirty days prior to the expiration date of

the license. If an application for renewal is not filed, such license shall be automatically cancelled as of the expiration date.

(d) Each license shall be issued only for the home health agency named in the application and shall not be transferable nor assignable to any other agency or person.

(e) The license issued by the director shall be posted in a conspicuous place on the premises of the home health agency.

(f) A home health agency shall notify each patient concerned and the patient's physician directly at least thirty days prior to the voluntary surrender of its license or as directed under any order of revocation or suspension of license by the department. The license shall be promptly surrendered to the department when revoked, suspended or when the home health agency terminates services.

(g) Personnel service reports.

(1) The home health agency, at the time of initial application for license, shall submit on a form provided by the department a list of all personnel employed by the agency who provided service to patients at their homes;

(2) The home health agency shall submit quarterly a list of all changes in the employment status of such personnel; and

(3) Shall promptly notify the department of any changes in services provided.

(h) Inspection visits may be made to a home health agency at any time by authorized staff of the department. [Eff. Feb. 01, 1982 ] (Auth: HRS Sec. 321-11) (Imp: HRS Sec. 321-11)

Sec. 11-97-4 Licensure revocation (a) The director, after due notice and an opportunity for a hearing, may suspend, revoke or refuse to issue or renew a license to any person because of failure to meet:

(1) The requirements of this chapter; or

(2) The conditions under which the license was issued.

(b) Any person affected by the director's decision for denial, suspension, or revocation, may appeal in accordance with the law. [Eff. Feb. 01, 1982 ] (Auth: HRS Sec. 321-11) (Imp: HRS Sec. 321-11)

Sec. 11-97-5 Policies and procedures (a) A home health

agency, or parent organization, shall have an advisory committee responsible for making policies. An organizational structure chart shall be established indicating the home health agency within the parent structure.

(b) A satisfactory statement of policy of the home health agency, including the scope of services, the conditions under which they are offered, and the geographic coverage, shall be submitted to the department.

(c) Services provided by the home health agency shall be available to any qualified patient in a home setting in the geographic area of the home health agency regardless of race, color, or national origin. Contracts with other agencies to provide services shall be approved by authorized persons of agencies involved.

(d) The basic services of professional nursing shall be provided by the home health agency.

(e) Policies governing medical services shall be provided through an advisory committee which shall include a practicing physician and such other specialists whose background and experience relate to the programs and activities of the agency. The committee may be an authorized existing committee. Minutes shall be kept of all meetings.

(f) Policies governing nursing and other therapeutic services shall be provided through an advisory committee which shall include a minimum of at least a practicing physician, a registered professional nurse with public health experience, a representative of other professional services such as dietary, occupational therapy, physical therapy, social work, or speech therapy; and community members who are aware of the needs of the community. The policies recommended by such committee shall meet current and acceptable professional practices. Minutes shall be kept of all meetings.

(g) Nursing and other therapeutic service policies.

- (1) Nursing and other therapeutic services provided shall be in accordance with the attending physician's written order and plan of treatment.
- (2) The nurses, therapists, social workers, aide or staff members rendering services shall meet qualifications prescribed in the definitions of this chapter.
- (3) A home health agency, in addition to providing nursing service, shall provide at least one other of the following therapeutic services: physical therapy, occupational therapy, speech, medical

social services, or home health aide services.

- (4) When a home health agency does not provide all of the nursing or therapeutic services specified above, it shall include in its written policies which govern such services, a plan for identifying, utilizing and cooperating with other resources and facilities including community social agencies for the purpose of providing such services to patients. The home health agency may arrange for the services which it does not provide by written agreements with other licensed home health agencies or by contracts with nonparticipating providers who shall meet the standards of this chapter.
  - (5) A home health agency shall maintain complete statistical information reflecting each category of service rendered to patients and summarize such annually.
- (h) Medical records.
- (1) A clinical record for each patient shall be maintained on the basis of standards acceptable to the department;
  - (2) Nurses, therapists and/or workers responsible for specific professional aspects of care to a patient shall record in the patient's record information about the services rendered.
- (i) Establishment and review plan of treatment.
- (1) A home health agency shall establish policies and procedures for assuring that services and items to be provided are specified under the plan of treatment established and regularly reviewed by the physician who is responsible for the use of the patient.
  - (2) The original plan of treatment shall be signed by the physician responsible for the patient and incorporated into the patient's medical record.
  - (3) The total plan shall be reviewed by the attending physician, in consultation with the agency's professional personnel at such intervals as the severity of the patient's condition may require, but not less than once every two months.
  - (4) The professional staff shall bring to the attention of the patient's physician changes in the patient's condition which may indicate the need

for altering the treatment plan or for the termination of service.

- (5) Only the attending physician shall terminate services. Upon termination of services, the physician shall prepare a discharge summary which includes reasons for termination of services, condition upon discharge and a summary of the course of the patient's illness.
- (6) Original orders of a physician and all changes in orders for the administration of dangerous drugs and narcotics shall be signed by the attending physician and incorporated into the patient's medical record.
- (7) All other changes in orders shall be either signed by the physician or by the professional nurse of the home health agency, if such changes are received verbally by the nurse.
- (8) When verbal orders are received by the professional nurse or other professional disciplines they shall be signed by the physician within a reasonable period of time.

(j) Home health agency shall provide:

- (1) Written job descriptions which specify the qualifications and experience of each category of health personnel and the type of activity each category of health personnel may perform;
- (2) Written personnel policies to each staff member, including but not limited to provisions concerning wage scales, hours of work, vacation and sick leaves, and use of car if provided, or mileage allowed if private transportation; and
- (3) A plan for a pre-employment and periodic medical examination, tuberculosis testing and/or chest x-ray and other appropriate tests and immunizations for all home health agency personnel.

(k) Home health agency shall provide for all personnel rendering service to patients, a planned program of orientation to the agency's policies and objectives and a continuous inservice education program.

(l) Home health agency shall prepare an annual budget, satisfactory auditing manuals, annual financial reports, use an accepted method of cost accounting to determine the cost per visit of each therapeutic service rendered, and prepare a schedule



of patient fees.

(m) Maintenance of records and reports.

- (1) Clinical records, service reports, fiscal reports, job descriptions, personnel reports, personnel policies and rosters, cost accounting data, committee reports, statements of policies, and such other records and reports as may be required shall be kept on file in the agency's office.
- (2) When a home health agency is a subdivision of a parent agency or organization, the fiscal accounting system shall be maintained in such a method to permit the costs of the home health agency to be easily identifiable.
- (3) Home health agency shall keep confidential all medical, nursing, paramedical, therapeutical, personnel, and financial information relating to each patient and make such available only to authorized persons.

(n) A home health agency shall provide for a systematic evaluation of its program and a periodic evaluation of employee performance on the basis of standards acceptable to the department. Evaluation of home health agency's program should be done at least once every two years. Method of program evaluation should include review of patients' records on a sample basis to determine that the services are being used appropriately, and the extent to which the needs of the patients are being met both qualitatively and quantitatively.

(o) The director may approve a modification of standards for a home health agency when exceptional circumstances warrant such modification. [Eff. Feb. 01, 1982 ] (Auth: HRS Sec. 321-11) (Imp: HRS Sec. 321-11).

Sec. 11-97-6 Administration and standards (a) The administrator of a home health agency shall be qualified by professional education, experience or the equivalent in the operation and provision of health care to patients.

(b) A home health agency shall have sufficient financial resources to allow for operation of the home health agency under these requirements, for a period of 90 days without regard to income from patient fees; and shall have a coordinator who shall be responsible and accountable for the functioning of the agency and services provided. [Eff. Feb. 01, 1982 ] (Auth: HRS Sec. 321-11) (Imp: HRS Sec. 321-11)


Sec. 11-97-7 Penalty. A person who violates any of the provisions of this chapter shall be fined not more than \$300.00,

or imprisoned nor more than one year or both. [Eff.Feb. 01, 1982  
(Auth: HRS Sec. 321-11) (Imp: HRS Sec. 321-11, 321-18)]


Sec. 11-97-8 Validity. If any provision of this chapter or the application thereof to any person or circumstances is held invalid, the remainder of this chapter, or the application of the provision to other persons or circumstances, shall not be affected thereby. [Eff. Feb. 01, 1982 ] (Auth: HRS Sec. 321-11) (Imp: HRS Sec. 321-11)

The Department of Health authorized the repeal of Chapter 12D, Public Health Regulations and the adoption of Chapter 97 of Title 11, Administrative Rules on January 13, 1982 following public hearings held on Oahu on October 26, 1981, on Hawaii on October 26, 1981, on Kauai on October 27, 1981, on Maui on October 30, 1981, after public notice was given in the Honolulu Star Bulletin on October 5, 1981, in the Hawaii Tribune-Herald on September 30, 1981, in the Garden Isle on September 23, 1981, and in the Maui News on October 1, 1981.

Chapter 97 of Title 11, Administrative Rules and the repeal of Chapter 12D Public Health Regulations shall take effect ten days after filing with the Office of the Lieutenant Governor.

  
\_\_\_\_\_  
GEORGE ZUEN  
Director  
Department of Health

APPROVED:

  
\_\_\_\_\_  
GEORGE R. ARIYOSHI  
GOVERNOR  
STATE OF HAWAII

Dated: 1-20-82

APPROVED AS TO FORM:

  
\_\_\_\_\_  
Deputy Attorney General

Filed: January 21, 1982

Effective Date: February 1, 1982

## APPENDIX F

### DEPARTMENT OF HUMAN SERVICES ELDER PROTECTIVE SERVICES SUMMARY DATA - CENTRAL REGISTRY March 1, 1989

CALENDAR YEAR 1988

TOTAL NUMBER OF REPORTS = 373

Female	= 221	(59.2%)
Male	= 151	(40.5%)
Unknown	= 1	(.3%)

#### Living Arrangement:

Most common living arrangements for victims:

Own Home	56%	(210)
Adult Offspring's Home	8%	( 31)
Other	8%	( 31)
Intermediate Care Facility	6%	( 24)
Other Relative's Home	5%	( 19)

Percentages for other living arrangements were less than 5%.

#### Ethnic Group:

Most common ethnic groups for victims:

Caucasian	35.1%	(131)
Filipino	22 %	( 82)
Japanese	18 %	( 67)
Hawaiian	9.7%	( 36)
Chinese	7.5%	( 28)

Percentages for other ethnic groups were less than 5%.

#### Age:

85+	24.9%	(93)
80-84	21.4%	(80)
75-79	22.8%	(85)
70-74	13.1%	(49)
65-69	9.9%	(37)
60-64	7.8%	(29)

#### Complainant:

Social Agency	19.8%	(74)
Nurse	16.6%	(62)
Hospital	15 %	(56)
Other	11.8%	(44)
Relative	8.3%	(31)
Nursing Home	5.4%	(20)

Percentages for other complainants were less than 5%.

Perpetrator:

Caretaker	40.8%	(152)
Self	30 %	(112)
Other	28.4%	(106)

Time Lapse:

Response time of staff to reported incident:

Within 24 hours	80.7%	(301)
Greater than 24 hours	10.7%	( 40)
No Contact-Report Only	7 %	( 26)
Could Not Locate	1.6%	( 6)

Severity of Incident:

None	35.9%	(134)
Mild	32.4%	(121)
Unknown	17.1%	( 64)
Serious/Permanent/Fatal	14.4%	( 54)

Source of Income:

Most common sources of income for victims:

Social Security	45.7%	(286)
Pension/ VA	20.1%	(126)
Fed/State Public Asst. (SSI, GA, Food Stamps, Medicaid)	17.0%	(106)
Other	16.3%	(102)

Confirmation Status:

Figures for abuse and neglect may be duplicated since both abuse and neglect may have been reported for each victim.

	ABUSE	NEGLECT
CONFIRMED	19.5% ( 41)	34.2% ( 77)
NOT CONFIRMED	54.8% (115)	43.6% ( 98)
SUSPECTED OR UNDETERMINED	25.7% ( 54)	22.2% ( 50)
TOTAL	100% (210)	100% (225)

Disposition:

Investigation & follow-up	42.1%	(157)
Report Only and Other	32.2%	(120)
Investigation Only	25.4%	( 95)

Problem Code by Sex:

	ABUSE	FINAN ABUSE	NEGLECT	POOR SELF CARE	OTHER	TOTAL
FEMALE	100	42	139	36	12	329
MALE	56	32	103	39	12	242

Problem Code by Ethnic Group:

	ABUSE	FINAN ABUSE	NEGLECT	POOR SELF CARE	OTHER	TOTAL
CAUC	38	25	94	30	9	196
FILIPINO	34	18	49	15	7	123
JAPANESE	40	13	38	4	4	99
HAWAIIAN	18	6	28	11	1	64
CHINESE	15	2	21	7	3	48

Problem Code by Age:

	ABUSE	FINAN ABUSE	NEGLECT	POOR SELF CARE	OTHER	TOTAL
60-69	36	14	40	11	4	105
70-79	56	23	77	23	8	187
80+	65	37	125	41	12	280

Primary Characteristics by Sex:

	MR/DD	MI	PHYS. DISAB.	OTHER/NONE	TOTAL
FEMALE	1	23	279	69	372
MALE	2	9	187	48	246

Primary Characteristics by Ethnic Groups:

	MR/DD	MI	PHYS. DISAB.	OTHER/NONE	TOTAL
CAUC	2	11	168	35	216
FILIPINO	0	5	107	26	138
JAPANESE	1	4	90	21	116
HAWAIIAN	0	3	45	13	61
CHINESE	0	5	30	14	49

Primary Characteristics by Age:

	MR/DD	MI	PHYS. DISAB.	OTHER/NONE	TOTAL
60-69	1	9	58	25	93
70-79	2	10	167	46	225
80+	0	13	242	47	302

Action Taken:

ACTION TAKEN

SERVICES	PROVIDED	CARETAKER REFUSED	VICTIM REFUSED	TOTAL
REFERRAL (Police/Prosec/ Court)	22	0	12	34
IN-HOME	329	24	70	423
OUT-OF-HOME	66	16	51	133
OTHER	91	1	16	108

## APPENDIX G

### Elder Abuse and Neglect Survey

This survey represents the first effort to collect data from all mandated reporters of elder abuse and neglect in Hawaii.

Given the nature of the issues involved and funding constraints, the study was directed towards providing a description of the problem, rather than measuring the extent of the problem. This ground breaking endeavor provides valuable information on the nature of elder abuse and neglect in Hawaii. The knowledge gained will make possible even better work in the future.

The mail survey was conducted in October 1987. The sample included: physicians, dentists, nurses, pharmacists, law enforcement officers, medical examiners and community health and social service workers. Attached is a summary of the survey findings.

A joint project of the Community Elder Abuse and Neglect Task Force (CEAN), Junior League of Honolulu, and Child and Family Service.  
Developed by: CEAN Research Committee.  
Received support from: Hawaii Medical Association, Hawaii Nurses Association, Hawaiian Telephone Company, Honolulu Police Department Community Relations Division, and McCully University Extension Club.  
Conducted with assistance of: SMS Research and Marketing Services, Inc.  
Data processing donated by: COMPUTAB, INC.





SMS RESEARCH  
& MARKETING SERVICES, INC.

November 30, 1987

Ms. Diane Murayama  
Chairperson  
Community Elder Abuse & Neglect Task Force  
c/o 200 N. Vineyard Boulevard, Suite 20  
Honolulu, HI 96817

Dear Diane:

It's been a pleasure and a privilege working with you and the members of the Task Force on such a pioneering project. Now, professionals and planners will have a comprehensive description of the nature of the elder abuse and neglect problem in Hawaii.

Attached are the frequency distributions and cross-tabulations of the survey data. I'd be happy to run additional tabulations if we find they are needed.

In the attachment, I've summarized the key points underscored by the survey. If you have any questions, please feel free to call me.

Sincerely,

A handwritten signature in cursive script, reading 'Barbara', followed by a long horizontal flourish line.

Barbara L. Okamoto  
Director of Public Opinion and  
Evaluation Research

BLO/eg

## KEY FINDINGS

### Is there a problem?

- o Yes, elder abuse and neglect is a problem in Hawaii. Although the survey does not measure the precise extent of the problem, 62 percent of the 608 mandated reporters who participated in the survey believe that Hawaii has such a problem.

### Is there an under-reporting problem?1

- o Yes, underreporting, as suspected, is definitely a problem. Among those who had seen abused or neglected elderly victims in the past six months, almost half (48%) had not reported the incidents.
- o Unfortunately for planners, there is not one barrier to reporting. Rather, there are many. The most important are the victim's fear or shame (51%) or limited mental capacity (43%); lack of awareness of reporting procedures (46%); the reporter's fear of retaliation (26%) and unwillingness to get involved (35%); and the perceived lack of appropriate services for victims (34%).
- o Of the available options for encouraging reporting, the most popular were public education on the issue (67%), clear definitions of reportable situations (50%), a hotline (39%), and publicizing reporting requirements (33%).

### Who are the victims?2

- o They are more often females (55%).
- o About half are under 75 and half are over 75 years of age.
- o Filipino victims are overrepresented (22%) compared to their proportion of the population.
- o About half (49%) suffer from partial or complete physical disability; and over a third (39%) have partial or total mental disability.
- o About half (46%) live with family or relatives and another quarter (24%) live alone. The rest live in institutions or other environments.

### What kinds of abuse and neglect are involved?3

- o The incidences described in the survey were for the most part mild (34%) or moderate (46%). But nearly a fifth were described as being severe (14%) or life-threatening (3%).

- o The most common types of abuse or neglect are neglect of basic (41%) or medical needs (32%), psychological abuse (33%), self-neglect (31%), and financial exploitation (29%).

#### Who is the abuser?4

- o Typically, the abuser is related to the victim--the child (21%), spouse (12%), or other relative (15%)--or is the victim himself or herself (13%). In other cases, it can be the professional care-giver (10%).
- o The person responsible for the abuse or neglect is as likely to be a woman as it is to be a man.
- o He or she is most likely to be between 35 and 65 years of age.
- o He or she is usually the victim's primary care-giver (61%), and living with the victim at the time of the incident (59%).
- o The abuser can be financially dependent on the victim (19%), physically disabled (14%), and abusive of drugs and/or alcohol (14%).
- o Factors contributing to the abuse or neglect include: excess stress on the care-giver (44%), impairment or disability of the victim (43%), and the isolation of the victim (29%).

#### Are current services to victims adequate?5

- o The overwhelming answer is, "I don't know." Fifty-four percent of the respondents did not know enough to rate current services to elder abuse and neglect victims. The remainder were divided pretty equally (23 percent and 23 percent) between adequate and inadequate ratings.
- o The most needed services to victims are emergency shelters, foster homes, and alternative housing (24%); assistance, counseling, and respite services to the care-givers (16%); education and awareness of the abuse and neglect problem (15%); medical assistance (13%); counseling (11%); and increased staffing and social workers (10%).

#### Are current prevention services adequate?6

- o Once again, the resounding answer is, "I don't know" (56%). The remainder tended to rate existing prevention services as inadequate (28%) rather than adequate (16%).
- o Education and awareness (50%) is regarded as the key to the prevention problem. Also important is assistance, counseling, and respite services for care-givers (21%).

Who were the respondents?

- o The respondents were from medical and dental facilities (38%), police departments (14%), and government health services (12%).
- o The individual respondents were predominantly nurses (27%), physicians (14%), police officers (13%), social workers (11%), or dentists (11%).
- o About a third (35%) have been in their professions for at least 15 years, a quarter for less than five.
- o The majority live and work on Oahu (70%).

Endnotes

1. Based on the 242 respondents who had seen victims of elder abuse or neglect in the last six months.
2. Based on the 242 respondents who had seen victims of elder abuse or neglect in the last six months.
3. Based on the 242 respondents who had seen victims of elder abuse or neglect in the last six months.
4. Based on the 242 respondents who had seen victims of elder abuse or neglect in the last six months.
5. Based on all 608 respondents.
6. Based on all 608 respondents.

## Helpful Free Publications

- Biannual Inventory of Statewide Aging Programs;  
Translations of Selected Health and Related Topics  
  
Executive Office on Aging (548-2593)  
335 Merchant Street, Room 241  
Honolulu, HI 96813
- County Newsletters  
  
Kauai 245-4737  
Honolulu 523-4545  
Maui 243-7774  
Hawaii 961-3418
- "HEADLINES" Newsletter on Health Topics  
  
HEADLINES  
UH Cooperative Extension Services  
2515 Campus Road  
Honolulu, HI 96822  
948-6519
- "CAREGIVER TO CAREGIVER" Newsletter for Caregivers of  
Homebound Patients  
  
Community Long Term Care Branch  
33 South King Street, Suite 223  
Honolulu, HI 96813  
548-2233
- Health Promotion and Education Program for Seniors  
  
Health Promotion and Education Office  
Department of Health  
1250 Punchbowl Street  
Honolulu, HI 96813  
548-5886  
  
Or contact your local Health Department Branch
- The People Connection: The Oahu Handbook of Mutual  
Support/Self-Help Groups  
  
Central Oahu Preventive Education  
Department of Health  
860 Fourth Street  
Pearl City, HI 96782  
456-4224

APPENDIX I

HALE KU'IKĀHI LIKE  
SHARED HOUSING PROGRAM

1. PARTIES

The parties to this agreement are \_\_\_\_\_  
\_\_\_\_\_, hereafter called "Homeprovider";  
and \_\_\_\_\_, hereafter called "Homesharer."

2. PROPERTY

a. Homeprovider shares the following property with Homesharer  
for the term of this agreement:

1. Premises located at \_\_\_\_\_  
\_\_\_\_\_.

2. The following furniture, appliances and other items of  
property:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. b. The following areas of the house or itmes of property are  
not to be shared or shared only as specified:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. Other restrictions:	Homeprovider	Homesharer
Pets (#, kind, etc.)	_____	_____
Smoking (acceptable locations)	_____	_____
Alcohol Consumption	_____	_____
Guests (Age/gender limits)	_____	_____
Days/Hrs limits	_____	_____
Location limits	_____	_____

3. TERM

This agreement shall run month-to-month \_\_\_\_  
\_\_\_\_-month lease.

4. RENT

The monthly rent shall be \$\_\_\_\_\_, due and payable by  
the Homesharer on the first of each month;

-or-

The monthly rent shall consist of the following activities to  
be performed by the Homesharer as specified: (include how  
often) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. SERVICES

The Homeprovider agrees to provide the following services:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. UTILITIES

Utilities shall be paid by:

	Homeprovider	Homesharer	Shared Household Expenses:	
Electricity	_____	_____	<input type="radio"/> No	<input type="radio"/> Yes phone
Gas	_____	_____	<input type="radio"/> No	<input type="radio"/> Yes normal maintenance (light bulbs)
Water	_____	_____	<input type="radio"/> No	<input type="radio"/> Yes cleaning supplies
	_____	_____	<input type="radio"/> No	<input type="radio"/> Yes paper products

7. SECURITY DEPOSIT

- a. Homeprovider hereby acknowledges receipt of a security deposit  
of \$\_\_\_\_\_, to be applied toward costs incurred by  
Homeprovider because of Homesharer's violation of this  
agreement.

- b. Homeprovider shall deposit this security deposit in the following depository: \_\_\_\_\_ located at \_\_\_\_\_.
- c. Within 14 days after Homesharer vacates, Homeprovider shall return the security deposit, with accrued interest, less any deductions Homeprovider is entitled to make under subparagraph (a) of this paragraph. If any deductions are made, Homeowner shall give Homesharer a written itemized statement of the deductions and an explanation of why each deduction was made. No deductions shall be made for normal wear and tear to the premises.

8. HOMESHARER'S DUTY TO MAINTAIN PREMISES

Homesharer shall keep the dwelling unit in a clean and sanitary condition. Homesharer shall be liable for any damage to the dwelling unit (other than normal wear and tear) which is caused by acts of neglect of Homesharer. Homesharer shall also be liable for any damage to the dwelling unit which he or she permits to be caused by any member of his or her family, invitee, licensee, or any person acting under his or her control.

9. HOMEPROVIDER'S OBLIGATION TO MAINTAIN PREMISES

- a. Homeprovider shall maintain the premises in a decent, safe, and sanitary condition.

10. REPAIRS

- a. Any repairs to the premises that become necessary due to the negligence of any party shall be the responsibility of the negligent party;
- b. Any minor repairs to the premises that become necessary due to normal wear and tear shall be the responsibility of:
  - 1. both parties in equal shares \_\_\_\_\_
  - 2. Homeprovider \_\_\_\_\_
  - 3. Homesharer \_\_\_\_\_



- c. The responsibility for major repairs to the premises due to the normal wear and tear shall be the responsibility of the Homeprovider.

11. ALTERATIONS

No alteration, addition, or improvement shall be made by Homesharer in or to the dwelling unit without the prior consent of Homeprovider in writing.

12. NOISE

Both parties agree to refrain from excessive noise or any other activity which disturbs peace and quiet.

13. NOTICE OF TERMINATION

- a. Homesharer may terminate this agreement by giving Homeprovider written notice at least 28 days before the end of the rental term;
- b. Homeprovider may terminate this agreement by giving Homesharer written notice at least 42 days before the end of the rental term;
- c. Homeprovider may terminate this agreement in the following ways:
  - 1. 15 days written notice if Homesharer fails to pay/perform rent;
  - 2. Three days written notice if Homesharer destroys property or maintains any nuisance upon or about the premises; or is a threat to health or safety, and
  - 3. Ten days written notice if Homesharer continues to violate any material provision of this agreement after written notice is given to Homesharer to discontinue such violation.

d. Homeprovider may agree to provide Homesharer with additional days written notice for each of the three terminations outlined in 12.(c) above. If Homeprovider so agrees, mark down the total number of written notice days agreed upon:

\_\_\_\_\_ days for failure to pay or perform rent;  
\_\_\_\_\_ days for destruction of property or causing a nuisance;  
\_\_\_\_\_ days for material breach of agreement.

14. DISABILITY TERMINATION

If either party becomes substantially disabled, or unable to provide services agreed upon, this agreement will terminate on 28 days written notice and a new agreement may be entered into if both parties agree.

15. Both parties agree that this agreement contains all of the parties' rights and obligations. The parties further agree that the living arrangement outlined in this document, being new and unique in the State of Hawaii, Chapter 521, Hawaii Revised Statutes shall be used for guidance but shall not be controlling.

WHEREFORE We, the undersigned, do hereby execute and agree to this rental agreement.

HOMEPROVIDER:

HOMESHARER:

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

## A Program for Caregivers

Suppose that suddenly an elderly relative needed assistance; no one else in the family was available to help, so you became the caregiver. What would you do? What would your options be? Where would you look for community resources?

As our population ages, such situations become more likely. It's better to be prepared for them than to search frantically for solutions when you are faced with an emergent, acute problem.

One of the best and most satisfying ways of supporting an elderly person is to help him or her maintain independence and continue with familiar rou-

tines. A drastic change in living arrangements or in lifestyle can be stressful and may actually add to problems.

Straub Clinic & Hospital will address these issues in a program for caregivers and other interested individuals: "Choices for Caregivers: A Guide for Maintaining Elderly Independence." It will be presented from 12:15-1:15 pm on Tuesday, September 12 in the Hawaii Tower of Amfac Center in the 3rd floor conference room.

For more information and to register for this free program, call Tracie at 522-3479.

### **Straub Clinic & Hospital**

invites you to attend:

#### **Choices for Caregivers: A Guide for Maintaining Elderly Independence**

**Date:** Tuesday, September 12  
**Time:** 12:15-1:15 p.m.  
(Please bring a brown bag lunch.)  
**Place:** Hawaii Tower, 745 Fort Street,  
3rd Floor Conference Room  
**Fee:** None; free of charge  
**To Register:** Phone 522-3479

Members of Straub's staff will discuss basic safety for the elderly, options in home care and health programs for seniors. If you are involved in caring for an elderly person, this session is for you!

**Straub**  
CLINIC & HOSPITAL

Star-Bulletin

Wednesday, July 12, 1989 □ A-7

## Hot line to aid those who need social services

By Helen Altman  
Star-Bulletin

A single telephone number may be available statewide in April for people who need social services and don't know where to turn for help.

The number — ASK-2000 — will be the 911 of human services, according to Aloha United Way President Thomas A. Ruppanner.



Thomas  
Ruppanner

Ruppanner said the new service is being planned by the AUW and the Health and Community Services Council in response to a challenge from Gov. John Waihee to do something about fragmentation

and access problems in community human services.

The private agencies have been talking to state officials about establishing the clearinghouse as a public-private partnership with matching support, said Dan Watanabe, executive director of the council.

"The concept is to create a single number where people can call for information and be referred to appropriate services whether public or private," said Watanabe. "We've got the beginnings of it here with the Volunteer Information and Referral Service (which operates the Community Clearinghouse). We would be expanding it statewide and making it a more effective operation."

The partnership would include the state departments of Human Services, Health, and Labor; the AUW; the Health and Community Services Council; and the referral service, Watanabe said.

A state task force headed by Peter Sybinsky, a deputy health director, is working with the private group, which includes Watanabe, AUW board volunteer Alan Yasue, and Chuck Wothke, director of the referral service.

The project team recently looked at six mainland programs, and all of them have paid staff to answer telephones, Watanabe said.

Some programs actually patch people by telephone to places providing services such as child care so they don't have to make two or three more calls, he said.

There are a lot of different ways this project could evolve... One is just getting people to know what door to knock on to get services, he said.

Another is to include case management and tracking in a system that crosses state departments to connect people with services.

"The state is delivering 150 services and the welfare worker has no idea that the person also is eligible for job training, public health services, etc.," Watanabe said.

## APPENDIX L

### MEDICAL PERSONNEL POOL PATIENT RIGHTS AND RESPONSIBILITIES

Each patient receiving care from Medical Personnel Pool Home Health Agency shall have the following rights and responsibilities:

1. To be fully informed, as evidenced by the patient's written acknowledgement, prior to or at the time of admission, of these rights, and of all rules and regulations of the agency affecting the patient.
2. To be fully informed, prior to or at the time of admission, of services available in the agency and of any charges for services not covered under Title XVIII or XIX of the Social Security Act; in addition, a fee schedule will be given to all private patients.
3. To be fully informed by a physician of his medical condition including diagnoses and prognosis unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his/her medical treatment and to refuse to participate in experimental research.
4. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
5. To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual.
6. To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
7. To be informed in writing by the agency of procedure for registering complaints confidentially on the initial visit. The patient has a responsibility and a right to voice any grievances or recommendations regarding care and treatment without any reprisals.
8. To be assured the patient and his/her family will be taught about the illness so that the patient can help him/herself, and the family can understand and help the patient, and to be notified of any change in treatment.

## APPENDIX M

JOHN WAIHEE  
GOVERNOR



STATE OF HAWAII  
DEPARTMENT OF HUMAN SERVICES

WINONA E. RUBIN  
DIRECTOR

ALFRED K. SUGA  
DEPUTY DIRECTOR

MERWYN S. JONES  
DEPUTY DIRECTOR

### Agreement to Participate in Project Malama

Project Malama has been set up by the State of Hawaii and funded by the City & County of Honolulu to help elderly people live independently.

In order to know what health care or social services you may need, I would like to ask you some questions about your health, your living situation, and how you get along day-to-day. In addition, to better understand what services you need, I will need your OK to get information from agencies or people who help you.

We will not look at any of your records without your OK. The case manager would also like to talk to the friend or family member who helps you the most. We would like you to tell us who that person is. We will not talk to anyone unless we first have your OK.

There is one more important thing you should know. Any information you tell us or allow us to see will be kept strictly confidential. It will be used only for developing and carrying out your service plan.

I will use this information to make a list of all the health care or social services you need and when and where you will receive them. This is called a Service Plan. (I/someone from) Project Malama will be in touch with you soon to review your service plan with you. You will be asked to approve the plan. If you disagree with all or part of the plan, you may request that we review it. If you still do not agree after that, you can appeal it. Some of the health care or social services the project sets up for you may be paid for by Medicare and other programs created for people who need them. There are other services the project can set up, but you may have to pay for all or part of them yourself if you want to receive them.

From time to time we will be in touch with you to see if you are satisfied with the services you are receiving. We will also want to find out if your needs have changed. We will keep on doing this until you no longer require our services. The case manager services you receive through Project

Page 1 of 2

AN EQUAL OPPORTUNITY AGENCY

Malama may no longer be available if program funding is not continued. If this happens, we will work with you to help you meet your needs in some other way.

-----  
I have read the above explanation or have had it read to me. I understand what I read and any questions I had were answered.

I understand that my taking part in the project is voluntary. If I decide now to take part, I can change my mind later. I understand that I will not lose services or programs normally available to me if I decide not to participate or to drop out of the project.

I agree to take part in the project. I can change my mind at any time by contacting Project Malama, 810 N. Vineyard Boulevard, Honolulu, Hawaii 96817, Ph. #847-2064.

\_\_\_\_\_  
CLIENT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE (if Client unable to  
read or write)

\_\_\_\_\_  
DATE

I certify that the Client has read the consent form or had had it read to her/him. I have answered thoroughly any questions the respondent had. To the best of my judgement, the respondent understands the consent form.

\_\_\_\_\_  
ASSESSOR'S/INTERVIEWER'S SIGNATURE

\_\_\_\_\_  
DATE

## APPENDIX N

### ACT 381

H.B. NO. 1844

A Bill for an Act Relating to Adult Protective Services.

*Be It Enacted by the Legislature of the State of Hawaii:*

SECTION 1. Chapter 346, Hawaii Revised Statutes, is amended by adding a new part to be appropriately designated and to read as follows:

#### **"PART      DEPENDENT ADULT PROTECTIVE SERVICES**

**§346- Purpose; construction.** The legislature recognizes that citizens of the State who are elderly and mentally or physically impaired constitute a significant and identifiable segment of the population and are particularly subject to risks of abuse, neglect, and exploitation.

The legislature also recognizes that it is a person's dependency status, not age, which is often encountered in cases of abuse, neglect, and exploitation. While advanced age alone is not sufficient reason to intervene in a person's life, the legislature finds that many elderly have become subjects of abuse and neglect. Substantial public interest exists to ensure that this segment of the population receives protection.

The legislature declares that the State shall develop and promote community services for the economic, social, and personal well-being and protection of its elderly citizens who are mentally or physically impaired.

In taking this action, the legislature intends to place the fewest possible restrictions on personal liberty and to permit the exercise of constitutional rights by adults consistent with protection from abuse, neglect, and exploitation.

#### **§346- Definitions.**

"Abuse" means actual or imminent physical injury, psychological abuse or neglect, sexual abuse, financial exploitation, negligent treatment, or maltreatment as further defined in this chapter.

Abuse occurs where:

- (1) Any dependent adult exhibits evidence of:
  - (A) Substantial or multiple skin bruising or any other internal bleeding;
  - (B) Any injury to skin causing substantial bleeding;
  - (C) Malnutrition;
  - (D) A burn or burns;
  - (E) Poisoning;
  - (F) The fracture of any bone;
  - (G) A subdural hematoma;
  - (H) Soft tissue swelling;
  - (I) Extreme physical pain; or
  - (J) Extreme mental distress which includes a consistent pattern of actions or verbalizations including threats, insults, or harassment, that humiliates, provokes, intimidates, confuses, and frightens the dependent adult;and the injury is not justifiably explained, or where the history given is at variance with the degree or type of injury, or circumstances indicate that the injury is not the product of an accidental occurrence;
- (2) Any dependent adult has been the victim of non-consensual sexual contact or conduct, including, but not limited to:
  - (A) Sexual assault, molestation, sexual fondling, incest, prostitution;
  - (B) Obscene or pornographic photographing, filming, or depiction;
  - or
  - (C) Other similar forms of sexual exploitation;



- (3) Any dependent adult is not provided in a timely manner with adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision;
- (4) Any dependent adult is provided with dangerous, harmful, or detrimental drugs as defined by section 712-1240; however, this paragraph shall not apply when such drugs are provided to the dependent adult pursuant to the direction or prescription of a practitioner, as defined in section 712-1240;
- (5) There has been a failure to exercise that degree of care toward a dependent adult which a reasonable person with the responsibility of a caregiver would exercise, including, but not limited to, failure to:
  - (A) Assist in personal hygiene;
  - (B) Provide necessary food, shelter, and clothing;
  - (C) Provide necessary health care, access to health care, or prescribed medication;
  - (D) Protect a dependent adult from health and safety hazards; or
  - (E) Protect against acts of abuse by third parties;
- (6) Any dependent adult appears to lack sufficient understanding or capacity to make or communicate responsible decisions concerning the dependent adult's person, and appears to be exposed to a situation or condition which poses an imminent risk of death or risk of serious physical harm; or
- (7) There is financial and economic exploitation in addition to other manifestations of abuse as enumerated herein. For the purpose of this part, "financial and economic exploitation" means the wrongful or negligent taking, withholding, misappropriation, or use of a dependent adult's money, real property, or personal property. "Financial and economic exploitation" can include but is not limited to:
  - (A) Breaches of fiduciary relationships such as the misuse of a power of attorney or the abuse of guardianship privileges, resulting in the unauthorized appropriation, sale, or transfer of property;
  - (B) The unauthorized taking of personal assets;
  - (C) The misappropriation, misuse, or transfer of moneys belonging to the dependent adult from a personal or joint account; or
  - (D) The intentional or negligent failure to effectively use a dependent adult's income and assets for the necessities required for the person's support and maintenance.

The exploitation may involve coercion, manipulation, threats, intimidation, misrepresentation, or exertion of undue influence.

"Capacity" means the ability to understand and appreciate the nature and consequences of making decisions concerning one's person or to communicate such decisions.

"Court" means the family court having jurisdiction over a matter under this part.

"Department" means the department of human services and its authorized representatives.

"Dependent adult" means any adult who, because of mental or physical impairment is dependent upon another person for personal health, safety, or welfare.

"Emergency medical treatment" means those services necessary to maintain a person's physical health and without which there is a reasonable belief that the person will suffer irreparable harm or death.

"Imminent abuse" means that there exists reasonable cause to believe that abuse will occur or recur within the next ninety days.

"Party" means those persons entitled to notice of proceedings under sections 346- and 346- , including any state department or agency that is providing services and treatment to a dependent adult in accordance with a protective services plan.

"Protective services plan" means a specific written plan, prepared by the department, setting forth the specific services and treatment to be provided to a dependent adult.

**§346- Jurisdiction; venue.** The family court shall have jurisdiction in protective proceedings under this part concerning any dependent adult who was or is found within the circuit at the time such facts and circumstances occurred, were discovered, or were reported to the department, which constitute the basis for a finding that the person has been abused and is threatened with imminent abuse; provided that the protective proceedings under this part are not exclusive and shall not preclude the use of any other criminal, civil, or administrative remedy. The protective proceedings under this part shall be held in the judicial circuit in which the dependent adult resides at the time of the filing of the petition or in which the dependent adult has assets.

**§346- Reports.** (a) The following persons who, in the performance of their professional or official duties, know or have reason to believe that a dependent adult has been abused and is threatened with imminent abuse shall promptly report the matter orally to the department of human services:

- (1) Any licensed or registered professional of the healing arts and any health-related occupation who examines, treats, or provides other professional or specialized services to dependent adults, including, but not limited to, physicians, physicians in training, psychologists, dentists, nurses, osteopathic physicians and surgeons, optometrists, chiropractors, podiatrists, pharmacists, and other health-related professionals;
- (2) Employees or officers of any public or private agency or institution providing social, medical, hospital or mental health services, including financial assistance;
- (3) Employees or officers of any law enforcement including, but not limited to, the courts, police departments, correctional institutions, and parole or probation offices;
- (4) Employees or officers of any adult residential care home, adult day care center, or similar institution; and
- (5) Medical examiners or coroners.

(b) The initial oral report required by subsection (a) shall be followed as soon as possible by a written report to the department; provided that where a police department is the initiating agency, a written report shall not be required unless the police department has declined to take further action and the department informs the police department that it intends to pursue the matter of the orally reported incident of abuse. All written reports shall contain the name and address of the dependent adult and the person who is alleged to have been responsible for the dependent adult abuse, if known; the nature and extent of the dependent adult's injury or harm; and any other information the reporter believes might be helpful in establishing the cause of the dependent adult abuse.

(c) This section shall not prohibit any of the persons enumerated in subsection (a) from reporting incidents which those persons have reason to believe involve abuse which came to their attention in any private or nonprofessional capacity.

(d) Any other person who has reason to believe that a dependent adult has been abused or is threatened with abuse may report the matter orally to the department.

(e) Any person who knowingly fails to report as required by this section or who wilfully prevents another person from reporting pursuant to this part shall be guilty of a petty misdemeanor.

(f) The department shall maintain a central registry of reported cases.

**§346- Confidentiality of reports.** All reports made pursuant to this part, including the identity of the reporting person, as well as all records of such reports, are confidential and any person who makes an unauthorized disclosure of a report or records of the court proceedings under this part shall be guilty of a misdemeanor. The director of human services may adopt, amend, or repeal rules, pursuant to chapter 91, to provide for the confidentiality of reports and records, and for the authorized disclosure of reports and records.

**§346- Access to records.** Records of a dependent adult shall be obtained by the department or the dependent adult's court-appointed guardian ad litem with the written consent of the dependent adult or that person's representative, or by court order. Any person who reports to the department under section 346- , upon demand of the department, shall provide all information related to the alleged incident of dependent adult abuse or neglect, including, but not limited to, financial records and medical reports, which were not included in the written report submitted pursuant to section 346- (b).

**§346- Investigation.** Upon receiving a report that abuse of a dependent adult has occurred and is imminent, the department shall cause an investigation to be commenced in accordance with this part as the department deems appropriate.

**§346- Action upon investigation.** Upon investigation the department shall take action toward preventing further abuse and shall have the authority to do any or all of the following:

- (1) Resolve the matter in an informal fashion as is appropriate under the circumstances;
- (2) Exercise its right of entry under section 346- ;
- (3) Seek an order for immediate protection;
- (4) Seek a temporary restraining order;
- (5) File a petition with the court under this part; and
- (6) Seek any protective or remedial actions authorized by law.

**§346- Right of entry.** (a) An employee of the department engaged in an investigation under this part shall be authorized to visit and communicate with the dependent adult who is the subject of the report. Any person intentionally or knowingly obstructing or interfering with the department's access to or communication with the dependent adult shall be guilty of a misdemeanor.

(b) Any employee of the department engaged in an investigation under this part, having probable cause to believe that a dependent adult will be physically injured through abuse before a court order for entry can be obtained, without a warrant, may enter upon the premises where the dependent adult may be found for the purpose of ascertaining that person's welfare. Where a warrantless entry is authorized under this section, the employee of the department may request the assistance of a police officer to gain entrance.

**§346- Termination of services.** The department shall act only with the consent of the victim, unless the department obtains court authorization to provide necessary services, as provided in section 346- . Investigation and services provided under this part shall be immediately terminated if:

- (1) A dependent adult does not consent to the receipt of protective services;
- (2) The dependent adult withdraws the consent;
- (3) The department determines that protection is no longer needed under this part; or
- (4) The court so orders.

Upon the department's determination that protective services are no longer needed, the dependent adult shall be referred to the agency responsible for follow-up services. For the mentally ill and developmentally disabled adult, the state agency designated to provide services shall be the department of health.

**§346- Order for immediate protection.** (a) If the department believes that a person is a dependent adult and it appears probable that the dependent adult has been abused and is threatened with imminent abuse unless immediate action is taken; and the dependent adult consents, or if the dependent adult does not consent and there is probable cause to believe that the dependent adult lacks the capacity to make decisions concerning the dependent adult's person, the department shall seek an order for immediate protection in accordance with section 346-

(b) A finding of probable cause may be based in whole or in part upon hearsay evidence when direct testimony is unavailable or when it is demonstrably inconvenient to summon witnesses who will be able to testify to facts from personal knowledge.

(c) Upon finding that the person is a dependent adult and that there is probable cause that the dependent adult has been abused and is threatened with imminent

abuse unless immediate action is taken; and the dependent adult consents, or if the dependent adult does not consent and there is probable cause to believe that the dependent adult lacks the capacity to make decisions concerning the dependent adult's person, the court shall issue an order for immediate protection. This order may include, but is not limited to:

- (1) An authorization for the department to transport the person to an appropriate medical or care facility;
- (2) An authorization for medical examination;
- (3) An authorization for emergency medical treatment; and
- (4) Such other matters as may prevent imminent abuse, pending a hearing under section 346-

(d) The court may also make orders as may be appropriate to third persons, including temporary restraining orders, enjoining them from:

- (1) Removing the dependent adult from the care or custody of another;
- (2) Abusing the dependent adult;
- (3) Living at the dependent adult's residence;
- (4) Contacting the dependent adult in person or by telephone;
- (5) Selling, removing, or otherwise disposing of the dependent adult's personal property;
- (6) Withdrawing those funds from any bank, savings and loan association, credit union, or other financial institution, or from a stock account in which the dependent adult has an interest;
- (7) Negotiating any instruments payable to the dependent adult;
- (8) Selling, mortgaging, or otherwise encumbering any interest that the dependent adult has in real property;
- (9) Exercising any powers on behalf of the dependent adult by representatives of the department, any court-appointed guardian or guardian ad litem or any official acting on their behalf;
- (10) Engaging in any other specified act which, based upon the facts alleged, would constitute harm or present a threat of imminent harm to the dependent adult or would cause the loss of the dependent adult's property.

(e) Court orders under section 346- and this section may be obtained upon oral or written application by the department, without notice and without a hearing. Any oral application shall be reduced to writing within twenty-four hours. The court shall issue its order orally, provided that it shall reduce the order to writing as soon as possible thereafter and in any case not later than twenty-four hours after the court received the written application. Certified copies of the application and order shall be personally served upon the dependent adult and any other person or entity affected by the order together with notice of the order to show cause hearing in section 346-

(f) If a written order for immediate protection is issued, the department shall file a petition invoking the jurisdiction of the court under this part within twenty-four hours.

**§346- Order to show cause hearing.** (a) When a written order for immediate protection is issued, the court shall hold a hearing on the application for immediate protection, no later than seventy-two hours after issuance of the oral order excluding any Saturday or Sunday, requiring cause to be shown why the order or orders should not continue. The department shall make arrangements to have the dependent adult attend the hearing or show cause why the dependent adult cannot attend.

(b) When the court finds that there is probable cause to believe that a dependent adult has been abused and is threatened with imminent abuse, and the dependent adult consents, or if the dependent adult does not consent and the court finds that there is probable cause to believe that the dependent adult lacks the capacity to make decisions concerning the dependent adult's person, the court may continue or modify any order pending an adjudicatory hearing on the petition. These orders may include orders for the dependent adult's temporary placement and ordinary medical care.

(c) The parties personally or through counsel may stipulate to the entry or continuance of such orders as the court deems to be in the best interest of the dependent adult, and the court shall set the case for an adjudicatory hearing as soon as it is practical.

**§346- Petition.** (a) A petition invoking the jurisdiction of the court under this part shall be entitled "In the matter of the protection of \_\_\_\_\_," and shall be verified.

- (b) The petition shall set forth with specificity the:
- (1) Reasons the person is considered to be a dependent adult;
  - (2) Facts which bring the dependent adult within this part;
  - (3) Name, birth date, sex, and residence address of the dependent adult;
  - (4) Names and addresses of any living persons, or entities required to be notified pursuant to section 346- ; and
  - (5) If appropriate, allegations describing any lack of capacity of the dependent adult.

**§346- Guardian ad litem; counsel.** (a) In any case where the court has reason to believe that a dependent adult or any other party lacks the capacity to effectively make decisions concerning the party's person, it may appoint a guardian ad litem to represent the interests of that party throughout the pendency of proceedings under this part. The court shall appoint counsel for the dependent adult at any time where it finds that the dependent adult requires a separate legal advocate and is unable to afford private counsel.

(b) The court may order reasonable costs and fees of the guardian ad litem to be paid by the party for whom the guardian ad litem is appointed, if that party has sufficient financial resources to pay such costs and fees. The court may also order the appropriate parties to pay or reimburse reasonable costs and fees of the guardian ad litem and counsel appointed for the dependent adult.

**§346- Consolidation with guardianship proceedings.** A proceeding for the appointment of a guardian of the person or property under article V of chapter 560 may be consolidated with the proceedings under this part as the applicable circuit court and the family court in the exercise of their discretion shall permit.

**§346- Permanent changes.** Permanent changes in the living situation of an abused dependent adult shall not ordinarily be made under authority of this part. If permanent changes in the living situation or nonemergency medical treatment are necessary, the appropriate guardianship, or civil commitment action shall be initiated pursuant to applicable state law.

**§346- Notice of proceedings.** After a petition has been filed, the matter shall be set for hearing and a notice of hearing shall be issued to all parties to the proceeding. The parties to the proceeding shall include:

- (1) The dependent adult;
- (2) Any caregiver or facility in which the dependent resides or is a patient;
- (3) The spouse and adult children of the dependent adult;
- (4) The parents of the dependent adult, unless waived by the court for good cause;
- (5) Any guardian of the person or property who may have been appointed; and
- (6) Any person or entity affected by an order for immediate protection which has been sought or issued including any alleged perpetrator of abuse.

Where the name or whereabouts of a potential party is unknown, the court may require the petitioner to set forth the reasonable efforts the petitioner made to ascertain the party's name or whereabouts and why the petitioner has been unable to determine those facts.

**§346- Service.** (a) Service of the notice shall be made by delivery of a copy thereof together with a certified copy of the petition to each person or entity to be given notice either by personal service, by certified mail, return receipt requested and addressed to the last known address, by publication, or by other means authorized by the court. Upon a showing of good cause, the court may waive notice to any party except the dependent adult.

(b) Service shall be effected at least forty-eight hours prior to the time fixed in the notice for hearing when held pursuant to section 346- (a), or at least fifteen days prior to the time fixed in the notice for an adjudicatory, disposition, or review hearing, unless the party otherwise was ordered by the court to appear at those hearings.

**§346- Required findings concerning postponed hearings.** Except as otherwise provided, no hearing shall be delayed upon the grounds that a party other than the dependent adult is not present at the hearing or has not been served with a copy of the order for immediate protection or the petition, where reasonable efforts have been made to effect service and it would be detrimental to the dependent adult to postpone the proceedings until service can be made. Whenever a hearing is delayed or postponed under this section, the court shall enter a finding that it will not be detrimental to the dependent adult and shall also specify what additional measures shall be undertaken to effect service.

**§346- Adjudicatory hearing.** (a) When a petition has been filed, the court shall set a return date hearing to be held within thirty days of the filing of the petition. On the return date, the parties personally or through counsel may stipulate to the entry or continuance of the orders as the court deems to be in the best interests of the dependent adult, and the court shall set the case for an adjudicatory hearing as soon as is practical.

(b) In an adjudicatory hearing, the court shall determine whether the person is a dependent adult, and whether the dependent adult has been abused and is threatened with imminent abuse, based upon a preponderance of the evidence. Evidence which is contained in a written report, study, or examination shall be admissible, provided that the maker of the written report, study, or examination be subject to direct and cross-examination upon demand when the maker is reasonably available. A social worker employed by the department in the area of adult protective services shall be presumed to be qualified to testify as an expert in the field of protective services.

(c) If facts sufficient to sustain the petition are established in court, or are stipulated to by all parties, the court shall enter an order finding that the dependent adult has been abused and threatened with imminent abuse and shall state the grounds for the finding. The court shall also make a finding concerning the capacity of the dependent adult to effectively make decisions concerning personal needs or property or both. If the capacity of the dependent adult is at issue, the court shall require that the dependent adult be examined by a psychiatrist or other physician who is skilled in evaluating the particular area in which the dependent adult is alleged to lack capacity before making any finding that the dependent adult lacks capacity. If there is no finding that the dependent adult lacks capacity to make such decisions and if the dependent adult does not give consent, the court shall not have authority to proceed further and the court shall dismiss the case.

(d) Upon the completion of the adjudicatory hearing, the disposition hearing may commence immediately after the required findings are made, provided the requirements of subsection 346- (a) have been met, or the court may set the disposition hearing for such time as it deems appropriate.

(e) If facts sufficient to sustain the petition under this part are not established, the court shall dismiss the petition and shall state the grounds for dismissal.

(f) If the court sustains the petition and does not commence immediately to the disposition hearing, it shall determine, based upon the facts adduced during the adjudicatory hearing and any additional facts presented to it, whether any temporary orders should be issued pending final disposition.

**§346- Disposition.** (a) Unless waived by the parties who have entered an appearance, the department shall prepare a proposed protective order and a written protective services plan, and submit copies to the court and each of the parties or their counsel at least seven days prior to the disposition hearing.

(b) The proposed protective order may include any of the provisions set forth in section 346- , and, in addition may include an order that:

- (1) The person inflicting abuse on the dependent adult participate in counseling or therapy as the court deems appropriate;
- (2) Any party report to the department any violation of the protective order or protective services plan;
- (3) The department make periodic home visits to the dependent adult; and
- (4) The department monitor compliance with the order.

(c) The proposed protective services plan shall set forth the following:

- (1) Specific services or treatment to be provided to the dependent adult and the specific actions the parties shall take;
- (2) Specific responsibilities that the parties shall assume;
- (3) Period during which the services shall be provided;

- (4) Dates by which the actions shall be completed;
- (5) Specific consequences that may be reasonably anticipated to result from a party's failure to comply with any terms and conditions of the plan; and
- (6) Steps that shall be necessary to terminate the court's jurisdiction.

(d) In preparing such a proposed protective order, the department shall seek to impose the least restrictive limitation on the freedom and liberties of the dependent adult. To the greatest extent possible, the dependent adult should be permitted to participate in decisions concerning the dependent adult's person, or property, or both.

(e) The court shall conduct a disposition hearing concerning the terms and conditions set forth in the proposed protective order and proposed protective services plan unless each of the parties has signed and fully understands and accepts the order and plan, in which event, the court may approve the order and plan without hearing. If a party cannot or does not accept the terms and conditions set forth in the proposed order or proposed plan, and, after such hearing as the court deems to be appropriate, the court shall order such terms and conditions, as are deemed to be in the best interests of the dependent adult.

**§346- Review hearings.** Except for good cause shown, the court shall set each case for a review hearing not later than six months after the date that a protective order and protective services plan are ordered by the court and, thereafter, the court shall set subsequent review hearings at intervals of not longer than six months until the court's jurisdiction has been terminated. The department and the guardian ad litem, if any, shall submit a written report, with copies to the parties or their counsel, at least fifteen days prior to the date set for each review hearing. The report shall evaluate whether the parties have complied with the terms and conditions of the protective order and protective services plan; shall recommend any modification to the order or plan; and shall recommend whether the court shall retain jurisdiction or terminate the case. At each review hearing, the court shall determine whether the parties have complied with the terms and conditions of the order and plan; enforce such sanctions for noncompliance as may be appropriate; and order such revisions to the existing order or plan as are in the best interests of the dependent adult. At each review hearing, the court shall make an express finding as to whether it shall retain jurisdiction or terminate the case, and, in each instance, shall state the basis for its action.

**§346- Appeal.** Any party aggrieved by an order or decree of the court may appeal as provided by section 571-54.

**§346- Admissibility of evidence.** The physician-patient privilege, the psychologist-client privilege, and the spousal privilege shall not be grounds for excluding evidence in any judicial proceeding resulting from a report pursuant to this part.

**§346- Hearings.** The protective proceedings shall be heard without a jury. The hearing may be adjourned from time to time. The general public shall be excluded, and only such persons as are found by the court to have a direct interest in the case shall be admitted.

**§346- Failure to comply with court orders.** The court may apply contempt of court provisions and all other provisions available under the law if a party fails to comply with the terms and conditions of any order issued under this part.

**§346- Payment for service or treatment provided to a party.** Whenever service, treatment, care, or support of a dependent adult is provided under this part, the persons or legal entities who may be legally obligated to pay for the service, treatment, care, or support of the dependent person, may be ordered by the court to pay the cost of the service, care, support, or treatment provided to the dependent adult in whole or in part, after notice and hearing.

**§346- Fiscal and service responsibility.** The department or other authorized agencies shall provide only the care, service, treatment, support, or payment authorized by law. The department or authorized agencies shall have the authority to establish priorities and limitations of services based on their resources.

**§346- Cooperation.** Every public official or department shall render all assistance and cooperation within the official's or department's power and which may further the purpose and objectives of this part. The department and the court may seek the cooperation of organizations whose objectives are to protect or aid dependent adults.

**§346- Immunity from liability.** (a) Anyone participating in good faith in the making of a report pursuant to this part shall have immunity from any liability, civil or criminal, that might be otherwise incurred or imposed by or as a result of the making of such a report. Any participant shall have the same immunity with respect to participation in any judicial proceeding resulting from that report.

(b) Any individual who assumes a duty or responsibility pursuant to this part shall have immunity from civil liability for acts or omissions performed within the scope of the individual's duty or responsibility. Nothing in this part shall limit the liability of the department, any other state agency, or any private organization for the conduct of individuals acting within the scope of their duties provided immunity under this section.

**§346- Presumption of capacity.** An individual shall be presumed capable of making decisions concerning the individual's person. A determination that an individual lacks capacity under this part shall not be construed as a finding that the individual lacks capacity for any other purpose.

**§346- Advanced age.** An individual shall not be involuntarily subjected to the provisions of this part solely based on advanced age.

**§346- Rules.** The department shall adopt rules pursuant to chapter 91 necessary for the purposes of this part."

SECTION 2. Chapter 346, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

**"§346- Confidentiality of court records.** (a) The court shall maintain records of all adult protective proceedings under this chapter. All court documents and records pertaining to the action or proceeding shall be subject to inspection only by the dependent adult, guardian of the person, guardian of the property, their respective attorneys, and the guardian ad litem of the dependent adult, with the consent of the court.

(b) All other requests for information contained in the confidential record shall be made in writing and shall include the reasons for the request and how the information is to be used and may be granted by the court for good cause."

SECTION 3. Section 571-14, Hawaii Revised Statutes, is amended to read as follows:

**"§571-14 Jurisdiction; adults.** The court shall have exclusive original jurisdiction:

- (1) To try any offense committed against a child by the child's parent or guardian or by any other person having the child's legal or physical custody, and any violation of section 707-726, 707-727, 709-902, 709-903, 709-904, 709-905, 709-906, or 298-12, whether or not included in other provisions of this paragraph or paragraph (2).
- (2) To try any adult charged with:
  - (A) Deserting, abandoning, or failing to provide support for any person in violation of law;
  - (B) An offense, other than a felony, against the person of the defendant's husband or wife;
  - (C) Any violation of a domestic abuse protective order issued pursuant to chapter 586; or
  - (D) Any violation of an order issued by a family court judge.

In any case within paragraph (1) or (2) [of this section], the court [may], in its discretion, may waive its jurisdiction over the offense charged.



- (3) In all proceedings under chapter 580, and in all proceedings under chapter 584.
  - (4) In proceedings under chapter 575, the Uniform Desertion and Non-support Act, and under chapter 576, the Uniform Reciprocal Enforcement of Support Act.
  - (5) For commitment of an adult alleged to be mentally defective or mentally ill.
  - (6) In all proceedings for support between parent and child or between husband and wife, and in all proceedings to appoint a guardian of the person of an adult.
  - (7) In all proceedings for waiver of jurisdiction over an adult who was a child at the time of an alleged criminal act as provided in section 571-22.
  - (8) In all proceedings under chapter 586, Domestic<sup>1</sup> Protective Orders.
  - (9) In all proceedings to appoint a guardian of the person of an adult.
  - (10) For the protection of dependent adults under chapter 346, part.
- In any case within paragraph (3), (4), or (6) [of this section], the attorney general, through the child support enforcement agency, may exercise concurrent jurisdiction as provided in chapter 576E."

SECTION 4. Section 571-87, Hawaii Revised Statutes, is amended to read as follows:

**"[~~§~~571-87] Appointment of counsel and guardian ad litem; compensation.** (a) When it appears to a judge that a person requesting the appointment of counsel satisfies the requirements of chapter 802 for determination of indigency, or the court in its discretion appoints counsel under chapter 587[,], and 346, or that a person requires appointment of a guardian ad litem, the judge shall appoint counsel or a guardian ad litem to represent the person at all stages of the proceedings, including appeal, if any. Appointed counsel and the guardian ad litem shall receive reasonable compensation for necessary expenses, including travel, the amount of which shall be determined by the court, and fees pursuant to subsection (b). All of these expenses shall be certified by the court and paid upon vouchers approved by the judiciary and warrants drawn by the comptroller.

(b) The court shall determine the amount of reasonable compensation to appointed counsel and guardians ad litem, based on the rate of \$40 an hour for out-of-court services, and \$60 an hour for in-court services with a maximum fee in accordance with the following schedule:

- (1) Cases arising under chapter 587[:], and 346:
  - (A) Predisposition \$1,500;
  - (B) Postdisposition review hearing \$ 500;
- (2) Cases arising under chapters 560, 571, 580, and 584 \$1,500.

Payments in excess of any maximum provided for under paragraphs (1) and (2) may be made whenever the court in which the representation was rendered certifies that the amount of the excess payment is necessary to provide fair compensation and the payment is approved by the administrative judge of such court."

SECTION 5. Chapter 349C, Hawaii Revised Statutes, is repealed.

SECTION 6. Statutory material to be repealed is bracketed. New statutory material is underscored.<sup>2</sup>

SECTION 7. This Act shall take effect on July 1, 1991, and shall be repealed as of June 30, 1993.

(Approved June 26, 1989.)

#### Notes

1. So in original.

2. Edited pursuant to HRS §23G-16.5.