Approved 1-25-89
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 a.m./p.m. on January 18, 1998 in room 313-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Dick Hummel, Kansas Health Care Association
Terri Roberts, Kansas State Nurses Association
Linda Lubensky, Kansas Home Care Association
Michael Lechner, Executive Director/Dept. Human Resources
Kethy Noland, American Nursing Resources, Inc.
Judith Bellome, Exec. Director/Clinicare Family Health Services, Inc.
George Dugger, Department on Aging
Barbara Bradford, Interested citizen, Lawrence, Ks.

Chair called meeting to order, he recognized Mr. Dick Hummel.

Mr. Hummel gave hand-out of draft for legislation, (Attachment No. 1). He gave details of draft which concerns adult care home licensure act. Concluding his remarks on this bill request, he asked the committee consider the introduction of such legislation.

Rep. Foster made a motion to request this legislation and have it returned to this committee. Motion was seconded by Rep. Flower. No discussion. Vote taken, motion carried.

Testimony began on **HB 2012**:

Attachments No. 2. E. Maxwell,and Attachment No.3,Nancy Buer. Chairman noted opponents and proponents will not be scheduled at separate times, he asked that conferees keep their remarks as brief as possible so that we may hear as many as possible. It is the desire of the Chair to give as full a hearing as possible on bills before committee. He also asked members be direct and brief with their questions of conferees so work may proceed as quickly as possible. It will be the practice of this committee that no final action will be taken on a bill as soon as hearings are concluded. We hope there can be a delay of at least one day so members can make their cecisions with care.

Terri Roberts, Ks. State Nurses Association, (Attachment No.4). Ms. Roberts stated their organization is unable to support **HB 2012** as it is currently written. There are many unanswered questions. When such a sweeping change is made to the Nurse Practice Act, it should be done very carefully. We do recognize the need for handicapped to have control over their lives. She questioned New Section (2) language and is concerned if it should in fact be in the Nurse Practice Act. She answered questions, i.e., perhaps wording in lines 48-50 need to be clarified.

Linda Lubensky, Kansas Home Care Association gave hand-out, (Attachment No. 5) gives details. She noted **HB 2012** does not address some primary issues, and their Association cannot support it in its current form. The bill does not set adequate parameters for appropriate/inappropriate

HEARINGS CONTINUED ON HB 2012:--

Linda Lubensky:--

health maintenance activities. She drew attention to language describing "health maintenance activities", and the concerns regarding same. She offered in hand-out some proposals to changes for the Kansas Nurse Practice Act.

Michael Lechner, Executive Director, Dept. Human Resources, (see Attachment No. 6), for details of testimony. He commended members of Interim for producing a bill that will make significant differences in the way self-directed Kansans with disabilities may live their lives. HB 2012 will allow unlicensed people to provide attendant care for pay to individuals with disabilities, will provide for expansion of services available to clients of SRS' Home/Community Based Services, (HCBS), will mandate inclusion of consumers in the planning, start-up, delivery and administration of attandant care programs. He recommended amendments to language in New Section 2, (4), and (m). He answered questions.

Kathy Noland, American Nursing Resources, Inc. see (Attachment No. 7) for details of her testimony. She stated concerns that HB 2012 is flawed in that it has no safeguards to protect the most vulnerable members in our society from exploitation/abuse. She noted growth in home health care has drastically changed these service. Many such services have become highly skilled and technological. She cited such speciality services. She spoke of training and monitoring and supervision of care givers. As HB2012 is currently written, there are no safeguards to protect clients from incompetent caregivers. HB 2012 states the physician will be responsible for training/supervision. It is ludicrous to believe the physicians will have time to do this. As written, HB 2012 is not the answer to problems discussed this date, it will present even greater problems of safety, liability, and quality of care. She answered questions.

George Dugger, Ks. Dept. on Aging, provided (Attachment No. 8), for details. He stated their Department supports HB 2012 as a way for certain persons in need of in-home care to increase control over their own lives. This can give greater personal satisfaction, improve sense of well-being, preserve ability to live independently in a less costly manner. However, he said, HB 2012 is permissive. It does not require increased responsibility by individuals in need of in-home care who do not want to or are not capable of assuming responsibility for their own care, and many elderly will fall into this category. This bill will pose a challenge, but we think liability and other concerns can be resolved. He answered a few questions.

Judith Bellome, Clinicare, Family Health Services, (Attachment No.9). She spoke in opposition of HB 2012 as written and offered suggestions, i.e., the care giver not the client should be taught procedures to meet personal care needs; the RN should be the teacher, not the physician; assessment of care; competency of care giver evaluated by RN; limitation of liability to the RN trainer after written documentation is made; pilot study conducted only within the SRS, HCBS programs. Her hand-out cited specific cases of medical concerns of a patient who did not have proper medical care. She answered numerous questions.

Barbara Bradford, from Lawrence spoke with personal experience in regard to having care givers perform services for her. She is now able to be at home, work a full time job, and she is in control of her care, and pays the care-giver. She explained the need for many requiring care several times during the day, not just to get dressed and have medication in the mornings. Yes, she said, it is the RN's who instruct the patient on their care, not the physicians. HB 2012 will provide for care-givers to accompany persons outside the home setting if necessary. She is grateful

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 313-S Statehouse, at 1:30 a.m./p.m. on January 18, 1989

HEARINGS CONTINUED ON HB 2012:---

Barbara Bradford continued:---

she has a job, can pay for her own care. Most cannot and must depend on State Funding. It is a shame, she said, that a person's civil rights depends on how much money a person has. (Whether they can receive care or not). **HB 2012** will rectify this situation. She also supports both proposed amendments she said.

In closing comments, she said the Interim Report is one of the most literate and sensitive documents she has read for a while. It gives great background, shows understanding, gives a good insight to independent living, and she would recommend all committee members read the report if they have not yet done so.

Chair stated he regrets we were not able to conclude the prepared agenda this date. He asked those who were to testify on HB 2012 and did not get that opportunity today if they could return tomorrow.

Hearings on **HB 2012** will continue tomorrow.

Meeting adjourned, 3:10 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date Jan 18, 1989

Name	Organization	Address
Mitzi Richards	HOMECARE	2803 Claflin Manhtt. Ks
Nancy Barnaby Rn	HOMECARE	2803 Claflin Manhtt. Ks
Dr Lois R. Scibetta	KSBN	551 Landon S Topeka Off
George A. Dugger	Dept on Aging	Rm. 122-S Docking
John O. Miller	AARP	5230 W. 24th St. Topeka
George Adolf	AARP	711 Crest Dr. Topeka 66606
Ellen Parker	SRS	Rm 600N Docking Office Bldg.
Michael Byington	Helen Keller Center for Prof/Blind - Ks. Project	300. S. W. Oakley Topeka 66606
Bonnie Byington	Ks. Assn for Blind and Visually Impaired Inc.	416. S. W. McVicar Topeka, KS. 66606 66603
Judy Beeson	Clinicare	413 Division, KCK
Judy Davis	HOME PARENTERAL SERVICES	114 ABILENE, KCK 66103
Kathy Noland	American Nursing Resources Joint Commission	11050 Roe Blvd Overland Park, Ks. 66211
Ray Petty	TOPEKA INDEPENDENT LIVING RESOURCE CENTER, INC.	1119 W. 10TH, SUITE #2 TOPEKA 66604
Jolene Zivnuska	AARP task force	Wichita
John Grove	Ks Homes for Aging	641 SW Harrison Topeka
Dick Hummel	Ks Health Care Assn	Topeka
Sister Dominic Haug	Goodwin Best Home Health Service Ks Home Care Assn	PO Box 1937 Great Bend Lawrence
Marcia Lauppe	Douglas County Visiting Nurses	336 Missouri Lawrence Ks 66044
Marlene Forney	SRS Adult Services	300 SW Oakley West Hall 600
Janet Schalansky	"	"
Jan Allen	SRS Adult Services	"
M. Marlene Hall, RN	Homecare	1000 W 10th Topeka Ks
Linda Lukensky	KS Home Care Assn	4101 W. 13 Lawrence
Carolyn Middendorf	KSNA	4507 SW 29 66614

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date Jan 18, 1989

Name	Organization	Address
Barbara Bradford	Consumer	1521 Vermont Lawrence
Carol Renzulli	LCCD	533 Alabama Lawrence KS
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
GREG RESSER	KDHE	900 Jackson Topeka, KS.
Richard Morrissey	KDAE	Topeka
Michael Horak	AP	Topeka
Bob Corkins	Kan. Hospital Assn	Topeka
Jon Brax	Kansans for Lifestyle Best	Topeka
Mary Ellen Conlee	KS. Assoc for Small Business	
Melba Gwaltney	SRS/-Rehab Svs.	Topeka
Lee Graybeal	TILRC, Inc.	Topeka
Fred Markham	LCCD	Lawrence
KARLA R. Clevenger	LCCD	Lawrence
Sherri L Axline	LCCD	Lawrence
Mike Oxford	KACEH	Topeka
Mike Leehner	"	"
William Beyer	RCIL	OSAGE CITY
Ryal Armitage	KANA	Salina, KS 67401
Pat Roth	KANA	Newton

DRAFT

_____ BILL NO. _____

By

_____

AN ACT concerning the adult care home licensure act; placing certain restrictions on the development of such homes; amending K.S.A. 39-926a and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. K.S.A. 39-926a is hereby amended to read as follows: 39-926a (a) Except as otherwise provided in this ~~section~~ subsection (a), no more than three different persons shall be licensed to operate any one adult care home under the adult care home licensure act, and no license to operate any one adult care home shall be issued under that act to more than three different persons. The provisions of this ~~section~~ subsection (a) shall not apply to any license to operate an adult care home which is in effect on the effective date of this act and which is issued to more than three different persons, or the renewal of any such license, unless subsequent to the effective date of this act or fewer persons operate the adult care home or the license to operate the adult care home is denied or revoked.

(b) On and after the effective date of this act, no new license to operate an adult care home shall be issued for a period of one year. (1) Notwithstanding the provisions of this section to the contrary, any adult care home licensed prior to the effective date of this act may increase its bed capacity by 15% of current capacity or by no more than 15 beds. Section 2. This act shall not apply to the following: (1) intermediate nursing care facilities for the mentally retarded; (b) intermediate personal care homes; (c) intermediate nursing care homes for the mentally ill; (d) the conversion of existing adult care home beds from one licensure category to another category if the redistribution does not increase the overall bed capacity of the facility; (e) a facility project submitted within 60 days prior to ~~after~~ the effective date of this act to the department of health and environment with evidence of the permanent financing of the project.

Attm. #1.
1-18-9

Section 3. (a) The secretary of health and environment upon application of an adult care home may grant an emergency waiver from the provisions of this act if the need for the adult care home project is a result of fire, tornado, flood, storm damage or other similar disaster, if adequate health care facilities are not available for the people who previously used the applicant adult care home's facility and if the request for an emergency waiver is limited in nature and scope only to those repairs necessitated by the natural disaster.

Section 4. The secretary of health and environment may adopt rules and regulations necessary to administer the provisions of this act.

Section 5. This act shall take effect and be in full force from and after its publication in the statute book.

Attm #1
pg 2
1-18-9

Evelyn M. Maxwell, MN, RN
414 Wayne Avenue
Salina, Kansas 67401
Telephone 913-827-3304

January 14, 1989

Members of the House Public Health and Welfare Committee
Re: HB 2012

I have four concerns related to the protection of the individual in need of in-home-care.

1. Managing finances, line 45. Individuals in need of in-home-care who need assistance with finances need the protection of an independent audit at least annually to protect assets of persons in declining health. Guidelines for the proposed attendants need to be compared to those required of guardians, but outside the court system.

2. Training, lines 46-50. Physicians rarely go into homes to provide the time consuming type of training and supervision needed to safeguard the patient. The training provision needs clarification regarding the health care professionals--LMHT's, psychologists, med aides, etc., do not have the qualifications for training the attendant for "health maintenance activities." The safeguards for in-home-care should be similar to those required of Home Health Agencies and require registered nurse supervision periodically as appropriate to the patient's changing level of acuity, changes in the attendants and/or their abilities.

3. Functionally disabled (line 51-e) should include emotionally impaired persons also. They need the stability of their own home, family, friends, and neighbors as much as the physically impaired. This would allow real "community" mental health care rather than relegating the emotionally ill to group homes in poor neighborhoods waiting for sporadic treatment in a centralized comprehensive mental health center. Treatment at home by social workers and nurses using the psychiatrist's or other mental health professional's treatment plan in conjunction with their own expertise could be much more "comprehensive" than being uprooted and taken to a strange place for an indefinite period of time.

4. This act should in no way be an exception to the nurse practice act. Social workers are not trained to supervise health care and health maintenance procedures. Providing nursing supervision of home care should be one of the priorities of the state to meet the desires and needs of the elderly as well as provide huge financial savings.

Sincerely,

Evelyn Maxwell

attm #2
1-18-89
PHW

January 14, 1989

From: Nancy Buck RN
P.O.B. 388
Colby, Ks 67701

Re: House Bill 2012
On Home Care

Dear Rep. Littlejohn and Committee,

It is with great concern that I address you on the issue of HB 2012 and the proposed changes to the Kansas Nurse Practice Act.

While having experience in Home Care and understanding with appreciation the disabled and elderly persons desire for control over their health maintainence, I also know the importance of quality and safety in performing health Maintainence procedures.

Health maintainence activities as defined on line 46 of this bill are often recognized as skilled. This means they need to be performed in a specialized manner according to medical and nursing standards of practice.

It is worrisome enough that

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persons who may have no training at all prior to being hired will be performing these tasks, but it's illogical that they will not be trained or supervised by a skilled professional nurse. These health maintainence activities fall under nursing practice. This makes the R.N. the appropriate "trader."

Lines 49 and 50 explains that the physician will train and supervise the individual who will perform these activities. This is totally unrealistic especially in rural Kansas where the population is underserved by doctors. Our few doctors have neither the time, equipment, nor expertise in many of these health maintainence activities to be responsible for the training. It's unfair to expect them to do so.

I empathize and applaud the elderly and/or disabled person's desire to control their lives. I also understand their frustration with the present reimbursement systems they have to contend with; but waiving the need for quality assurance and nursing input (as SRS has already done with their HCBS program) is not the answer.

Thankyou for your attention.

Sincerely,
Nancy Baer

#3
2.
1-18-9

KSNA
the voice of Nursing in Kansas

FOR MORE INFORMATION CONTACT
Terri Roberts J.D., R.N.
Executive Director
Kansas State Nurses' Association
(913) 233-8638
January 18, 1989

H.B. 2012 In-Home Care and Services for Handicapped and Functionally Disabled Persons

Chairman Littlejohn and Members of the House Public Health and Welfare Committee, my name is Terri Roberts R.N. and I am a registered nurse representing the Kansas State Nurses' Association. Thank you for the opportunity to speak on H.B. 2012.

As you may suspect, any proposed chnages in the Kansas Nurse Practice Act K.S.A. 65-1113 are of great concern to Registered Nurses. Licensure laws of health care personnel were originally designed to protect the public through the limited use of titles. Today, Nurse Practice Acts continue to protect the public by limiting individuals performing nursing services, to those who are licensed to do so.

Currently the more than 20,000 R.N.'s in Kansas are responsible for supervising LPN's, LMHT's, Certified Medication Aides, Nursing Homes Aids, Home Health Aides and other unlicensed personnel employed by agencies providing health care in a variety of settings.

The Kansas State Nurses' Association would support a state model for the delivery of services in home care that provided for professional nurse supervision over services provided, including, but not limited to case management. We presented information about the Oklahoma Model during the interim study. It provides a statewide network of in-home services that is provided by unlicensed individuals called Non-Technical Medical Care providers. They receive 40 hours of training and they are supervised by Registered Nurses who make periodic visits to the clients they serve.

The model that was selected by the Interim Committee to be used in Kansas is the Pennyslvania model. In reviewing H.B. 2012, specifically "Health Maintenance Activities" on line 46, page 2 there are many questions that emerge. The words "but are not limited to" is very broad, that section of the bill implies that there is no limit to the services that constitute "health Maintenance activities". The Pennyslvania Model specifically defines such activites as "those activities which are necessary to maintain health and normal bodily functions and would be carried out by the consumer if physically able." Line 48 indicates that physicians will be providing the training and supervision to the clients. We question whether or not physicians will be actually carrying out this function, it has not been one that they have been traditionally assuming. Registered nurses in hospitals, rehabilitation centers, nursing homes and home health agencies have assumed responsiblity for teaching clients about their medical needs in the home. This bill provides training and supervision to the individuals in need of in-home care. The

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attm #4

Pennyslvania Model is much different in this provision. Health Maintenance Activities can only be performed by unlicensed attendants under the following conditions, none of which appear in this bill draft, nor or they referred to as being contemplated as part of implementing regulations:

a. The provider has assessed the consumer as being capable of directing and supervising the attendant in the specified Health Maintenance activities;

b. The attendant is trained and supervised in the prescribed activities by the consumer's physician and/or a qualified health professional;

c. The attendant's ability to carry out the activities safely has been documented by the provider agency;

d. The attendant's prior experience and work history do not indicate unsafe performance of such activities;

e. Disposable items or devices are used in caring for the consumer whenever they are obtainable;

f. The provider has ensured that the consumer has in place appropriate referral arrangements with health providers to respond to health emergencies; and,

g. The provider, the consumer, the attendant(s), and others who have committed to provide Health Maintenance Activities must sign the service plan.

The Pennsylvania model also has parameters for the client population served. This bill, at the direction of the interim committee has no limit on such a client population. The Pennyslvania Model defines "eligible individual" as any physically disabled/mentally alert person 18-59 years who meets the following requirements:

(1) Experiences any medically determinable physical impairment which can be expected to last for a continuous period of not less that 12 months.

(2) Is capable of selecting, supervising, and, if needed, firing an attendant.

(3) Is capable of managing his own financial and legal affairs.

(4) Because of physical impairment, requires assistance to complete functions of daily living, self-care and mobility, including, but not limited to, those functions included in the definition of attendant services.

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1-18-9

The Pennsylvania Model was implemented after demonstration projects in that state. While we believe that such demonstration projects are not necessary to have a viable plan for providing services, it is noteworthy that after such demonstration projects there are limitations on the program in Pennsylvania, none of which appear in H.B. 2012.

The Kansas State Nurses' Assocation strongly objects to the lack of parameters in the definition of "health maintenance activities" and strongly believes that such a sweeping change to the Nurse Practice Act must be more carefully constructed. One of the key elements that must be addressed is the issue of "training" and "supervision". The Pennsylvania Model provides the training to the attendants, the actual caregivers, by qualified health professionals. H.B. 2012 provides for training only to the individual in-need of home health services, and implies that they will be responsible for further training to their caregivers (attendants). It is critical that whomever is delivering the care is adequately prepared to do so. H.B. 2012 provides no safequards for insuring that the training is appropriate for caregivers (attendants) by individuals in-need. When licensed nurses deliver services to clients they are legally bound to act in a prudent and reasonable fashion, according to recognized standards of care in the delivery of services. Services that fall below the acceptable standard of care can be addressed by the client/consumer in two different arenas. The licensed nurse can be disciplined by the Board of Nursing, or the client/consumer can seek civil remedies for damages incurred as a result of the failure to act in a reasonably prudent fashion. Licensed nurses have tremendous motivation to appropriately serve the public. This client population is one that can be characterized as particularly vulnerable. The severely and multiply handicapped, and elderly individuals with chronic illnesses are at greatest risk for being exploited and/or abused by their caregivers. We believe that it is essential to provide licensed nursing supervision to ensure that the individuals who elect self-directed care will not be placed at risk. The Pennsylvania Model does provide safeguards, H.B. 2012 does not.

Philosophically speaking, Registered Nurses incorporate promoting self-care and health maintenance into their clinical practice. We recognize the need for individuals who are handicapped to maintain control over their lives. Some of the issues regarding flexibility in the HCBS program, control over attendant hours that were raised during the interim committee hearings are of concern. They must not however, be allowed to overshadow the need to protect the public.

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1-18-9

New Section 2 of H.B. 2012 is an amendment to the Nurse Practice Act that instructs the Secretary of SRS to make changes in the HCBS program. The Nurse Practice Act does not seem the most logical place for these directives to the Secretary of SRS and I wonder if this section would be better placed in a seperate bill, or as part of other statutes governing the Department of Social and Rehabilitation Services elsewhere.

The amendment to the Nurse Practice Act exceptions section, K.S.A. 65-1124 (m) on page 4, line 151 refers to the New Section 1 in the bill for definitions. The problems identified with the broad language in New Section 1 must be addressed prior to the implementation of this change.

The Interim Committee on Public Health and Welfare collected a tremendous amount of data. The report was very concisely written. It provides a very valuable explanation of the many variables that are impacting the home health setting and delivery of in-home services. I am afraid at this time, we are unable to support H.B. 2012. There are many unanswered questions about unlicensed individuals performing nursing services, their training, their supervision and a need to insure appropriate services to a extremely vulnerable client population.

Thank you for the opportunity to speak.

attm #4
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KHCA
Kansas Home Care Association · 4101 West 13th Street · Lawrence, Kansas 66046 · (913) 841-2833

To: The House Committee on Public Health & Welfare

From: Linda Lubensky, Executive Director, KHCA

Date: January 18, 1989

Subject: House Bill No. 2012

On behalf of the Kansas Home Care Association, I would like to express my appreciation for the opportunity to testify before you concerning H.B. 2012. KHCA is an association representing providers of in-home services across the state of Kansas. Our members are those intimately involved with the specifics of home care, its limitations as well as its benefits.

The Kansas Home Care Association opposes H.B. 2012, not because of its concept, but because of its failure to address some primary issues. The concept, that generated H.B. 2012, supports greater autonomy and independence for individuals receiving in-home services, when desired and when appropriate. Home Care, by its very nature, is a strong proponent for self-reliance and independence. Home care allows the individual to remain in his home and community; it encourages patient and family participation; and it supports the individual's control over his environment.

It is the language used in H.B. 2012 that fails to recognize and speak to some principal issues. In Section I (d), in attempting to define "health maintenance activities," the bill does not set adequate parameters for appropriate and inappropriate health maintenance activities. Instead, the phrase "include, but are not limited to" is employed, leaving the possibilities for interpretation unlimited. In this same section, the physician is designated to provide the training and supervision to the client. The Kansas Home Care Association agrees that the physician should play a primary role in determining which individuals are capable of self-direction and which tasks are fitting for delegation. However, "health maintenance activities" are essentially nursing tasks and, consequently, the Registered Nurse would more appropriately fill the role of "teacher". Her judgement and assessment skills should be incorporated in the determination of self-direction as well as that of the health maintenance activity. In addition, we feel that the training should be of a more immediate nature, rather than second-hand, and occur with the nurse, the caregiver and the patient participating. As environmental conditions can and do affect the provision of care services, we feel it equally important that the training of the caregiver be conducted in the actual home setting. Lastly, both

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the patient and the nurse should supervise and evaluate the performance of the tasks during training, to determine the caregiver's ability to provide for the needs of the client safely and effectively.

The state of Kansas, mindful of its responsibilities to the public, has always been supportive of licensure and certification regulations for those providing health care services. H.B. 2012, in its present form, could serve to establish a double standard for quality of care between in-home care and other care situations. This legislation should be one that enables individuals to have care choices and not one that encourages society to by-pass accepted state standards for quality care. Some limitations are necessary for any program that allows for self-direction of health care. Self-direction is neither safe nor appropriate for everyone. Some standards must be applied when determining self-directed individuals and those health maintenance activities that may be safely performed by an unlicensed caregiver.

To help the committee in its deliberations, I have included in this testimony the Kansas Home Care Association's recommendation for changes to the Nurse Practice Act. Rather than just adding to the exemption portion of the Practice Act, we would hope that this committee will chose to emphasize the uniqueness of the home care situation. The KHCA proposal deals with the nurse's role within the home setting and is similar, in form, to the school nurse modifications to the Practice Ace. We do feel that our proposal addresses the issues discussed in this testimony.

Thank you for your consideration. I would be happy to answer any questions or provide any information that the committee might require.

Attm #5
2 pg
1-18-9

KHCA
Kansas Home Care Association · 4101 West 13th Street · Lawrence, Kansas 66046 · (913) 841-2833

PROPOSAL
CHANGES TO THE KANSAS NURSE PRACTICE ACT

In order to allow for the delegation of selected nursing tasks to designated unlicensed persons in the home setting, the Kansas Home Care Association proposes that the following be added to the Kansas Nurse Practice Act:

Article: Performance of Selected Nursing Procedures in the Home Setting.

1. Each licensed registered professional nurse in the home setting shall be responsible for the nature and quality of all nursing care that a patient is given under the direction of the nurse in the home setting. Assessment of the nursing needs of a patient, the plan of nursing action, implementation of the plan, and evaluation are essential components of professional nursing practice and are the responsibility of the licensed registered professional nurse.
2. When used in these regulations, the following definitions shall apply:
   - A. Unlicensed person - includes certified and non-certified caregivers in the home setting.
   - B. Delegation - means authorizing an unlicensed person to perform selected nursing tasks in the home setting under the supervision of the licensed registered nurse.
   - C. Activities of daily living - means basic caregiving.
   - D. Basic caregiving - means bathing, dressing, grooming, routine dental, hair and skin care, preparation of food for oral feeding, exercising (excluding occupational therapy and physical therapy procedures), toileting (diapering, toilet training), hand washing, transfer and ambulation.
   - E. Specialized caregiving - means procedures ordinarily performed by a nurse.
   - F. Nursing judgement - means the exercise of knowledge and discretion derived from the biological, physical and behavioral sciences.
   - G. Supervision - means that the licensed registered professional nurse shall oversee the delegated task.
   - H. Immediate supervision - means that the delegating licensed registered nurse is physically present while the task is being administered.
   - I. Indirect supervision - means the delegating licensed registered nurse shall be readily available whether in person or by telecommunications.
3. The full utilization of the services of a licensed registered professional nurse maybe supplemented by the delegation and supervision, during training, of selected nursing tasks to

PHCW
attm #5
pg 3
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unlicensed personnel.

4. Delegation Procedures: delegation of nursing tasks to a designated unlicensed person in the home setting shall comply with the following requirements:

A. A physician's order is required to teach specialized care giving tasks to non-medical personnel who are reimbursed for their services.

B. Each licensed registered professional nurse shall assess the patient's nursing care needs and formulate a written nursing plan of care before delegation of any nursing task to an unlicensed person.

C. The selected nursing task to be delegated must be one that a reasonable and prudent licensed registered professional nurse determines to be within the scope of sound nursing judgement.

D. Activities of daily living, as defined in 2 C as basic caregiving, need not be delegated. Activities of daily living defined as specialized caregiving, as defined in 2 E, shall be assessed and delegated as appropriate.

E. The selected nursing task shall be one that, in the opinion of the delegating licensed registered professional nurse, can be properly and safely performed by a designated unlicensed person without jeopardizing the patient's welfare.

F. The selected nursing task shall not require the designated unlicensed person to exercise nursing judgement or intervention except in emergency situations.

G. The designated unlicensed person to whom the nursing task is delegated shall be adequately identified by name in writing for each delegated task.

H. The licensed registered professional nurse shall orient, instruct and document in writing that the designated unlicensed person has demonstrated the competency necessary to perform the delegated task. The designated unlicensed person shall co-sign the documentation indicating the person's concurrence with this competency evaluation.

I. The licensed registered professional nurse shall relinquish responsibility for the task/client specific delegated nursing task upon satisfactory competency evaluation.

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KANSAS DEPARTMENT OF HUMAN RESOURCES

ADVISORY COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED
1430 S.W. Topeka Boulevard, Topeka, Kansas 66612-1877
913-296-1722 (Voice) • 913-296-5044 (TDD) • 561-1722 (KANS-A-N)

Mike Hayden, Governor

Dennis R. Taylor, Secretary

TESTIMONY ON HB 2012
JANUARY 18, 1989

Members of the House Committee on Public Health & Welfare, thank you for the opportunity to testify before you on House Bill 2012. I commend those of you who sat on the Interim Study for producing a bill which will make significant and positive differences in the way self-directed Kansans with disabilities may live their lives. Several people will appear before you to describe some of these differences.

HB 2012 is a strong, consumer-oriented piece of legislation which affirms the right to self-direction by those disabled individuals who are capable and wish to manage their own care. This right has been traditionally ignored or compromised by home health care agencies under the guise of protecting the client from harm and protecting the agency from liability.

HB 2012 would allow unlicensed people to provide attendant care for pay to individuals with disabilities. Under current law, unlicensed people are permitted to provide attendant care services in the home as long as they do not receive payment for rendering such services. It is very difficult to hire anyone to perform these services; to acquire these services gratuitously is more than close enough to impossible.

HB 2012 provides for the expansion of services available to clients of the SRS' Home & Community Based Services (HCBS). These services are not currently available because there is no state law which defines them as part of attendant care services.

HB 2012 mandates the inclusion of consumers in the planning, start-up, delivery and administration of attendant care programs. After speaking to individuals and groups concerned with this bill, the following language is recommended for this section:

> New section 2. (4) ~~providers, where appropriate, shall include~~ individuals in need of in-home care **shall be substantially included** in the planning, startup, delivery and administration of attendant care services and the training of personal care attendants, **including the promulgation of rules and regulations to implement this act**; and

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Consumers are quite distrustful of bureaucracies and feel the intent of this section is made clearer by the inclusion of this amendment.

The other amendment arising from these discussions would incorporate the following language:

> (m) performance of attendant care services ~~in the residence of an~~ for individuals in need of in-home care as the terms "attendant care services" and "individuals in need of in-home care" are defined under section 1. of K.S.A. _____.

This amendment would allow these services to be performed in a college dormitory room, congregate living quarters or other places of residence in the community outside an institution; not just in the traditional residence.

Aside from these two amendments, the Kansas Department of Human Resources' Advisory Committee on Employment of the Handicapped strongly favors and supports HB 2012. We ask that you report this bill favorably with these amendments.

Again, I thank you for your excellent work on this significant legislation. I will be pleased to entertain any questions.

Respectfully submitted,

Michael Lechner
Executive Director

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Testimony on HB 2012 Proposed Amendment to the Kansas Nurse Practice Act

January 18, 1989

Chairman Marvin Littlejohn and members of the House Public Health and Welfare Committee, thank you for the opportunity to make this presentation. I am Dr. Kathy M. Noland, R.N., Ph.D. I am a registered nurse. I am the corporate director of quality assurance for a national home care organization and a home care surveyor for the Joint Commission on Accreditation of Health Care Organizations. I believe the House Bill No. 2012 re: Proposal Nos. 37 and 40 to be vague and very broad in its definition and illustration of "health maintenance activities" and further believe its application will have many unintended ramifications resulting in detrimental and dangerous health care for the population it is intended to serve. This bill attacks the fundamental issue of quality home care and the established mechanisms to ensure this quality. Although the intent of this bill is to enable a certain group in society greater access and control over their home care services, HB 2012 is flawed in that it has no safeguards to protect the most vulnerable members in society from exploitation and abuse. The following discussion will clarify and support this stance.

Growth in the aged population, increase in morbidity, technological advances, rising health care costs, pressure to decrease budget deficits and social programs, growth of alternative health care payment systems such as health

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maintenance organizations and preferred provider organizations, and the demand for consumer participation have made home care the fastest growing segment of the health care arena. Hundreds of thousands of individuals who, ten years ago, would not have survived or would be destined to institutional care are now thriving at home with the assistance and support of home health care. However, this growth process has drastically changed the activity level of home health care. These services have become highly skilled and technological in nature. With these advancements have come increased responsibility on the part of the client and the home care provider. The client must be an active participant and decision maker in his care. And, it is imperative for the provider to assume the responsibility for ensuring that the caregivers are adequately trained to provide the level of care needed and that they are supervised to ensure that they are providing quality care. (8,10)

In my role as home care surveyor for the Joint Commission on Accreditation of Health Care Organizations, I travel across the country surveying home care organizations in relation to established standards of care. In this process, I accompany home care providers on home visits and have the opportunity to view firsthand the broad spectrum of "health maintenance activity" needs that exist across the nation. These "health maintenance activities" as defined in HB 2012, for example, include procedures as highly technical as the administration of intravenous cancer therapy, the administration of complete nutrients through a catheter leading into the heart via a computerized infusion pump, and the procedures involved in maintaining an individual on a mechanical ventilator. And I assure you these activities are not the exception. It is estimated that in 1988, in the Metropolitan Kansas City Area alone, approximately 450

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individuals received intravenous hydration and nutrition in the home and 1030 individuals received antibiotic and chemotherapy in the home. It is projected that these numbers will triple during the next two years. (6)

Although it is possible to train an individual to perform these specific tasks, the expertise that is needed to monitor and supervise these tasks requires theoretical knowledge which cannot be acquired through a demonstration of technique. The performing of specific tasks is only a portion of safely maintaining an individual needing the care described above. The ongoing skilled assessment of the overall condition of the individual is imperative in identifying changes in condition and care needs and preventing complications. As HB 2012 is currently written, there are no safeguards to protect the most vulnerable members of society from incompetent caregivers who could be administering life threatening medications and procedures.

HB 2012 states that the physician will be responsible for training and supervision. Physicians do not have the time, nor the inclination to perform this training and supervision. Traditionally, this training has been provided by professional nurses. It is ludicrous to believe that physicians will have the time to provide individualized instruction and supervision in the home setting. When one calculates the physicians' time this teaching and supervision would require, it is preposterous to suppose physicians could provide these services without financial remuneration.

As I stated earlier, I am a home care surveyor for the Joint Commission on Accreditation of Health Care organizations. I want to briefly review with you

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the development of this accreditation program and its mission. The Joint Commission is a non-profit organization which was established in the 1950's to develop standards of care and accreditation for hospitals. As health care has developed alternative care services, so too have the accreditation programs of the Joint Commission grown. Three years ago, in response to the growth in home health care, consumer and health care groups formed a national advisory committee to work with the Joint Commission in establishing standards of home care to measure the quality of care provided in the home. The development of this committee was consumer driven and was comprised of 18 consumer and health care associations. Committee representation included such groups as the American Association for Retired Persons, Health Insurance Association of America, The National Association of Area Agencies on Aging, The National Association for Home Care, the American Nurses Association, the American Medical Association, and the National Council on Aging. This committee worked with home care agencies and the recipients of home care in a three year study process. In recognition of the complexity of home care services and the need for monitoring and supervision in assuring quality services, the committee developed over 500 standards. The program began surveying home care agencies in June of 1988 and it is projected that by the end of this year, that 1100 home care agencies will have been surveyed through this voluntary process. (7) I emphasize that this is a voluntary process and the overwhelming community response to this process indicates the need for accountability and close supervision in providing quality home care. For your review, I have attached the "Personal Care and Support Services" chapter from the Joint Commission Home Care Standards Manual. This chapter refers to the home care services included in personal care and activities of daily living administered

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by home health aides and personal care attendants. These standards include guidelines for the screening, hiring, training, and supervision of these caregivers in addition to specific guidelines regarding the qualifications of those who supervise the caregivers. Please note the asterisks following most of these standards. These are items that the committee identified as key items in the provision of safe, quality home care, yet these are the areas that are inadequately addressed in HB 2012. I attached this chapter for your review, to illustrate the acuity level of home care services and the degree of screening, training and supervision which has been identified by consumers as required components for safe, quality home care services. (7)

In closing, I must share with all of you that I find myself in a very awkward position. As someone who has dedicated her professional career to providing quality home care, I believe completely in the ethical tenets of our health care system. The most fundamental of these tenets is the nurse/client relationship. This is a symbiotic relationship to which the client brings his self-awareness, knowledge, and belief system and the nurse in turn brings his nursing knowledge, expertise and commitment to facilitate the most independent level of functioning possible for the client. When this relationship is severed, both parties are left impotent to attain the goal of independence. The provision of HB 2012 will indeed threaten this relationship. I will be the first person to acknowledge that our present system has problems. However, HB 2012 is not the answer to these problems and in fact will create much greater problems of safety, liability, and quality. I implore you to reevaluate this issue and take the time to explore other alternatives. I am most willing to assist in the process in any capacity that you desire. Again, I thank all of you for the opportunity to provide this testimony.

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10. Personal Care and Support Services (SS)

This chapter applies to organizations that provide personal care and/or other support services. Personal care and support services are provided in an individual's place of residence on a visit or hourly basis to meet the identified needs of patients/clients who have or are at risk of an injury, an illness, or a disabling condition and who require assistance in personal care, activities of daily living, and maintenance and management of household routines. These services may include, but are not limited to, those provided by home health aides, homemakers, personal care aides, home attendants, chore service workers, or companions. These services may be provided directly or through contract with another organization.

Standard		Circle One
SS.1	A consistent process is used for the selection of personal care and support service staff.	1 2 3 4 5 NA

Required Characteristics

SS.1.1	The process, as defined in written policy and procedure, demonstrates at least*	1 2 3 4 5 NA
	SS.1.1.1 the use of personal interviews;*	1 2 3 4 5 NA
	SS.1.1.2 follow-up of employment references and job history;* and	1 2 3 4 5 NA
	SS.1.1.3 as appropriate, verification of education, experience, training, or certification.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of key factors, see "Using the Manual," page vii.

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Standard		Circle One
SS.2	Personal care and support service staff complete appropriate training and orientation before being assigned to provide care or services for patients/clients.*	1 2 3 4 5 NA

Required Characteristics

SS.2.1	Staff demonstrate knowledge of the subjects taught and proficiency in skills appropriate to their assigned responsibilities.*	1 2 3 4 5 NA
SS.2.2	There is a system to determine when training may be waived for individuals with experience equivalent to required training.	1 2 3 4 5 NA
SS.2.3	Training includes instruction in the following areas:	
	SS.2.3.1 Communication skills;*	1 2 3 4 5 NA
	SS.2.3.2 Observation, reporting, and documentation of patient/client status and the care or service provided;*	1 2 3 4 5 NA
	SS.2.3.3 The needs of and ways to work with children, the elderly, and physically and/or mentally ill, disabled, or dying individuals in order to meet assigned responsibilities;*	1 2 3 4 5 NA
	SS.2.3.4 Maintenance of a clean, safe, and healthy environment;*	1 2 3 4 5 NA
	SS.2.3.5 Basic infection control procedures;*	1 2 3 4 5 NA
	SS.2.3.6 Basic nutrition and food preparation techniques, as appropriate;* and	1 2 3 4 5 NA
	SS.2.3.7 Other areas as needed to prepare staff for the responsibilities assigned.*	1 2 3 4 5 NA
SS.2.4	For individuals providing personal care, the training includes instruction in the areas listed in Required Characteristics SS.2.3 through SS.2.3.7 and the following additional areas:	
	SS.2.4.1 Basic elements of body functioning;*	1 2 3 4 5 NA
	SS.2.4.2 Appropriate and safe techniques in bathing, oral hygiene, shaving, feeding, and dressing;*	1 2 3 4 5 NA
	SS.2.4.3 Safe transfer techniques and ambulation;*	1 2 3 4 5 NA
	SS.2.4.4 Obtaining vital signs, if appropriate to assigned care responsibilities;* and	1 2 3 4 5 NA
	SS.2.4.5 Specified exercises and treatments as assigned.*	1 2 3 4 5 NA
SS.2.5	The training complies with applicable law and regulation.	1 2 3 4 5 NA
SS.2.6	The duration of the training is sufficient to address the content required.	1 2 3 4 5 NA

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*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of key factors, see "Using the Manual," page vii.

Standard **Circle One**

SS.3 Supervision of personal care and support service staff is appropriate and timely and is provided by qualified individuals.* 1 2 3 4 5 NA

Required Characteristics

SS.3.1 The minimum education and experience required for the supervisor of personal care and support services is documented in a written job description(s). 1 2 3 4 5 NA

SS.3.2 The qualifications of the supervisor are appropriate to the personal care and support services provided under his/her supervision.* 1 2 3 4 5 NA

SS.3.2.1 When personal care and home health services are provided to meet health needs, a registered nurse or other appropriately qualified health professional supervises the care and services.* 1 2 3 4 5 NA

SS.3.2.2 When personal care and support services are provided to meet social and/or environmental needs, a qualified individual supervises the care and services.* 1 2 3 4 5 NA

SS.3.2.2.1 The organization has a process by which an individual providing personal care or support services consults with an appropriately qualified health professional if a health problem is identified or a significant change in a patient's/client's physical condition is noted.* 1 2 3 4 5 NA

SS.3.3 Supervision of personal care and support service staff includes regular assessment of the following:

SS.3.3.1 Staff's ability to carry out assigned responsibilities;* and 1 2 3 4 5 NA

SS.3.3.2 Staff's ability to effectively interact with the patient/client to accomplish the goals of care or service.* 1 2 3 4 5 NA

SS.3.4 Appropriate supervision is available during all hours care or services are provided.* 1 2 3 4 5 NA

SS.3.5 The designated supervisor observes personal care and support service staff providing care or service every 750 hours of service, but not less than every six months.* 1 2 3 4 5 NA

Standard

SS.4 The personal care and support services provided are based on the initial and ongoing assessments of patient/client needs and are conducted by an appropriately qualified individual in the patient's/client's home.* 1 2 3 4 5 NA

Required Characteristics

SS.4.1 The assessments of patients/clients receiving any personal care or support service are appropriate to the type of care or service provided and include evaluation of 1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of key factors, see "Using the Manual," page vii.

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Circle One

SS.4.1.1 the patient's/client's functional status in regard to the degree of self-care the patient/client can perform and the amount and level of assistance needed;* 1 2 3 4 5 NA

SS.4.1.2 the patient's/client's psychosocial status (eg, cognitive level and environmental factors);* and 1 2 3 4 5 NA

SS.4.1.3 the availability of able and willing support.* 1 2 3 4 5 NA

SS.4.2 The assessments of patients/clients receiving personal care are conducted by a qualified health care professional.* 1 2 3 4 5 NA

SS.4.3 In addition to the provisions specified in Required Characteristics SS.4.1 through SS.4.1.3, the assessments of patients/clients receiving personal care include evaluation of the patient's/client's general health status and of the medications and equipment used in the home.* 1 2 3 4 5 NA

SS.4.4 The frequency of assessment is sufficient to evaluate the current needs of the patient/client and, if necessary, to adjust the care or services provided.* 1 2 3 4 5 NA

SS.4.4.1 When personal care services are provided, the assessment occurs at least every two months.* 1 2 3 4 5 NA

SS.4.4.2 When support services are provided, the assessment occurs at least every three months.* 1 2 3 4 5 NA

SS.4.4.3 When personal care is provided to a patient/client with an unstable medical condition or to a patient/client who is also receiving home health services, assessment occurs at least every 14 days or more frequently if indicated by the patient's/client's needs.* 1 2 3 4 5 NA

Standard

SS.5 The personal care and support services staff understand the duties to be performed and the arrangements for providing services as stated in the plan of care or service. 1 2 3 4 5 NA

Required Characteristic

SS.5.1 For additional requirements, see the "Patient/Client Care" chapter, Standard PC.2, Required Characteristics PC.2.6.1 through PC.2.6.2.

Standard

SS.6 Each patient/client receives care or service in accordance with the plan of care or service and related instructions.* 1 2 3 4 5 NA

Required Characteristics

SS.6.1 The care or service provided is appropriate to the identified needs of the patient/client.* 1 2 3 4 5 NA

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*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of key factors, see "Using the Manual," page vii.

		Circle One
SS.6.2	The patient/client consistently receives care or service on the assigned days at the times scheduled with the patient/client.	1 2 3 4 5 NA
	SS.6.2.1 The patient/client is notified in a timely manner of any changes in the agreed upon schedule.*	1 2 3 4 5 NA
SS.6.3	When possible, the patient/client receives care or service from a limited number of identified staff.	1 2 3 4 5 NA
	SS.6.3.1 When changes in staff occur, the new staff member is oriented to his/her assigned responsibilities and to the individual patient's/client's needs.*	1 2 3 4 5 NA
	SS.6.3.1.1 As appropriate, the orientation to assigned responsibilities occurs on-site.	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of key factors, see "Using the Manual," page vii.

Notes and Comments:

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TESTIMONY BEFORE THE HOUSE COMMITTEE ON PUBLIC HEALTH & WELFARE
ON HB 2012
JANUARY 18/19, 1989
By
Kansas Department on Aging

The Kansas Department on Aging (KDOA) supports HB 2012 as a way for certain individuals in need of in-home care to increase the control over their own lives. Such increased control results in greater personal satisfaction and an improved sense of well-being. It can also help preserve an individual's capability to live independently in less costly non-institutional settings.

HB 2012 is permissive. It does not require increased responsibility by individuals in need of in-home care who either do not want or are not capable of assuming increased responsibility for their own care. Many elderly in-home care recipients will probably fall into this category. While implementing HB 2012 will pose a challenge, we think liability and other administrative issues can be resolved.

The critical issue of in-home service availability, which underlies the issue of service delivery, can not be resolved by this bill. In August when KDOA testified before the Interim Committee, we identified Kansas' FY 86 rank in spending for long-term care services. In terms of total spending, Kansas ranked 41st on a per capita basis. For exclusively state-funded long-term care programs, Kansas' ranking fell to 46th.

The money that Kansas does expend for LTC services is primarily directed toward institutional services. This institutional bias results in Kansas ranking 38th in support for community-based LTC services. Consistent with this ranking is our 7th place ranking in the percentage of our 85+ population that is institutionalized.

The demand for community based LTC services is not being met. In August, we provided the Interim Committee with data about the extensive waiting lists for two portions of SRS' home care worker program.

In some respects the status quo has deteriorated since that time. SRS reduced its funding allocation to the Social Services Block Grant (SSBG) funded portion of the home care worker program this past fall and anticipates a second reduction later this year. An additional funding shortfall of $800,000 is projected for FY 1990. The impact of these funding changes can not be measured in terms of waiting lists as SRS no longer maintains a waiting list for this program.

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The impact can somewhat be determined by looking at the demographic profile of SSBG funded home care worker clients for November, 1988:

- 95% are age 60+
- 83% are age 70+
- 50% are age 80+
- 89% live alone
- 29% live in communities of less than 2,500 people
- 51% live in communities of less than 10,000 people
- 44% of case closures were due to death or placement in an adult care home.

This profile shows a well-targeted program serving primarily older women in rural communities where often the only other community based LTC services are home-delivered meals and home health. Funding for this program is a critical issue which should not be overlooked as this committee considers ways to restructure the delivery of in-home services.

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Clinicare

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Testimony on HB 2012 Proposed Amendment

to the Kansas Nurse Practice Act

Chairman Littlejohn and members of the House Public Health and Welfare Committee my name is Judy Bellome. I am the Executive Director of Clinicare Family Health Services in Kansas City, Kansas. Clinicare is a non-profit organization and has been serving the Kansas City Metropolitan area for over 15 years. Services include both skilled and supportive care that enable individuals to remain in their own homes as a choice over institutionalization. In the last two years, Clinicare has provided over $500,000 in charitable service to the elderly and the medically indigent needing in-home health service.

I have been a Registered Nurse for over twenty-two years and have received both a Bachelor of Science degree in Nursing Education and a Masters degree. My experience in Community Health and home care span a period of time over twelve years.

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The Mission Statement and Philosophy of Clinicare promote independence, freedom of choice, and dignity of the individual (See attachments #1 and #2).

A "Patient's Bill of Rights" has been developed and used throughout the agency (See attachment #3).

In 1988, I served as Chairman of a Task Force appointed by the Kansas Home Care Association to review home care service and training of care givers.

The Task Force recommended an Interim Committee Legislative study to review concerns for:

1. The present State required training of 110 hours for certification of a Home Health Aide that will be providing personal care through a licensed home health agency.

2. The lack of communication and coordination for in-home support services between private and state organizations.

I bring these facts to your attention in order to establish credibility for myself and the concerns and recommendations I present to you today.

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I strongly oppose HB 2012 as written and suggest:

1. The care giver not the client should be taught procedures to meet personal care needs.

2. The Registered Nurse should be the teacher, not the physician. (RN's are currently the primary professional in-home care givers and teachers.)

3. An assessment tool should be developed and utilized to determine cognitive ability of the client to self-determine supervision of their own care.

4. A demonstration of care giver competency as evaluated by the RN.

5. A limitation of liability to the RN trainer after written documentation of satisfactory return-demonstration of the specified care giving task to only that client.

6. Pilot study be conducted only within the SRS HCBS programs.

Quality of care, safety concerns, and potential exploitation of vulnerable, disabled persons are critical issues.

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Increasing costs affecting licensed and certified home care agencies can be directly attributed to imposed state and federal regulations. I believe that Registered Nurses, experienced in home care and working through licensed home care organizations are the key to cost-effective, quality personal care delivered in the home.

Attached is a xeroxed photograph of an ulcer that developed while a disabled woman was receiving self-selected, self-directed, private pay attendant care (Attachment #4). This is only one example of the many abuses that will occur if HB 2012 is passed.

Thank you for your time and attention to this testimony. I appreciate the opportunity to share my concerns with you.

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ATTACHMENT #1

MISSION STATEMENT

Clinicare seeks to provide comprehensive community-based services which promote physical, social, emotional and spiritual well-being in a compassionate, professional and affordable manner.

(Adopted by the Board of Directors, November 10, 1983).

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ATTACHMENT #2

Clinicare

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PHILOSOPHY

We believe that every person has the right to achieve the fullness of their potential as individuals. We recognize that the development of individual potential can be achieved by focusing on physical, emotional, social, economic and spiritual needs. This belief assumes that the promotion of health and well-being lies on a bi-polar illness-wellness continuum. Health is defined as not merely the absence of illness but creative movement toward selfhood and well-being.

Clinicare Family Health Services, Inc., proposes to provide a range of services to meet these needs. These health services include, but are not limited to, health assessment, evaluation, treatment and referral. These social services include, but are not limited to, counseling, referral and providing opportunities for both paid and voluntary services. These services will not be restricted solely by economic considerations.

To provide the best possible service to our clients and community, the staff members themselves will strive for mutual professional and personal development. This will include being fully aware of our responsibility as citizens of the community and as providers of quality care.

(Revised and proposed at the Annual Board-Staff Retreat, November 1980. Adopted by the Board in 1981).

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ATTACHMENT #3

PATIENT'S BILL OF RIGHTS

Clinicare Family Health Services, Inc. states your rights as a home health patient are as follows:

1. You have the right to be fully informed of all your rights and responsibilities by the home care agency.

2. You have the right to appropriate and professional care relating to physician orders.

3. You have the right of choice of care providers.

4. You have the right to receive information necessary to give informed consent prior to the start of any procedure or treatment.

5. You have the right to refuse treatment within the confines of the law and to be informed of the consequences of your actions.

6. You have the right to privacy.

7. You have the right to receive a timely response from the agency to your request for service.

8. You shall be admitted for service only if the agency has the ability to provide safe and professional care at the level of intensity needed. You have the right to reasonable continuity of care.

9. You have the right to be informed within a reasonable time of anticipated termination of service or plans for transfer to another agency.

10. You have the right to voice grievances and suggest changes in service or staff without fear of restraint or discrimination.

11. You have the right to be fully informed of agency policies and charges for services, including eligibility for third party reimbursements.

12. You (and the public) have the right to honest, accurate forthright information regarding the home care industry in general and your agency in particular.

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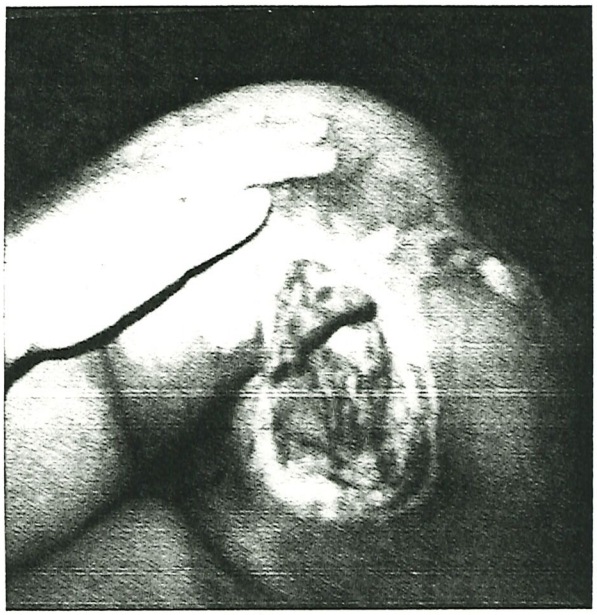
ATTACHMENT #4



This 27 year-old female with Spina Bifida is wheelchair-bound. She hired, trained and supervised her "attendant." This bedsore developed on her buttocks during the 8 month period of "attendant" care and required surgical repair.

The ulcer measured 3 1/2" x 3 1/2" x 2".

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