State of Washington
Joint Legislative Audit and Review Committee (JLARC)

Home Care Quality Authority Performance Review and Supplementary Questions

Report 07-2

January 4, 2007

Upon request, this document is available in alternative formats for persons with disabilities.

JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE
506 16th Avenue SE
PO Box 40910
Olympia, WA 98501-2323
(360) 786-5171
(360) 786-5180 Fax
http://jlarc.leg.wa.gov

Committee Members

SENATORS

Brad Benson
Jeanne Kohl-Welles
Bob Oke
Linda Evans Parlette, Vice Chair
Debbie Regala
Phil Rockefeller, Asst. Secretary
Pat Thibaudeau
Joseph Zarelli

REPRESENTATIVES

Gary Alexander, Secretary
Glenn Anderson
Kathy Haigh
Ross Hunter, Chair
Fred Jarrett
Kelli Linville
Deb Wallace
Vacancy

LEGISLATIVE AUDITOR

Ruta Fanning

The Joint Legislative Audit and Review Committee (JLARC) carries out oversight, review, and evaluation of state-funded programs and activities on behalf of the Legislature and the citizens of Washington State. This joint, bipartisan committee consists of eight senators and eight representatives, equally divided between the two major political parties. Its statutory authority is established in RCW 44.28. This statutory direction requires the Legislative Auditor to ensure that performance audits are conducted in accordance with Government Auditing Standards as applicable to the scope of the audit.

JLARC staff, under the direction of the Committee and the Legislative Auditor, conduct performance audits, program evaluations, sunset reviews, and other policy and fiscal studies. These studies assess the efficiency and effectiveness of agency operations, impacts and outcomes of state programs, and levels of compliance with legislative direction and intent. The Committee makes recommendations to improve state government performance and to correct problems it identifies. The Committee also follows up on these recommendations to determine how they have been implemented. JLARC has, in recent years, received national recognition for a number of its major studies.

HOME CARE QUALITY PERFORMANCE REVIEW AND SUPPLEMENTARY QUESTIONS

REPORT 07-2

REPORT DIGEST

JANUARY 4, 2007

STATE OF WASHINGTON

JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE

STUDY TEAM
Fara Daun
John Woolley
Sylvia Gil

LEGISLATIVE AUDITOR
Ruta Fanning

Copies of Final reports and Digests are available on the JLARC website at:

http://jlarc.leg.wa.gov

or contact

Joint Legislative Audit & Review Committee
506 16th Avenue SE
Olympia, WA 98501-2323
(360) 786-5171
(360) 786-5180 FAX

When a person falls ill and needs services for an extended period of time, the services are called **long-term care**. This report refers to persons receiving long-term care as "consumers." Long-term care can be provided in settings other than nursing homes; these are called "community-based" settings and include the consumer's home. "Home care" or "in-home care" services typically include assistance with activities such as eating, bathing, and dressing. Demand for community-based services, including in-home care, is rising across the nation.

The increase in in-home care raises a concern with ensuring the quality of that care. In response to the growing demand for home based long-term care and concerns over quality, Washington State's voters passed Initiative 775 in 2001. Initiative 775 created the Home Care Quality Authority (HCQA) to improve the quality of publicly funded in-home care services. It focused HCQA on recruiting, training, and stabilizing the work force of **individual providers (IPs)** of in-home care. Consumers of publicly funded in-home care recruit, employ, and directly manage their IPs, but the state pays IPs. In-home care is also provided by agency-employed providers, but HCQA has no duties with regard to agency providers.

Initiative 775 also directs the Joint Legislative Audit and Review Committee (JLARC) to conduct a biennial performance review of HCQA duties and answer a number of supplementary questions.

JLARC'S ANALYSIS OF THE HOME CARE QUALITY AUTHORITY

Performance Review

In this first of the Initiative's required reviews, JLARC found that **HCQA has met its statutory duties**, including offering consumer input during collective bargaining, background checks of IPs, IP and consumer training, IP recruitment, and developing a referral registry. However, we note that HCQA is still a developing agency, thus, this performance review should be seen as a basis for future required reviews.

Supplementary Quality of Care Questions

Initiative 775 also directs JLARC to look at a number of supplementary questions regarding the quality of in-home long-term care.

To what extent are required services delivered and why might consumers of IP services require more intensive services?

HCQA is a stand-alone component of a system dominated by the Department of Social and Health Services (DSHS). DSHS authorizes services based on its assessment of each consumer's unmet needs, and each consumer's authorization is unique. There are no set "required services." Thus, as consumers' needs change or are met elsewhere, the authorization also changes.

Because consumers, not DSHS, choose whether to remain at home or move to another care setting, the care setting is a separate question from the intensity of services the consumer needs. IPs provide in-home services to consumers who, on average, need more intensive services than consumers in most community-based settings. Further, because consumers may change care settings for many reasons, it is a poor indicator of the success or failure of the care setting or the IP's services.

How are health, welfare, and satisfaction with services tracked and monitored?

For this first review, JLARC focused on how health and welfare are tracked and monitored to understand HCQA's role in these activities. Here too, HCQA has a limited role: DSHS is required to track and monitor consumers and the services provided to them.

However, HCQA analyzes consumer satisfaction with services through post-employment surveys and annual consumer surveys—HCQA is now completing the second annual survey.

Because HCQA has only an incidental role in the tracking and monitoring of consumers' health and welfare, this question would be more appropriate in a full audit of the long-term care system, where the impact of the much larger DSHS tracking and monitoring process could be assessed.

How are complaints resolved?

While HCQA has no specific statutory duty to resolve complaints, they do have processes in place to deal with complaints, primarily for complaints related to consumers and IPs using the referral registry. However, both federal and state mandates direct DSHS to establish both a grievance policy and a complaint process. Again, because HCQA has only an incidental role in complaint resolution, this question would be more appropriate in a full audit of the home care delivery system.

What are the full costs of the Individual Provider service option?

JLARC was asked to develop an estimate of the full cost of an hour of service, including employee benefits and administrative costs. IPs are paid an average of $9.45 per hour. After careful analysis of other costs, JLARC estimates that the state's full cost of an hour of IP services is $12.60. This can be compared to an estimated full-state cost of $17.60 for an hour of in-home care provided by an agency provider.

Is it appropriate for HCQA to assume additional duties such as the verification of IP hours worked or responsibility for payment of individual providers?

JLARC looked at three key points to answer this question:

(1) Would these new responsibilities be consistent with HCQA's mission and duties?

While HCQA's duties do not directly address verification of IP hours or payment of IPs, HCQA's mission is broad enough to include such activities.

(2.) What changes would be required of HCQA to assume these duties?

These additional duties would require substantial increases to HCQA's staff and budget, and require an expertise not currently found in HCQA.

(3) Does HCQA believe it should assume these duties?

HCQA answers this question "No."

JLARC identified no compelling need for the transfer of the duty for IP payments or verification of hours to HCQA at this time.

In order for JLARC to determine whether there is a problem that can be solved by transferring "other duties" not currently performed by HCQA to the agency, a broader analysis is required. Such an analysis would need to include the entire system of long-term care. A complex analysis of this sort was beyond the scope of this current audit.

CONCLUSION AND RECOMMENDATIONS

HCQA is a relatively new organization, currently meeting its statutory duties. However, it is only one component of a large, complex system of delivering community based long-term care services.

Any review of HCQA's performance or questions about HCQA's future role must be addressed with an understanding that HCQA is a small and developing part of a large process.

Recommendations:

1. **The Home Care Quality Authority should review its 2004 "Outcome and Output Measures" document in light of experience, the current statute, and its strategic plan, to ensure that its performance targets are clear and adequately reflect HCQA's current duties and goals.**

2. **The Legislature should reexamine the Home Care Quality Authority performance review timing and questions to be considered under RCW 74.39A.290 to ensure that future JLARC reviews best meet the needs of the state.**

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION & REPORT SUMMARY

OVERVIEW

This report presents the results of the Joint Legislative Audit and Review Committee's (JLARC) performance review of the Home Care Quality Authority (HCQA). The review was mandated by Initiative 775, which Washington voters passed into law on November 6, 2001.

This chapter provides an overview of how long-term care is provided in Washington State, and a brief discussion of the origins of HCQA, and then describes how the remaining chapters of the report will present the results of the JLARC's analysis. It also includes a brief note on the organizations involved in the delivery of long-term care in Washington State.

This report on JLARC's analysis has two parts. Part One addresses basic performance review questions on how well HCQA has met its duties. Part Two addresses a set of supplementary questions raised by I-775 that refer to the broader long-term care system.

COMMUNITY-BASED LONG-TERM CARE

When a person falls ill, his or her care needs are usually met on a short-term basis: a call to the doctor, a visit to a therapist, or an emergency visit to the hospital. These needs are referred to as "short term" or "acute" care needs.

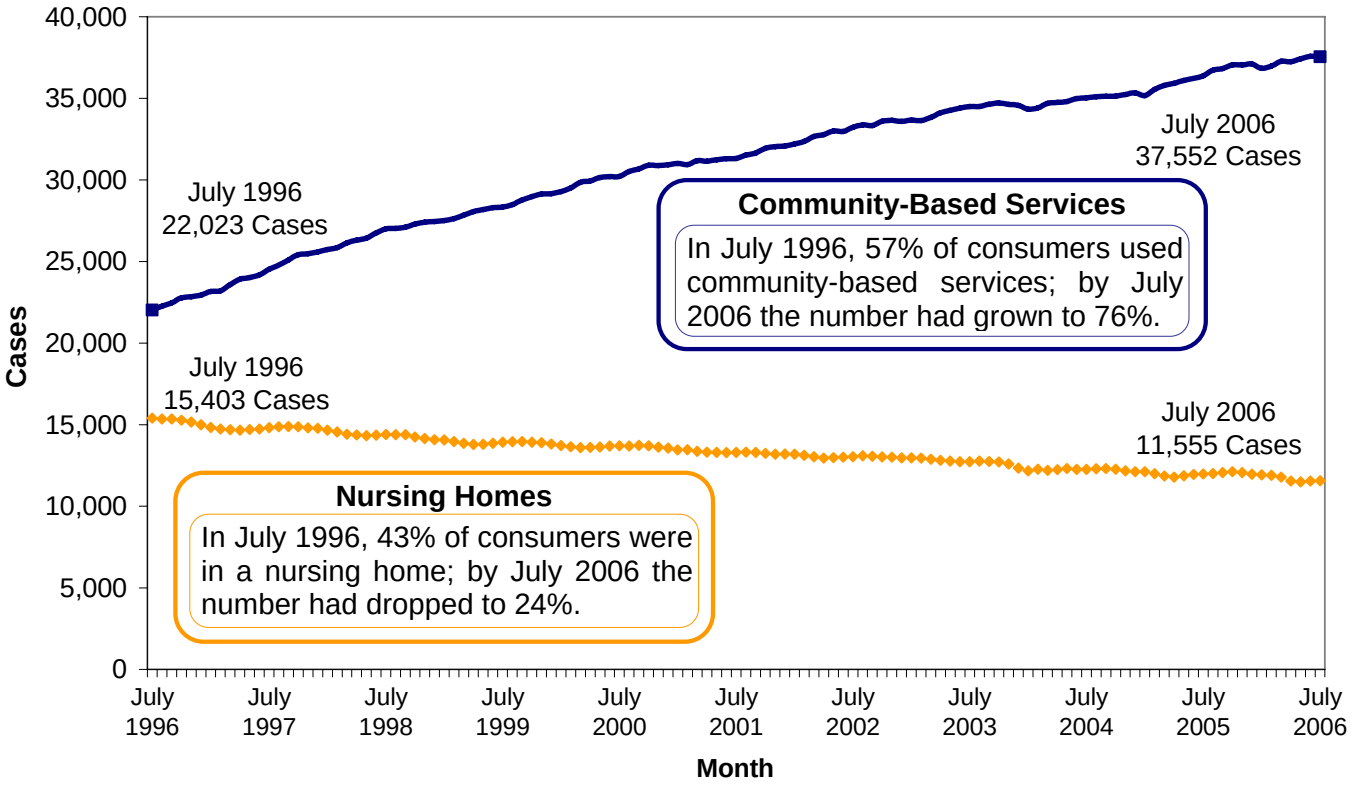
Sometimes, a person's care needs become chronic or long term. **Long-term care** is based on the assumption that care needs will last for long periods, perhaps the remainder of a person's life. Both adults and children may need long-term care. Often, a person's long-term needs are for assistance with everyday tasks such as eating, bathing, and dressing. When these needs are met in a person's home they are referred to as home care or in-home care. For those who meet financial requirements to receive publicly funded care, long-term care services, including home care, are provided through long-term care programs operated by the Department of Social and Health Services (DSHS).

Traditionally, publicly funded long-term care was provided in institutional settings such as nursing homes. Beginning in the 1960s with the Chore Services program, Washington has approached providing publicly funded long-term care by offering consumers alternatives to nursing homes.

Washington's priority, since the 1980s has been to focus the use of nursing homes on those for whom they are medically necessary, while providing most consumers of long-term care services a choice of community settings in which to receive care. This priority attempts to ensure that consumers' care is cost-effective and provided in the most independent setting possible. The options to nursing home settings are called community-based settings. In addition to receiving services in a consumer's own home, the options include community residential settings such as residential and enhanced residential facilities, assisted living facilities, and adult family homes. Figure 1 illustrates the increasing number of consumers using long-term care services and the increasing proportion of those consumers who obtain that care in community-based settings, rather than nursing homes.[1]

[1] Chapters 74.39 and 74.39A RCW govern Washington's long-term care system and establish priorities for service.

Figure 1 – The Number of Consumers Using Community-Based Services is Rising While the Number Using Nursing Homes is Decreasing



Source: JLARC analysis of DSHS data. Totals include consumers served by the former Aging and Adult Services Administration, but not those served by the Division of Developmental Disabilities (DDD), because DDD services were not historically tracked the same way.

IN-HOME CARE: ONE FORM OF COMMUNITY-BASED CARE

Most consumers choose to remain in their own homes after being assessed by DSHS as both requiring long-term care and being financially eligible. Services provided in the consumer's home are called "in-home care" or "home care." Figure 2, on the following page, illustrates that while both in-home care and residential care are growing, in-home care currently accounts for 72 percent of community-based long-term care consumers.

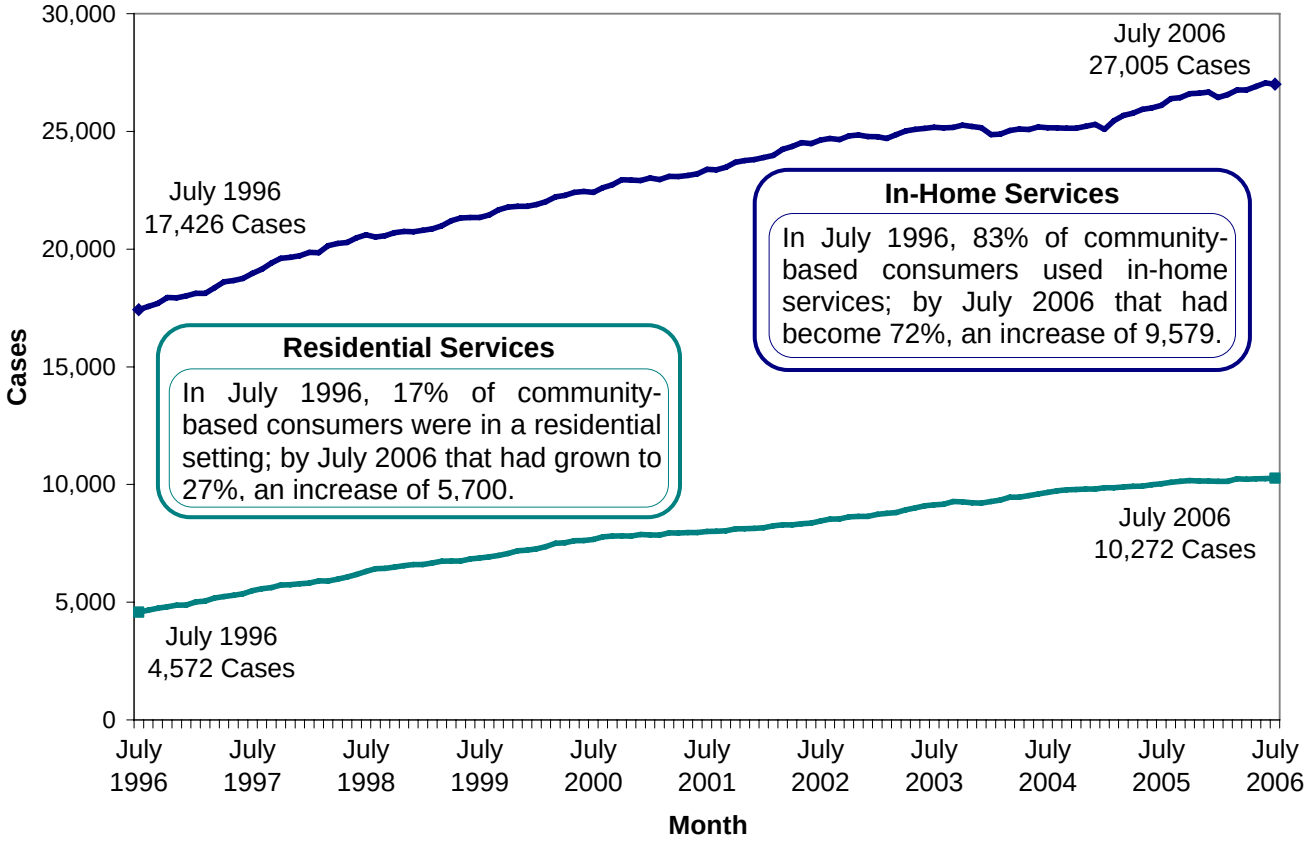
Two Types of In-Home Care Providers

When a consumer is eligible for publicly funded in-home care services, DSHS will pay for one of two main options for meeting a consumer's in-home care needs: an agency provider or an individual provider (IP).

Agency providers of in-home care are employed by private organizations that recruit, hire, pay, schedule, and generally manage the provider. DSHS and the Area Agencies on Aging (AAAs) contract with and pay the provider agency. The agency employs and pays the provider.

For consumers choosing IPs, the consumer is the employer and must recruit, employ, manage, and, if necessary, terminate the IP. While DSHS contracts with and pays individual providers, it does not hire or supervise IPs. The IP option provides consumers more control over which individuals provide their care. It also requires more active involvement from consumers, about 65 percent of whom currently hire a relative.

Figure 2 – While All Community-Based Services are Growing, Most Consumers Continue to Choose In-Home Services



Source: JLARC analysis of DSHS data. Totals include consumers served by the former Aging and Adult Services Administration, but not those served by the Division of Developmental Disabilities (DDD), because DDD services were not historically tracked the same way.

All but about 100 consumers using in-home care services are adults served by the Aging and Disability Services Administration (ADSA) of DSHS. ADSA uses a combination of state and federal funding to pay for long-term care services. Federal funding comes through the Medicaid program, which pays about one-half of the cost of services and imposes detailed eligibility and program management requirements on DSHS. During Fiscal Year 2006, ADSA averaged approximately 13,500 consumers using agency providers of in-home care and approximately 23,000 consumers using IPs for their in-home care.

Establishment of the Home Care Quality Authority

The number of consumers needing long-term care has been growing for many years. Estimates are that the national need for long-term care will increase from 13 million persons in 2000 to 27 million in 2050. The Federal Bureau of Labor Statistics estimates that between 2000 and 2010 there will be, nationwide, 395,000 new jobs for providers of community-based long-term care in addition to the 584,000 jobs that existed in 2000.[2] Figure 2, above, indicates that need for long-term care services and community-based providers in Washington will follow a similar trend.

[2] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, et al., The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation: Report to Congress, May 14, 2003.

In response to this growing demand, Washington State's voters passed Initiative 775 on November 6, 2001. Initiative 775 states: "Washington seniors and persons with disabilities would benefit from the establishment of an authority that has the power and duty to regulate and improve the quality of long-term, in-home care services…. The home care quality authority is established to regulate and improve the quality of long-term in-home care services by recruiting, training, and stabilizing the work force of individual providers."[3] The Initiative specifies that HCQA's focus is to be on individual providers for DSHS consumers.

Initiative 775 is part of a national movement to increase both the stability of the individual provider work force and consumers' direction of their long-term care. Oregon, California, Michigan, and Massachusetts have laws or agreements that created agencies similar to HCQA.

HCQA started operations in 2002. Its Board was appointed by the Governor in May, and by October, the Board had hired an Executive Director. HCQA now has the equivalent of four staff and annual expenditures of about $3.4 million.

A REVIEW OF THE HOME CARE QUALITY AUTHORITY

When it established the HCQA, the Initiative also directed JLARC to conduct a performance review of HCQA every two years: the first report is due December 1, 2006. The Initiative also directed JLARC to address a set of broader questions related to the provision of long-term care.

This report is organized in two parts. Part One focuses on answering a basic performance review question: How successful has HCQA been in meeting its statutory duties? Part Two addresses five supplementary questions posed by Initiative 775.

The report is presented as follows:

Part One, comprised of **Chapter 2**, looks at how well the HCQA has performed the duties laid out in the Initiative.

Part Two, comprised of Chapters 3 through 7, addresses the supplementary questions raised by Initiative 775.

Chapter 3 first describes how services are delivered in the long-term care system, then looks at the question of the need for additional and more intense services.

Chapter 4 looks at how health, welfare, and satisfaction with services are tracked and monitored in the long-term care system, including how complaints are resolved.

Chapter 5 presents information on the full costs to the state of individual provider services, comparing these full costs to the state's full costs of agency providers.

Chapter 6 is JLARC's assessment of whether or not additional duties, such as the verification of hours worked and responsibility for IP payroll payments, should be transferred to HCQA.

Chapter 7 ends the report with conclusions, findings, and recommendations.

A Note on the "System" of In-Home Care

This report refers to a number of organizations that are the major components of what is referred to as the service delivery "system" for in-home care.

DSHS has most of the responsibility for case management (assessing a person's need, determining functional and financial eligibility, arranging for care, paying for care, assuring quality control, and the ongoing monitoring of care). The care itself is provided by contracted agency providers and

[3] Initiative 775, Sections 1 and 2. Initiative 775 was later codified as RCW 74.39A.220 to 300.

IPs, who also play a critical role in monitoring the consumer's condition. DSHS also contracts with the Area Agencies on Aging (AAAs) to provide ongoing case management for adults after the initial assessment and care plan have been developed. The AAAs are local and tribal government-based agencies that operate from regional offices across the state.

Within ADSA, the Home and Community Services Division has the primary responsibility for providing long-term care for adults while the Developmental Disabilities Division (DDD) is responsible for providing long-term care services to eligible children and adults who meet the legal definition of developmentally disabled. ADSA accounts for the vast majority of consumers using in-home care services, but there are approximately 100 consumers served by the Children's Administration.

HCQA was established in addition to, and outside of, the DSHS service provision process to improve the quality of in-home care services and to help stabilize the IP workforce. HCQA provides some services that are not provided elsewhere in the long-term care system. These include recruiting and providing screened provider referrals to consumers and case managers, as well as providing personal safety training for all IPs, training in what it means to be a professional IP for prospective new IPs before listing on the registry, and consumer training on how to be a more effective employer. In addition, HCQA provides a formal place for IPs to raise concerns or complaints about consumers.

REPORT SUMMARY

The need for community-based services in the public long-term care system is growing and in-home care is the largest segment of community-based long-term care. The establishment of HCQA may help Washington face the growing need for a stable workforce of in-home providers. HCQA actively recruits IPs, provides training to both individual providers and consumers, and provides referrals to consumers and case managers from a statewide registry. Because IPs cost the state $5 per hour less than agency-employed providers of in-home care, emphasizing the use of individual providers in appropriate cases is an efficient use of the state's resources.

HCQA is meeting its duties, and the primary services that it provides are not generally duplicated elsewhere in the long-term care system.

FINDINGS

1. The Home Care Quality Authority has fulfilled its statutory duties and substantially met those outcome measures that could be evaluated at this time.
2. After carefully estimating total costs to the state for both individual and agency providers, individual providers cost the state $12.60 per hour, which is $5 per hour less than the state's total cost for agency providers.
3. JLARC has identified no compelling need that warrants transferring IP payments, the verification of hours, or other duties to the Home Care Quality Authority at this time.
4. The Initiative 775 questions are not directly related to a performance review of the Home Care Quality Authority.

RECOMMENDATIONS

1. **The Home Care Quality Authority should review its 2004 "Outcome and Output Measures" document in light of experience, the current statute, and its strategic plan, to ensure that its performance targets are clear and adequately reflect HCQA's**

current duties and goals. HCQA should provide JLARC with revised Outcome Measures by June 30, 2007.

2. **The Legislature should reexamine the Home Care Quality Authority performance review timing and questions to be considered under RCW 74.39A.290 to ensure that future JLARC reviews best meet the needs of the state.**

PART ONE
PERFORMANCE REVIEW OF THE HOME CARE QUALITY AUTHORITY

CHAPTER TWO: TO WHAT EXTENT HAS THE HOME CARE QUALITY AUTHORITY FULFILLED ITS STATUTORY DUTIES?

OVERVIEW

This chapter forms the performance review component of JLARC's report. Initiative 775 requires the Home Care Quality Authority (HCQA) to perform duties in four areas:

1. Collective bargaining;
2. Background checks;
3. Training; and
4. Recruitment and referral of individual providers (IPs).

This chapter examines the statutory requirements in each group and assesses HCQA's performance. In addition, Appendix 4 contains the specific outcome and output measures that HCQA established for itself in 2004 and an assessment of HCQA's performance against these measures. These targets are discussed very briefly at the end of this chapter and are otherwise included only to the extent that they provide evidence whether HCQA has met its statutory duties.

DUTY #1: COLLECTIVE BARGAINING

In Washington, IPs are employees of the roughly 25,500[4] consumers of in-home care services. These consumers have the authority to hire, supervise, set work hours and conditions, and terminate IPs. IPs work in the consumers' homes. Although consumers employ individual providers, the state pays their wages, taxes, and benefits.

HCQA's Collective Bargaining Duties

Initiative 775 granted IPs collective bargaining rights and authorized them to unionize. Individual providers organized as Service Employees International Union (SEIU) Local 775 in August 2002. Under the Initiative, HCQA was required to represent the consumers and bargain with SEIU as the "employer" of the IPs. The collective bargaining agreement was then subject to legislative approval.

The Initiative also required HCQA, as the consumers' representative, to obtain informed input from consumers on their interests for all issues proposed for collective bargaining, including the issues' impacts on consumer choice. The Initiative required HCQA to work with the Developmental Disabilities Council, the Governor's Committee on Disability Issues and Employment, the state Council on Aging, and other consumer advocacy organizations to obtain this information.

In 2004, the Legislature moved the collective bargaining duty from HCQA to the Governor.[5] However, the Legislature did not remove HCQA's duty to obtain informed input from consumers on collective bargaining issues. According to testimony on ESHB 2933 presented in House and

[4] This number differs from Figure 2 because it does not include those clients using agency providers. It also includes clients receiving services from the Division of Developmental Disabilities (DDD), who are not included in Figure 2.
[5] Engrossed Substitute House Bill 2933 (2004 Wash. L. ch. 3).

Senate committees, this change revised the IP collective bargaining process to reflect the new state employee collective bargaining process passed in 2002[6] and resolved questions about IPs' employment status.

HCQA's Performance of Collective Bargaining Duties

HCQA has met its collective bargaining duties.

After IPs organized as SEIU Local 775 in August 2002, HCQA bargained with SEIU and came to an agreement that Governor Locke submitted to the Legislature for the 2003 Legislative Session.

Because of the 2004 change in statute, HCQA no longer has a duty to bargain with SEIU as the employer of record, but continues to have a duty to obtain consumer input for the collective bargaining process. HCQA obtains this input from consumers in three ways. First, representatives of the Developmental Disabilities Council, the Governor's Committee on Disability Issues and Employment, the state Council on Aging, and other consumer advocacy organizations are voting members of the HCQA Board. The Board discusses collective bargaining matters in closed session and then directs HCQA staff to communicate its priority concerns to the bargaining team.

Second, the HCQA Board created an Employer Subcommittee that seeks input for collective bargaining from consumer/employers and advocacy groups. During the most recent negotiations with SEIU, this subcommittee met with the Governor's collective bargaining representative on at least two occasions to discuss issues important to consumers.

Third, HCQA uses both its website and its quarterly newsletter to solicit consumer input on issues of concern for contract negotiations. HCQA also uses its website and newsletter to inform consumers about the collective bargaining results, their rights under the contract, and impacts of any legislative changes.

DUTY #2: BACKGROUND CHECKS

Federal and state laws that predate the establishment of the HCQA require persons whose employment gives them unsupervised access to children or vulnerable adults to pass a background check. Background checks include reviews of criminal history and whether a person has a founded history of abuse or neglect in the DSHS database. Individual providers fall into the class of persons with unsupervised access to children or vulnerable adults. Certain criminal convictions and founded allegations of abuse or neglect disqualify a person from employment as an IP.

HCQA's Background Check Duties

Under Initiative 775, HCQA was required to establish qualifications and reasonable standards of accountability, and to obtain consumer input on these standards.

The standards were to include a "satisfactory" criminal background check and confirmation that the person was not currently listed on any long-term care abuse and neglect registry used by DSHS at the time of the background check. **The Initiative provided an exception** where federal law requires qualifications and standards for accountability to be established by another entity to preserve eligibility for federal funding. **Federal law requires DSHS to establish these standards.** Consequently**, the exception in the Initiative applies to HCQA.**

Initiative 775 also requires HCQA to investigate the backgrounds of IPs and prospective IPs. **DSHS must perform these background checks as a condition of receiving some kinds of**

[6] 2002 Wash. L. ch. 354 (SHB 1268).

federal funding, including Medicaid, and to comply with state law. As a practical matter, the actual checks are performed by the DSHS Background Check Central Unit for all DSHS offices, as well as for agencies that provide services to children or vulnerable adults. HCQA is one of many such agencies.

DSHS must perform background checks on in-home providers upon employment and must repeat them every two years during employment. By contrast, HCQA must ensure that prospective IPs pass a background check prior to inclusion in the referral registry (discussed below as Duty #4) and repeat the background check annually. **That is, while DSHS sets the standard for passing a check and performs the check, HCQA-requested checks on IPs listed on the referral registry must occur earlier than, and twice as often as, other DSHS checks.**

HCQA's Performance of Background Check Duties

HCQA has met its background check duties.

In 2003, HCQA held five focus groups and performed two surveys that included questions about accountability standards for providers. The focus groups were comprised of a mix of in-home care providers, long-term care professionals, consumers, and advocates. The groups discussed and made recommendations about qualifications and criteria for removal from the registry. The surveys were sent to random groups of consumers and long-term care professionals. There were several questions about registry qualifications. Both focus group and survey results were reviewed by a registry committee.

HCQA adopted DSHS standards for background checks and the checks are performed by the DSHS Background Check Central Unit. However, background checks must be completed prior to a prospective IP's listing on the referral registry and annually thereafter as long as the IP remains on the registry. Individual providers who are employed without being listed on the registry must pass a background check before beginning employment and every two years thereafter as long as the person is employed as an IP.

Despite the one- and two-year statutory timelines, and identical standards between DSHS and HCQA, according to DSHS, the Background Check Central Unit will only accept its own background check on a prospective IP for 90 days and therefore reruns the check prior to employment if it is older than 90 days.

DUTY # 3: TRAINING

Federal Medicaid protocols require "home and community-based programs" to be designed so that providers possess the skills, competencies, and qualifications to effectively support consumers. State law required DSHS to implement long-term care training by 1998 and, as of 2002, also required IPs and agency providers of in-home care to complete DSHS-approved orientation, basic training, and continuing education within timelines established in the state's Administrative Code.

DSHS requires IPs to complete the orientation course within fourteen days after employment. The basic training course, "Revised Fundamentals of Caregiving" must be completed within 120 days after employment. DSHS also requires ten hours of continuing education per year. Continuing education opportunities occur in classroom, online, and self-study structures. DSHS must withhold payment to those providers who fail to complete training within the timeframes.

HCQA's Training Duties and Performance

HCQA has met its statutory training duties.

Under Initiative 775, HCQA was required to establish training qualifications and is required to provide training. Figure 3 identifies HCQA's duties and how they have been accomplished.

Figure 3 – HCQA's Training Duties and Implementation

HCQA TRAINING DUTY	HCQA IMPLEMENTATION
1. Provide opportunity for consumer participation in determination of standards.	• In 2003, HCQA used consumer focus groups and three surveys to make recommendations, including the types of training and what training should be mandatory.
2. Establish qualifications that are in compliance with DSHS minimum training requirements.	• HCQA adopted standards that added mandatory safety training for all IPs to the orientation, basic training, and continuing education requirements already established by DSHS. • HCQA also requires prospective and inexperienced IPs to complete its course "*Becoming a Professional Individual Provider*" to enroll in the referral registry.
3. Identify existing training to consumers and coordinate with other agencies.	• After finding little available consumer training, HCQA obtained a federal grant to develop training focused on helping consumers become better employers.
4. Provide training opportunities for IPs, prospective IPs, consumers, and prospective consumers.	• In addition to the training in #2, above, HCQA's **IP training** focuses on safety training. The training is available in classroom settings, online, and through self-study texts. HCQA reports that 16,809 IPs have completed safety training since December 2004 and estimates 5,000 providers must still be trained by December 2006. • IPs hired after 2004 must take safety training within 120 days of employment. • HCQA's federal grant allowed it to make voluntary **consumer training focused on the employer role** available at the first four registry sites (see Duty #4). HCQA has now received federal permission to use unexpended funding to implement consumer training statewide and has submitted a budget request for matching funding for this purpose.
5. Give training preference to recipients of public assistance.	• HCQA works through WorkSource centers to provide opportunities for persons on public assistance to become familiar with the registry and become IPs. WorkSource centers operated by Employment Security Department are used by WorkFirst, the public assistance program, to assist recipients to find employment.

DUTY #4: RECRUITMENT AND THE REFERRAL REGISTRY

About 65 percent of IPs work for a family member and, according to surveys conducted by HCQA, nearly two-thirds of these providers do not intend to provide services for consumers after their family member no longer needs them. However, for consumers who cannot turn to family or friends to fill their unmet care needs, hiring an IP can be a difficult and uncertain task, especially given the highly personal nature of the duties and the fact that the work happens in the consumer's home.

HCQA's Recruitment and Referral Registry Duties

HCQA has met its statutory recruitment and registry duties.

Initiative 775 requires HCQA to undertake recruiting activities and establish a referral registry of prospective and current IPs for prospective and current consumers authorized to receive services from an IP. The Initiative specified eight recruitment and referral registry duties. Figure 4, on the following page, identifies HCQA's eight duties and how they have been accomplished.

In examining this duty, it is important to understand that, while there is an overall referral registry online, HCQA has implemented this duty by contracting with organizations to operate local Referral and Workforce Resource Centers which are physically established in 14 locations statewide. They are also often referred to as "RWRCs." To eliminate confusion this report will refer to them as RWRCs.

Figure 4 – HCQA's Recruitment and Referral Duties and Implementation

HCQA RECRUITMENT AND REFERRAL DUTY	HCQA IMPLEMENTATION
1. Provide opportunity for consumer participation in the determination of standards.	• In 2003, HCQA used focus groups and surveys to make recommendations, including standards for background checks and removal from the registry, whether the registry would be voluntary or mandatory, and emergency referrals.
2. Identify and recruit individual providers (IPs).	• HCQA produces recruitment materials for the contractors operating RWRCs, including suggestions for overcoming concerns. • Registry contractors recruit in a variety of settings, including schools, agencies, and WorkSource centers. Four RWRCs are co-located in WorkSource centers.
3. Identify existing IP recruitment and referral resources available to consumers.	• Although some case managers maintained ad hoc lists, HCQA was not able to find any formal or widely available recruitment or referral resources for consumers in 2003. Newspaper ads were a common method of seeking an IP.
4. Assist authorized consumers to find an IP by providing routine, emergency, and respite referrals.	• The various RWRCs provided 1,384 referrals to 684 consumers in the first 19 months of operation, which resulted in 373 jobs. • The first registry sites opened January 2005. By September 2006, all 14 RWRCs were open, giving statewide coverage.
5. Ensure that IPs meet legal requirements before placing them on the registry and remove IPs from the registry who no longer meet requirements.	• HCQA ensures that IPs on the registry meet legal requirements. It has denied enrollment based on background information. • After investigations in conjunction with case managers, HCQA removed one IP for cause and restricted one IP to consumers whose needs do not require the provider to physically transfer them.
6. Give preference to IPs who are recipients of public assistance.	• HCQA works through WorkSource centers to provide opportunities for persons on public assistance to become IPs. However, HCQA cannot give preference in the hiring decision because consumers make employment decisions.
7. Notify the appropriate case manager if it identifies concerns regarding services provided by an IP.	• HCQA works with case managers to investigate complaints and concerns. (See #5, above.)
8. Cooperate with DSHS, the Area Agencies on Aging (AAAs), and other agencies to provide IP services.	• HCQA works with DSHS and the AAAs on registry issues and with the Employment Security Department and the WorkFirst program on recruitment.

HCQA's 2006 survey of case managers indicates that RWRCs have more positive effects the longer they operate. Thus, it may take time for them to be fully utilized by case managers and consumers. Figure 5 shows how case manager perceptions differ by length of local registry operation.

Figure 5 – Case Manager Perceptions of the Referral RWRCs

Survey Question	Length of Registry Operation		
	3 Months	10 Months	17 Months
Case Manager is aware that they have access to a referral registry	36%	86% if open at least 10 months	
Case Manager is likely to direct consumer to referral registry	31%	64%	83%
Finding an individual provider takes less time after referral registry was launched	8%	10%	20%

Source: HCQA 2006 Case Manager Survey Results.

HCQA'S 2004 PERFORMANCE TARGETS

HCQA has substantially met those outcome measures that could be evaluated at this time.

In preparation for this performance review, HCQA established performance targets in 2004 related to eight outcome measures and eleven related output measures. These measures and HCQA's performance are detailed in Appendix 4. These are the first performance targets established for this agency and, as such, several produce baseline information for future performance reviews rather than targets for this review. In addition, HCQA explicitly specified that they established these targets as "dependent on legislative funding for noted results."

To some degree, funding was delayed or not granted, but HCQA attempted to meet each measure and to track its performance. It is not clear which performance targets should not be counted due to funding issues. Consequently, the evaluation of HCQA's performance against these measures has been separated from the more formal performance review of statutory duties in this chapter. However, in attempting to document performance against these targets, it is clear that some performance targets need further clarification and that some output measures may be insufficient to demonstrate performance of the related outcome measure.

FINDING

The Home Care Quality Authority has fulfilled its statutory duties and substantially met those outcome measures that could be evaluated at this time. (HCQA is in the process of conducting several surveys, as planned in 2004.)

RECOMMENDATION

The Home Care Quality Authority should review its 2004 "Outcome and Output Measures" document in light of experience, the current statute, and its strategic plan, to ensure that its performance targets are clear and adequately reflect HCQA's current duties and goals.

PART TWO
SUPPLEMENTARY QUESTIONS ASKED BY INITIATIVE 775

CHAPTER THREE: NEED AND DELIVERY OF CONSUMER SERVICES

OVERVIEW

Initiative 775 directed JLARC to look at several broader questions related to the delivery of in-home care to consumers. It is important to note that these questions relate to factors outside of HCQA's direct control, including demographic trends, policy changes, performance at DSHS, and the routine progress of some medical conditions.

In-home care services are those personal care services such as assistance with bathing, dressing, moving, or preparing meals, that a consumer needs in order to stay in his or her home. This chapter examines two of these questions:

1. To what extent have all required services been delivered?
2. To what extent have consumers required additional or more intensive services?

In order to answer these questions, one must first understand how a consumer's plan of care is developed, the difference between a "care plan" and a "care setting," the relative intensity of various care settings, and the role of consumer choice in the selection of a care setting.

CARE PLANS AND CARE SETTINGS

Developing the Care Plan

A care plan identifies the consumer's functional needs and who is providing for those needs. It also authorizes the hours of service that will be paid to provide for unmet needs.

When a person seeks long-term care in Washington and is financially eligible for publicly funded services, a DSHS case manager performs a functional assessment of the consumer's personal care needs using an assessment instrument called the "Comprehensive Assessment and Reporting Evaluation for Long Term Care" or, more commonly, the "CARE Tool." A functional assessment of personal care needs is an assessment of whether, and how much, the prospective consumer needs assistance in each measured area. Need is measured in a scale from "independent" (no help needed) to "total dependence" (full performance of activity by others).

The CARE Tool measures the prospective consumer's assistance needs in six areas:

1. Activities of daily living (ADLs);[7]
2. Medications;
3. Communication;
4. Mental and physical health concerns;
5. Social/cultural considerations; and
6. Health risk indicators.

Once the CARE Tool identifies a functional need for which the consumer requires some level of assistance, the DSHS case manager must indicate whether the need is unmet, partially met, or fully

[7] ADLs include such things as bathing, dressing, mobility, eating, toilet use, meal preparation, and the abilities to perform necessary housework and shopping.

met, and who is meeting the need. The CARE Tool then generates a list of unmet and partially met needs. The consumer's care plan includes both needs being met through unpaid assistance and needs for which the consumer requires a paid provider.

Because Washington's publicly funded care system is based on filling only unmet needs, the unmet needs identified using the CARE Tool generate the authorization for hours of paid in-home care. If the consumer's situation changes, for example, if a family member were no longer able to provide assistance, the consumer's care assessment would change. In this example, the care plan and authorized hours of service would change to permit a paid individual provider (IP) to provide those services that had become "unmet."

In addition to "*in-home care*," the CARE Tool may identify "*home health-care*" needs. Home health-care includes such things as visiting nurse services and a nurse's legally permissible delegation of certain treatments to a trained person. **Some consumers need home health-care, which is determined separately from home care needs, and both may be necessary.**

Care Plans vs. Care Settings

A care setting is where the consumer's needs are being met. Care settings include the person's home, adult residential facilities, enhanced adult residential facilities, assisted living facilities, adult family homes, and nursing homes. By contrast, a care plan identifies the consumer's functional needs, and who provides for those needs. It also authorizes the hours of service to be paid for those needs. Most needs can be met in any of the care settings. **The consumer's choice of care setting will influence how those needs are being met**. For example, in residential settings other than the consumer's home, the facility is responsible, within its daily rate, to meet the personal care needs that might be met by a consumer's family or an IP if the consumer were living at home. If the consumer moves or changes care settings, his or her care plan will be adjusted to reflect the current setting.

Consumer Choice

Although a DSHS or AAA case manager performs a CARE assessment to determine the consumer's care needs and may make a strong recommendation about the most appropriate care setting, ***it is the consumer, not the case manager, who chooses the care setting.***

Ultimately, the consumer's care plan is designed for the setting the consumer chooses, as long as he or she is eligible for the setting and there is space available. Thus, if two consumers are eligible for any care setting and have identical needs, one might opt for a residential facility while the other might choose to remain at home. Either choice is allowed within the system.

Relative Intensity of Care Settings

Initiative 775 lists several examples of "additional or more intensive" services and settings, including home health care, other residential settings, and nursing homes. **Contrary to the Initiative's characterization, home health-care is not necessarily a more intensive version of home care.** Home health-care services can be provided side-by-side with in-home care to preserve a person's ability to remain at home. Similarly, while nursing homes are clearly a more intensive setting, most other residential settings serve persons who, on average, have less serious needs than persons receiving in-home services from an IP.

Comparing the severity of the needs of those being served in various settings is done by comparing the average ADL scores for each setting. ADL scores range from 0 to 28, with 28 meaning total dependence. Figure 6, on the next page, shows that only skilled nursing facilities and adult family

homes serve a population with higher average ADL scores than those receiving in-home care from an IP. That is, consumers receiving in-home care from an IP are, on average, more dependent than consumers in any settings other than nursing homes and adult family homes.

Figure 6 – Individual Providers Serve Consumers With Higher Average ADL Scores Than Those In All But Two Care Settings

Care Setting	Average ADL Score
Skilled Nursing Facility	17.73
Adult Family Home	15.25
In-Home: Individual Provider	**13.25**
Enhanced Adult Residential Care	12.44
In-Home: Agency Provider	10.46
Adult Residential Care	7.22
Assisted Living	5.41

Source: DSHS, ADSA. Because these are averages, consumers in each grouping have a range of ADL scores.

Thus, the care setting a consumer chooses does not necessarily indicate his or her care needs. Because movement between care settings may be due to something outside an IP's control, or due to consumer choice, movement between settings is not a good indicator of the success or failure of a care setting.

TO WHAT EXTENT HAVE ALL REQUIRED SERVICES BEEN DELIVERED?

Those who work in the long-term care system believe that to determine whether an IP delivered all of the individual services called for in the consumer's care plan would require an intimate knowledge of every activity within each consumer's home on a daily basis. This is not realistic because ***the consumer retains, to a very large degree, control over his or her care***.

For example, a consumer may refuse to eat a particular meal or send the provider home without performing some aspect of the care plan: this is the consumer's decision. Thus, it is not possible to fully answer whether all services have been delivered, nor the underlying causes, which may be outside the control of the state or the IP.

It is important to note, however, that if the IP is concerned that the consumer is losing the ability to make good choices about his or her care or has other significant changes in his or her condition, it is the IP's responsibility to contact the consumer's case manager. The DSHS contract requires IPs to notify the case manager of **any** significant change in a consumer's condition within 24 hours. The case manager can intervene, perform another assessment, make a referral to other services, or discuss other care settings with the consumer, as appropriate.

TO WHAT EXTENT HAVE CONSUMERS REQUIRED ADDITIONAL OR MORE INTENSIVE SERVICES?

Because a consumer has the right to choose his or her care setting, it is difficult to determine whether a change from in-home care by an IP to another care setting was due to a need for more intensive services or due to the consumer's choice.

Further, while both home care and home health-care needs are determined using an integrated assessment, they are separate needs, and receiving home-health care services may not reflect an "additional" or "more intensive" service, as described in the Initiative. It may be that the consumer has received home-health care services for many years and only recently begun receiving personal care services. Conversely, it may be that the consumer's care plan has always included both in-home care from an IP and home health-care services, and the combination of services permits the consumer to remain in his or her home. The consumer's need for one service may be independent of his or her need for the other.

Finally, the consumer may require skilled nursing services due to acute or degenerative health issues that have no relation to the appropriate provision of in-home care by an IP. A consumer may also temporarily require skilled nursing services and then return home and resume in-home care with an IP. This may happen once or many times and be entirely unrelated to the IP's skill or availability.

CONCLUSION

The broader questions in this chapter appear to be based on assumptions about service delivery and care settings that do not correspond to the structure of the public long-term care system in Washington. Further, by placing these questions in a mandated performance review of the HCQA, the questions imply that the HCQA has direct control of their outcome. The HCQA has no role in the authorization of services, the consumer's decision about how or when services will be delivered, or what care settings consumers select.

The one role that HCQA has in this area is to notify the relevant case manager if it has concerns about an IP's performance of his or her duties. While HCQA has performed this duty and has worked with case managers to resolve the concerns, such a concern is only likely to come to HCQA's attention if there is a complaint.

Because HCQA has only an incidental role in determining the extent to which authorized services have been delivered or consumer's use of additional and more intensive services, these questions would be more appropriate in a full audit of the long-term care system, where the much larger impacts of both the DSHS authorization process and progressive or degenerative medical conditions could be assessed.

CHAPTER FOUR: CONSUMER HEALTH, WELFARE, AND SATISFACTION WITH SERVICES

OVERVIEW

Initiative 775 directed JLARC to look at two questions related to consumers' health, welfare, and satisfaction with services. Although the Initiative does not define these terms, JLARC has assumed that health and welfare have their ordinary meanings and that satisfaction with services is limited to the delivery of in-home care, rather than including the many other services that the consumer may be receiving simultaneously.

This chapter presents JLARC's analysis of how the current system tracks and monitors consumer health, welfare, and satisfaction with services, as well as the respective roles of DSHS and HCQA within that system. Here we address two questions:

1. How are health, welfare, and satisfaction with services tracked and monitored within the long-term care system?
2. When there are problems that result in complaints, how are those resolved?

While the initiative does not define "services," the answers to these two questions, taken together, can establish whether there is a system in place to identify health and welfare concerns as well as identify, from the consumer's view, how well the system is working.

FEDERAL AND STATE REQUIREMENTS

Federal and state requirements establish the framework within which consumers' health, welfare, and satisfaction with services must be addressed. Federal protocols for home and community-based service programs are identified in the *HCBS Quality Framework.*[8] Under these protocols, DSHS has four responsibilities:

1. The home- and community-based program must include regular, systematic, and objective methods — including consumer feedback — to monitor consumers' well being and health status, as well as service effectiveness in enabling consumers to achieve their personal goals;
2. The program must have risk and safety planning as well as interventions to promote health, independence, and safety with the informed involvement of consumers;
3. There must be due process for consumers' Medicaid rights when consumers are funded by Medicaid; and
4. Consumers must be informed how to register grievances and complaints and be supported in seeking resolution. Grievances and complaints must be resolved in a timely fashion.

In addition, Washington Executive Order 03-01 requires all state agencies to develop procedures for tracking complaints about service delivery and resolving problems. The procedures should facilitate prompt resolution after an initial contact with the agency and designate a clearly identified point of contact to assist in finding needed services and resolving problems.

[8] HCBS means Home and Community Based Services and has been established by the federal Centers for Medicare & Medicaid Services (CMS) in conjunction with several non-governmental partners. The *HCBS Quality Framework* is published by CMS to guide states with Medicaid Waivers for Home and Community Based Services in passing their federal reviews. http://www.cms.hhs.gov/HCBS/05_Quality%20Oversight.asp#TopOfPage.

HOW ARE CONSUMERS' HEALTH, WELFARE, AND SATISFACTION WITH SERVICES TRACKED AND MONITORED?

DSHS Role

Under the federal and state frameworks, DSHS has the primary role in tracking and monitoring consumer's health, welfare, and satisfaction with services. This role begins with the development of an individual's care plan, which was described at the beginning of Chapter 3.

While all consumers must have, at a minimum, annual in-person visits and three additional contacts per year from a DSHS or AAA case manager, several things can increase this frequency as the plan is established. These include:

- Information indicating a change in the consumer's condition triggers a required in-person assessment and update of the care plan.
- If the care plan indicates that the consumer has health conditions that require regular monitoring, the CARE Tool will trigger referrals to appropriate health professionals and flag the file for closer monitoring. DSHS and AAA case managers are required to make referrals to visiting nurses, physical and occupational therapists, and other health professionals when indicated by the CARE assessment. A decision not to make the referral requires documentation with the reason no referral was made.
- The case manager must manually flag a consumer's case for additional monitoring if he or she believes that the consumer's living situation is unstable or raises safety concerns, if the consumer is at risk for abuse or neglect, has unstable medical or psych-social conditions, has difficulty being understood, or if the case manager is concerned about the consumer's ability to supervise an individual provider (IP).
- The CARE Tool also requires the case manager to document how an IP will be supervised if the consumer, as employer, is unable to provide that supervision. Part of this plan can include additional monitoring by the case manager.

The Quality Assurance Group within ADSA conducts an annual review of how CARE assessments are done, whether the case managers have made necessary referrals (and if not, why not), and whether the care plan documented how IPs would be supervised if the consumer was unable to do so. This group also reports that it has begun to provide additional training and oversight in the field when the quality assurance review flags a particular case manager as not using the CARE Tool correctly.

Further, DSHS requires IPs to monitor the consumer's health and welfare by regularly documenting specified conditions and notifying the case manager within 24 hours when a consumer experiences any significant change in condition.

DSHS monitors consumer satisfaction by performing an annual customer satisfaction survey.

HCQA Role

HCQA's only duty in this area consists of notifying the consumer's case manager if it identifies concerns regarding the services being provided by an IP. Such a situation could be related to the consumer's health and welfare or to the consumer's satisfaction with the services. HCQA has done this, as discussed in Chapter 2, under its duties for recruitment and the referral registry.

HCQA monitors consumer satisfaction in two ways. First, when a consumer hires an IP from a registry referral, HCQA follows up by telephone at 5, 30, and 90 days after the IP is employed.

Consumers are asked to rate their satisfaction using a 1-5 scale with 5 being the highest satisfaction. The average response is 4.7 out of 5.

The second way HCQA monitors consumer satisfaction is as part of a broader consumer survey. That survey is currently in process.

HOW PROMPTLY ARE CONSUMER COMPLAINTS RESOLVED?

DSHS Role

As required by federal and state mandates, ADSA has both a grievance policy and an established complaint process. Under this process, consumers are informed of their rights and responsibilities at the time of initial program eligibility, which includes informing them of their right to bring issues forward for resolution. The policy requires complaints to be resolved in a timely manner at the lowest possible level within the organization.

Under the policy, each local office keeps a standardized complaint log to document complaints. The log includes the nature of the complaint, to whom it was assigned, the due date, and the outcome. Currently, information on the logs is not collected at the state level.

When DSHS takes an adverse action related to a consumer's service, the consumer is entitled to an administrative hearing. The hearing process is governed by Washington's Administrative Procedures Act.

HCQA Role

While **HCQA has no specific statutory duty to resolve complaints**, it does have two complaint systems. The first HCQA complaint system is for complaints about consumers and IPs who are part of the referral registry. The second complaint system is for complaints received by telephone, mail, or email at the HCQA headquarters that do not involve the referral registry.

Complaints can be from consumers, case managers, IPs, or members of the general public. They are usually about IPs, consumers, or wage and union issues. HCQA has received 17 complaints, and all were responded to within one day.

CONCLUSION

Because HCQA has only an incidental role in the tracking and monitoring of consumers' health, welfare, and satisfaction with services, these questions would be more appropriate in a full audit of the long-term care system, where the impact of the much larger DSHS tracking, monitoring, and complaint resolution process could be assessed.

CHAPTER FIVE: WHAT ARE THE FULL COSTS OF INDIVIDUAL PROVIDER SERVICES?

OVERVIEW

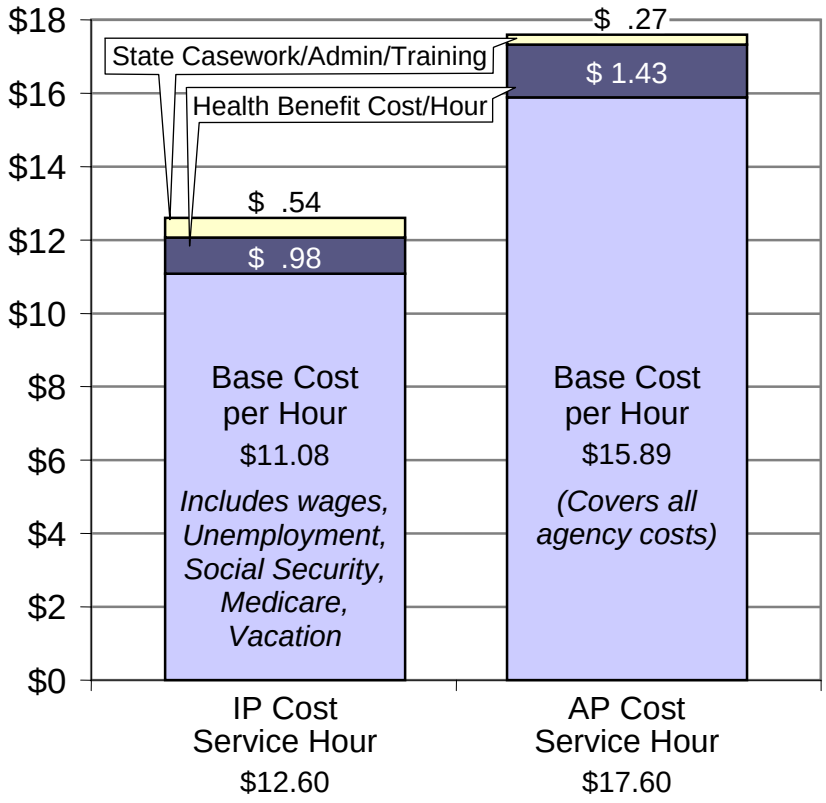
Initiative 775 directed JLARC to identify the full cost of individual provider (IP) services. Such costs are to include the administrative costs of HCQA, unemployment compensation, Social Security and Medicare payroll taxes, and AAA home care oversight costs. These costs are in addition to the hourly rate paid to providers. As a point of comparison, these full costs were compared to the full costs of an agency providing in-home care services.

This chapter summarizes JLARC's analysis of these costs. Once all costs are considered, **JLARC estimates that the state's average full cost of an hour of IP services is $12.60 and the state's average full cost of an hour of agency provided in-home care is $17.60, a $5.00 per hour difference.** Thus, based on a full cost estimate, agency provided care costs the state 40 percent more per hour than IP provided care.

What is Included in the Full Cost Estimate?

Figure 7 illustrates the three main cost groups included in the full cost estimate of in-home care provided by IPs or by agencies. Each is an average.

Figure 7 – Comparative Total Hourly Cost to the State of Individual and Agency Providers



Source: JLARC analysis of DSHS, OFM, and HCQA data.

These three main cost groups are divided between:

- **Base Cost Per Hour**: For IPs, this includes the hourly wage, vacation, worker's compensation, unemployment insurance, and Medicare and Social Security. It represents 88 percent of the total cost. For agency providers, it is the rate paid to agencies by the state for an hour of care. From this rate, agencies must cover the same costs as for IPs plus any agency overhead costs. The base cost per hour of care represents 90 percent of the total agency cost.
- **Health Benefit Cost Per Hour**: This is the cost of providing health benefits to providers. It includes the cost for IPs using the health benefits trust as well as agency providers using commercial health plans, such as Premera.
- **State/AAA Case Management, State Administration, and Training**: This category includes the many individual costs associated with DSHS and the AAAs. It includes costs associated with authorizing and paying providers. Costs of paying providers include the DSHS central administration costs associated with payroll (wages, taxes, etc.), as well as operating and maintaining the information systems needed for authorization and payment. The cost of HCQA, including the costs of the RWRCs and of collective bargaining, is applied only to the IP cost. Training costs are included for both IPs and agency providers.

Figure 8 illustrates how much of the hourly rate estimate falls into each category.

Figure 8 – The Three Main Cost Areas of IP and Agency Total Costs

	IP Cost Service Hour	% of Total	AP Cost Service Hour	% of Total
Base Cost per Hour	$11.08	88%	$15.89	90%
Health Benefit Cost/Hour	$0.98	8%	$1.43	8%
State Casework/State Administrative Costs/Training	$0.54	4%	$0.27	2%
Total Provider Cost/Hour	$12.60	100%	$17.60	100%

Source: JLARC analysis of DSHS, OFM, and HCQA data.

How Accurate is This Estimate?

Developing a model of the full cost of the in-home care services provided by IPs and agency providers required collecting information from a variety of sources. In some instances, this required developing special reports or making assumptions of how to allocate costs.

However, many costs are readily determined. This includes base hourly rates, health benefits, and the cost of the Home Care Quality Authority. The overall estimate is not, therefore, highly sensitive to large changes in areas where there is less certainty with the underlying data. Thus, while still an estimate, the estimate is accurate. **Appendix 5 contains additional detail on data reliability**.

FINDING

After carefully estimating total costs to the state for both individual and agency providers, IPs cost the state $12.60 per hour, which is $5 per hour less than the state's total cost for agency providers.

CHAPTER SIX: IS IT APPROPRIATE FOR HCQA TO ASSUME VERIFICATION OF HOURS WORKED, PAYROLL PAYMENTS, AND OTHER DUTIES?

OVERVIEW

In addition to the performance review of the Home Care Quality Authority and the broader questions explored in Chapters 3 and 4, Initiative 775 also requires JLARC, in this first report, to include findings and recommendations regarding the appropriateness of HCQA's assumption of the following responsibilities: verification of hours worked by individual providers (IPs), payment of IPs, and other duties. This chapter presents the results of JLARC's analysis, based on answers to three questions:

1. Would these new responsibilities be consistent with HCQA's mission and duties?
2. What changes would be required of HCQA to assume these duties?
3. Do HCQA or DSHS believe HCQA should assume these duties?

Is the Verification of Hours Worked or Payment of Individual Providers Consistent with HCQA's Mission and Duties?

HCQA's statutory ***mission*** is broad: the agency was created to ensure the quality of long-term in-home care provided by IPs through better regulation, higher standards, increased accountability, enhanced ability to obtain services, and stabilizing the workforce. HCQA's statutory ***duties*** fall into four categories: collective bargaining, background checks, training, and recruitment and referral.[9]

While HCQA's ***duties*** do not relate specifically to verification of hours or payment of providers, its ***mission*** would seem to allow such activities, particularly if a problem in either area created recruitment, training, or workforce stabilization issues.

Understanding whether payroll or verification of hours problems create recruitment, training, or workforce stabilization issue would require extensive analysis of the entire system of in-home care, from how services are authorized through how payments are made for those services. Such an analysis was not possible during this study, particularly as most of these activities are currently undertaken by DSHS or the AAAs.

We were able to gain insights into some of DSHS's current efforts around payroll as part of our analysis of the full cost of IP services. This is discussed in the next section.

What Changes Would Be Required of HCQA to Assume the Verification of Hours and Payment?

Assuming responsibility for payroll would be a sizeable change in the current activities of the HCQA.

[9] HCQA's mission and duties are found in RCW 74.39A.220 through 74.30A.250.

Chapter 1 of this report noted that HCQA has four employees, annual expenditures of about $3.3 million and focuses on the individual provider registry. It also noted that DSHS estimates the number of IPs to be about 32,500 over the course of a year.

Chapter 6 of this report identified the full cost of IP services. Included is $6.5 million per year for case management and the costs associated with paying IPs.

Such costs include four staff in DSHS's Office of Financial Services to process and account for IP payments—to process the "payroll." This staff performs duties such as ensuring that benefits are calculated properly, that taxes are withheld, and that tax forms are prepared and filed for every IP-consumer employment relationship. This same office has a request, in the 2007-2009 Budget, for six additional staff to meet the complex needs of paying this sizable, unionized workforce.

With between four and ten dedicated staff needed to process payments to IPs and an estimated annual costs over $2.2 million for the computer systems and people required to process these payments, taking over payroll duties would, at a minimum, double HCQA's current staff and increase their budget substantially. Processing payroll is an activity that requires an expertise that the HCQA does not currently have.

While JLARC was not able to isolate the costs associated with the verification of hours, such activities require some level of interaction with the IP and the consumer in the field. With 32,500 IPs providing care services in over 25,000 homes during one year, the need for field staff would be significant. This too would mean a substantial change in HCQA's operations.

Does HCQA Believe It Should Assume the Responsibility for the Verification of Hours or Payment of Individual Providers?

JLARC asked HCQA if it should assume the responsibility for the verification of hours or the payment of IPs. The agency's answer was "No." They consider these duties to be within the scope of DSHS's role.

JLARC asked the same question of DSHS. DSHS indicates that such a change in duties would complicate service delivery and would not improve services to consumers. So, neither HCQA nor DSHS believe that payroll or hours verification should be switched to HCQA.

CONCLUSION

While the verification of hours worked and the payment of IPs can fit into the HCQA's mission, neither are explicitly addressed in HCQA's duties. JLARC's analysis indicates that the assumption of these duties would require a substantial enlargement in HCQA's size and focus. The verification of hours worked and processing payments for over 32,000 unionized employees is a complex undertaking.

This is not to say that payroll, the verification of hours worked, or other duties currently undertaken by DSHS are perfect. DSHS believes that the system now used for paying IPs must be replaced at a cost of $7 million, and that they must more than double the number of staff dedicated to processing payments to IPs and to answer IP questions about benefits, union dues, and taxes.

JLARC identified no compelling need for the transfer the duty for IP payments, or verification of hours to HCQA. In order for JLARC to determine whether there is a problem that can be solved by transferring the other duties not currently performed by HCQA to the agency, a broader analysis would be required. Such an analysis would need to include the entire "system" of long-term care. This system includes HCQA and many others: the Divisions of Developmental Disabilities and

Home and Community Services within ADSA and the Children's Administration, as well as the Area Agencies on Aging. These organizations are all involved in activities such as authorizing hours, verifying hours, and in making certain IPs are paid. The "system" also involves parts of DSHS's central administration (such as the Social Services Payment System, used to pay providers). As a practical matter, such a complex analysis was beyond the scope of the current audit.

FINDING

JLARC has identified no compelling need that warrants transferring IP payments, the verification of hours, or other duties to the Home Care Quality Authority at this time.

CHAPTER SEVEN: CONCLUSIONS

SUMMARY

The demand for community-based services in the public long-term care system is growing and in-home care is the largest segment of community-based long-term care. Projections suggest that this trend will continue through 2050 and that there will be a shortage of family members to provide in-home care on an unpaid basis at the same time demand for these services increases.[10] Further, the Bureau of Labor Statistics estimates that between 2000 and 2010 the demand for community-based long-term care providers will grow by 395,000 jobs.

The establishment of HCQA, with its duties related to collective bargaining, background checks, training, and recruiting and referring individual providers (IPs) for in-home care can help Washington face the growing need for a stable workforce of in-home providers. HCQA actively recruits IPs, trains providers and consumers, and provides referrals to consumers and case managers from a statewide registry of IPs who are already screened and available for work. It appears that in areas where the registry has been available the longest, case managers are most likely to use it, refer consumers to it, and think that it reduces the time necessary to place an IP in a consumer's home. It may be that the effectiveness of the referral registry is dependent on the length of time it has been in place. Because IPs cost the state $5 per hour less than agency-employed providers of in-home care, emphasizing the use of IPs in appropriate cases is an efficient use of the state's resources.

The primary services that HCQA provides are not generally duplicated elsewhere in the long-term care system. HCQA provides the only statewide IP recruitment and referral resource. In addition, while DSHS provides basic training and continuing education to IPs related to caring for consumers, HCQA training is focused on workforce stability by training all IPs in their own safety, new IPs in what is expected of professional individual providers, and consumers to be better employers.

FINDINGS

1. The Home Care Quality Authority has fulfilled its statutory duties and substantially met those outcome measures that could be evaluated at this time.
2. After carefully estimating total costs to the state for both individual and agency providers, individual providers cost the state $12.60 per hour, which is $5 per hour less than the state's total cost for agency providers.
3. JLARC has identified no compelling need that warrants transferring IP payments, the verification of hours, or other duties to the Home Care Quality Authority at this time.
4. The Initiative 775 supplemental questions are not directly related to a performance review of the Home Care Quality Authority.

[10] The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation, *supra*, note 2 at pages 3, 7.

RECOMMENDATIONS

1. **The Home Care Quality Authority should review its 2004 "Outcome and Output Measures" document in light of experience, the current statute, and its strategic plan, to ensure that its performance targets are clear and adequately reflect HCQA's current duties and goals.**

   Legislation Required: No

   Fiscal Impact: None.

   Reporting Date: HCQA should provide JLARC with revised Outcome Measures by June 30, 2007.

2. **The Legislature should reexamine the Home Care Quality Authority performance review timing and questions to be considered under RCW 74.39A.290 to ensure that future JLARC reviews best meet the needs of the state.**

   Legislation Required: Yes

   Fiscal Impact: Fiscal impact is dependent on the scope and frequency of future reviews.

AGENCY RESPONSES

We have shared the report with the Home Care Quality Authority (HCQA), the Department of Social and Health Services (DSHS), and the Office of Financial Management (OFM), and provided them an opportunity to submit written comments. Their written responses are included as Appendix 2.

ACKNOWLEDGEMENTS

We appreciate the assistance provided by the staff of the Home Care Quality Authority, the Department of Social and Health Services, and the Office of Financial Management in conducting this study.

Ruta Fanning
Legislative Auditor

On January 4, 2007, this report was approved for distribution by the Joint Legislative Audit and Review Committee.

Representative Ross Hunter
Chair

APPENDIX 1: SCOPE & OBJECTIVES

Performance Review of the Home Care Quality Authority

SCOPE AND OBJECTIVES

AUGUST 2006

STATE OF WASHINGTON
JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE

STUDY TEAM

FARA DAUN
JOHN WOOLLEY

LEGISLATIVE AUDITOR

RUTA FANNING

Joint Legislative Audit & Review Committee
506 16th Avenue SE
Olympia, WA 98501-2323

(360) 786-5171
(360) 786-5180 Fax

Website: http://jlarc.leg.wa.gov
e-mail: neff.barbara@leg.wa.gov

WHY A PERFORMANCE REVIEW OF THE HOME CARE QUALITY AUTHORITY?

Initiative 775 (Chapter 3, Laws 2002) established the Home Care Quality Authority (HCQA) in December 2001. The Initiative directs the Joint Legislative Audit and Review Committee (JLARC) to conduct a performance review of the Authority every two years, beginning by December 1, 2006.

Background

There are approximately 25,500 people in Washington State who receive state-funded long-term care services at home. These people are served by either an employee of a home care agency or by individuals who work as independent contractors who provide their services through the Individual Provider Program.

Individual providers (IPs) assist clients by providing help with various personal care tasks, such as feeding, bathing, and dressing.

The Home Care Quality Authority was created by Initiative 775 to ensure that the quality of long-term care services provided by individual providers is improved through better regulation, higher standards, increased accountability, and improved access to IP services. HCQA is also to encourage stability in the IP workforce through collective bargaining and by providing training opportunities.

HCQA has four staff and is governed by a nine-member board appointed by the Governor. HCQA is charged with duties related to individual providers, including:

- Establishing qualifications;
- Recruiting and training;
- Assisting consumers to find IPs by establishing a referral registry;
- Obtaining background checks for criminal history, abuse, and neglect;
- Providing consumers with referrals to IPs;
- Cooperating with the Department of Social and Health Services and Area Agencies on Aging; and
- Consulting with the Governor on issues important to consumers of in-home IP services, including consultation during the collective bargaining process.

STUDY SCOPE

The performance review will analyze the Home Care Quality Authority's assumption and implementation of the duties defined in Initiative 775. As directed by Initiative 775, the review will analyze how the Authority's efforts impact client well-being and service efficiency. The review will include an evaluation of the health, welfare, and satisfaction with services provided to consumers receiving long-term in-home care from individual providers.

OBJECTIVES AND QUESTIONS TO BE ADDRESSED BY THE ANALYSIS

The performance review will analyze how the HCQA has implemented the provisions of Initiative 775 and the subsequent amendments passed by the Legislature. The review will identify and distinguish the responsibilities of the HCQA and the Department of Social and Health Services in the provision of individual provider-based services. Questions to be answered in this report include:

1. To what degree have all required services been delivered, and to what extent have consumers required additional or more intensive services?
2. How are consumer health, welfare, and satisfaction with services tracked and monitored?
3. How promptly are consumer complaints resolved?
4. What are the full costs of individual provider services, including all administrative and other costs?
5. To what degree would it be appropriate for the HCQA to assume responsibility for verification of hours worked by individual providers, payment of individual providers, and other duties?

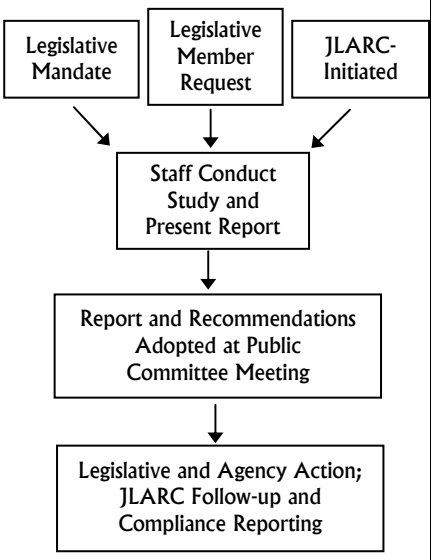
TIMEFRAME FOR THE STUDY

The preliminary report will be presented at the November 29, 2006, meeting, and the final report will be presented at the January 3, 2007, meeting.

JLARC STAFF CONTACT FOR THE STUDY

Fara Daun	(360) 786-5174	daun.f@leg.wa.gov
John Woolley	(360) 786-5184	woolley.john@leg.wa.gov

JLARC Study Process



Criteria for Establishing JLARC Work Program Priorities

- Is study consistent with JLARC mission? Is it mandated?
- Is this an area of significant fiscal or program impact, a major policy issue facing the state, or otherwise of compelling public interest?
- Will there likely be substantive findings and recommendations?
- Is this the best use of JLARC resources: For example:
  - Is the JLARC the most appropriate agency to perform the work?
  - Would the study be nonduplicating?
  - Would this study be cost-effective compared to other projects (e.g., larger, more substantive studies take longer and cost more, but might also yield more useful results)?
- Is funding available to carry out the project?

APPENDIX 2: AGENCY RESPONSES

- Home Care Quality Authority
- Department of Social and Health Services
- Office of Financial Management

STATE OF WASHINGTON

HOME CARE QUALITY AUTHORITY

515 15th Avenue SE
PO Box 40940
Olympia, Washington 98504
Phone 360-902-8856 Fax 360-586-0786 TTY360-493-2637

December 4, 2006

Ms. Ruta Fanning, Legislative Auditor
Joint Legislative Audit and Review Committee
506 16th Avenue SE
Olympia, WA 98501-2323

Re: Home Care Quality Authority (HCQA) Performance Review and Supplementary Questions – Preliminary Report – **HCQA Response**

Dear Ms. Fanning:

The Home Care Quality Authority has completed its review of the above entitled report. We respectfully submit the following responses to the report's recommendations:

JLARC Recommendation 1: The Home Care Quality Authority should review its 2004 "Outcome and Output Measures" document in light of experience, the current statute, and its strategic plan, to ensure that its performance targets are clear and adequately reflect HCQA's current duties and goals.

The Home Care Quality Authority **concurs**.

JLARC Recommendation 2: The legislature should reexamine the Home Care Quality Authority performance review timing and questions to be considered under RCW 74.39A.290 to ensure that future JLARC reviews best meet the needs of the state.

The Home Care Quality Authority **concurs** and offers the recommendations below for consideration.

1. Regarding the timing of a future performance review by JLARC, we have concluded that starting the next review in January, 2009 would be most desirable from our standpoint because:

- Grant funding of the referral registry operations and related grant activities will cease at the end of this biennium.

- This time period should be adequate for the Home Care Quality Authority to establish sufficient baseline data in all areas for comparison in a performance review.

2. Regarding the questions to be considered by JLARC under RCW 74.39A.290, we consider the following to be representative of factors that are in the Home Care Quality Authority's direct control:

   - Review the Home Care Quality Authority's performance in the management of the statewide referral registry including: recruitment, screening, referrals, accessibility and contract administration.

   - Review the Home Care Quality Authority's performance in carrying out the Authority's responsibilities related to collective bargaining including: consumer input, consultation with the governor or governor's designee and administration of the statewide workers' compensation program for providers.

   - Review the Home Care Quality Authority's delivery of training to consumers.

   - Review the Home Care Quality Authority's coordination and integration of services with the Department of Social and Health Services.

Please feel free to contact me if you have any questions.

Sincerely,

Rick Hall
Executive Director
Home Care Quality Authority

cc: Robin Arnold-Williams
Victor Moore
Liz Dunbar
Kathy Leitch
Charley Reed

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Olympia, WA 98504-5000

December 4, 2006

RECEIVED

DEC - 7 2006

JLARC

Ruta Fanning, Legislative Auditor
Joint Legislative Audit and Review Committee (JLARC)
PO Box 40910
Olympia, Washington 98504-0910

Dear Ms. Fanning:

The Department of Social and Health Services respectfully submits this formal response to JLARC's preliminary report entitled, Home Care Quality Authority Performance Review and Supplementary Questions.

RECOMMENDATION	AGENCY POSITION	COMMENTS
Rec. 1, page 5	Concur	
Rec. 2, page 6	Concur	

The report correctly notes the total costs to the state for an hour of individual provider services is $5 less than that of agency care. The higher cost for agency care pays for recruitment, supervision, monitoring and scheduling that under the individual provider system is performed by the client/employer. Many clients or family members are able and willing to perform those employer tasks at no cost to the state. For an average 100 hour-per month case, a $5 per hour savings in cost is substantial. Although there is a difference in the cost of in-home care based on provider type, it is vital to the long-term care system to have both individual providers and home care agencies available in Washington State. Clients who are unable to perform these employer functions, and have no one to perform them on their behalf, are more appropriately served by agencies.

The report accurately identifies the Department's role in managing, overseeing and establishing provider qualifications as required by federal and state mandates. The mandates of the Department and the Home Care Quality Authority (HCQA) are interconnected and therefore coordination and communication are required to assure efforts are not duplicated. The Department is committed to working closely with HCQA on issues related to consumer choice and satisfaction, workforce recruitment and retention and quality outcomes.

Sincerely,

Robin Arnold-Williams

Robin Arnold-Williams
Secretary

cc: Blake Chard
Kathy Leitch
Fara Daun

STATE OF WASHINGTON
OFFICE OF FINANCIAL MANAGEMENT
Insurance Building, PO Box 43113 • Olympia, Washington 98504-3113 • (360) 902-0555

December 8, 2006

TO: Ruta Fanning, Legislative Auditor
Joint Legislative Audit and Review Committee

FROM: Victor A. Moore, Director

SUBJECT: **HOME CARE QUALITY AUTHORITY PERFORMANCE REVIEW AND SUPPLEMENTARY QUESTIONS – PRELIMINARY REPORT**

Thank you for giving the Office of Financial Management (OFM) the opportunity to review JLARC's preliminary report on the Home Care Quality Authority.

OFM concurs with the recommendations in this preliminary report.

Recommendation	Agency Position	Comments
1. The Home Care Quality Authority should review its 2004 "Outcome and Output Measures" document in light of experience, the current statute, and its strategic plan, to ensure that its performance targets are clear and adequately reflect HCQA's current duties and goals.	Concur	
2. The Legislature should reexamine the Home Care Quality Authority performance review timing and questions to be considered under RCW 74.39A.290 to ensure that future JLARC reviews best meet the needs of the state.	Concur	

We look forward to your final report. If you have any questions, please contact Eric Mandt at (360) 902-0543.

APPENDIX 3: INITIATIVE 775

INITIATIVE 775
to the People

Chapter 3, Laws of 2002

LONG-TERM IN-HOME CARE SERVICES
EFFECTIVE DATE: 12/6/01

Approved by the	ORIGINALLY FILED
People of the state of Washington	April 17, 2001
in the General Election on	**Secretary of State**
November 6, 2001	**State of Washington**

AN ACT Relating to regulating and improving long-term in-home care services; amending RCW 74.39A.030 and 74.39A.095; adding new sections to chapter 74.39A RCW; adding a new section to chapter 41.56 RCW; adding a new section to chapter 70.127 RCW; adding a new section to chapter 74.09 RCW; and creating a new section.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** FINDINGS. The people of the state of Washington find as follows:
(1) Thousands of Washington seniors and persons with disabilities live independently in their own homes, which they prefer and is less costly than institutional care such as nursing homes.
(2) Many Washington seniors and persons with disabilities currently receive long-term in-home care services from individual providers hired directly by them under the medicaid personal care, community options programs entry system, or chore services program.
(3) Quality long-term in-home care services allow Washington seniors, persons with disabilities, and their families the choice of allowing seniors and persons with disabilities to remain in their homes, rather than forcing them into institutional care such as nursing homes. Long-term in-home care services are also less costly, saving Washington taxpayers significant amounts through lower reimbursement rates.
(4) The quality of long-term in-home care services in Washington would benefit from improved regulation, higher standards, better accountability, and improved access to such services. The quality of long-term in-home care services would further be improved by a well-trained, stable individual provider work force earning reasonable wages and benefits.

(5) Washington seniors and persons with disabilities would benefit from the establishment of an authority that has the power and duty to regulate and improve the quality of long-term in-home care services.

(6) The authority should ensure that the quality of long-term in-home care services provided by individual providers is improved through better regulation, higher standards, increased accountability, and the enhanced ability to obtain services. The authority should also encourage stability in the individual provider work force through collective bargaining and by providing training opportunities.

NEW SECTION. **Sec. 2.** AUTHORITY CREATED. (1) The home care quality authority is established to regulate and improve the quality of long-term in-home care services by recruiting, training, and stabilizing the work force of individual providers.

(2) The authority consists of a board of nine members appointed by the governor. Five board members shall be current and/or former consumers of long-term in-home care services provided for functionally disabled persons, at least one of whom shall be a person with a developmental disability; one board member shall be a representative of the developmental disabilities planning council; one board member shall be a representative of the governor's committee on disability issues and employment; one board member shall be a representative of the state council on aging; and one board member shall be a representative of the Washington State association of area agencies on aging. Each board member serves a term of three years. If a vacancy occurs, the governor will make an appointment to become immediately effective for the unexpired term. Each board member is eligible for reappointment and may serve no more than two consecutive terms. In making appointments, the governor will take into consideration any nominations or recommendations made by the groups or agencies represented.

NEW SECTION. **Sec. 3.** DEFINITIONS. The definitions in this section apply throughout RCW 74.39A.030 and 74.39A.095 and sections 1 through 9 and 12 through 14 of this act unless the context clearly requires otherwise.

(1) "Authority" means the home care quality authority.

(2) "Board" means the board created under section 2 of this act.

(3) "Consumer" means a person to whom an individual provider provides any such services.

(4) "Individual provider" means a person, including a personal aide, who has contracted with the department to provide personal care or respite care services to functionally disabled persons under the medicaid personal care, community options program entry system, chore services program, or respite care program, or to provide respite care or residential services and support to persons with developmental disabilities under chapter 71A.12 RCW, or to provide respite care as defined in RCW 74.13.270.

NEW SECTION. **Sec. 4.** AUTHORITY DUTIES. (1) The authority must carry out the following duties:

(a) Establish qualifications and reasonable standards for accountability for and investigate the background of individual providers and prospective individual providers, except in cases where, after the department has sought approval of any appropriate amendments or waivers under section 14 of this act, federal law or regulation requires that such qualifications and standards for accountability be established by another entity in order to preserve eligibility for federal funding. Qualifications established must include compliance with the minimum requirements for training and satisfactory criminal background checks as provided in RCW 74.39A.050 and confirmation that the individual provider or prospective individual provider is not currently listed on any long-term care abuse and neglect registry used by the department at the time of the investigation;

(b) Undertake recruiting activities to identify and recruit individual providers and prospective individual providers;

(c) Provide training opportunities, either directly or through contract, for individual providers, prospective individual providers, consumers, and prospective consumers;

(d) Provide assistance to consumers and prospective consumers in finding individual providers and prospective individual providers through the establishment of a referral registry of individual providers and prospective individual providers. Before placing an individual provider or prospective individual provider on the referral registry, the authority shall determine that:

(i) The individual provider or prospective individual provider has met the minimum requirements for training set forth in RCW 74.39A.050;

(ii) The individual provider or prospective individual provider has satisfactorily undergone a criminal background check conducted within the prior twelve months; and

(iii) The individual provider or prospective individual provider is not listed on any long-term care abuse and neglect registry used by the department;

(e) Remove from the referral registry any individual provider or prospective individual provider the authority determines not to meet the qualifications set forth in (d) of this subsection or to have committed misfeasance or malfeasance in the performance of his or her duties as an individual provider. The individual provider or prospective individual provider, or the consumer to which the individual provider is providing services, may request a fair hearing to contest the removal from the referral registry, as provided in chapter 34.05 RCW;

(f) Provide routine, emergency, and respite referrals of individual providers and prospective individual providers to consumers and prospective consumers who are authorized to receive long-term in-home care services through an individual provider;

(g) Give preference in the recruiting, training, referral, and employment of individual providers and prospective individual providers to recipients of public assistance or other low-income persons who would qualify for public assistance in the absence of such employment; and

(h) Cooperate with the department, area agencies on aging, and other federal, state, and local agencies to provide the services described and set forth in this section. If, in the course of carrying out its duties, the authority identifies concerns regarding the services being provided by an individual provider, the authority must notify the relevant area agency or department case manager regarding such concerns.

(2) In determining how best to carry out its duties, the authority must identify existing individual provider recruitment, training, and referral resources made available to consumers by other state and local public, private, and nonprofit agencies. The authority may coordinate with the agencies to provide a local presence for the authority and to provide consumers greater access to individual provider recruitment, training, and referral resources in a cost-effective manner. Using requests for proposals or similar processes, the authority may contract with the agencies to provide recruitment, training, and referral services if the authority determines the agencies can provide the services according to reasonable standards of performance determined by the authority. The authority must provide an opportunity for consumer participation in the determination of the standards.

NEW SECTION. **Sec. 5.** DEPARTMENT DUTIES. The department must perform criminal background checks for individual providers and prospective individual providers and ensure that the authority has ready access to any long-term care abuse and neglect registry used by the department.

NEW SECTION. **Sec. 6.** EMPLOYMENT RELATIONSHIP--CONSUMER RIGHTS. (1) Solely for the purposes of collective bargaining, the authority is the public employer, as defined in chapter 41.56 RCW, of individual providers, who are public employees, as defined in chapter 41.56 RCW, of the authority.

(2) Chapter 41.56 RCW governs the employment relationship between the authority and individual providers, except as otherwise expressly provided in this act and except as follows:

(a) The only unit appropriate for the purpose of collective bargaining under RCW 41.56.060 is a statewide unit of all individual providers;

(b) The showing of interest required to request an election under RCW 41.56.060 is ten percent of the unit, and any intervener seeking to appear on the ballot must make the same showing of interest;

(c) The mediation and interest arbitration provisions of RCW 41.56.430 through 41.56.470 and 41.56.480 apply;

(d) Individual providers do not have the right to strike; and

(e) Individual providers who are related to, or family members of, consumers or prospective consumers are not, for that reason, exempt from this act or chapter 41.56 RCW.

(3) Individual providers who are employees of the authority under subsection (1) of this section are not, for that reason, employees of the state for any purpose.
(4) Consumers and prospective consumers retain the right to select, hire, supervise the work of, and terminate any individual provider providing services to them. Consumers may elect to receive long-term in-home care services from individual providers who are not referred to them by the authority.
(5) In implementing and administering this act, neither the authority nor any of its contractors may reduce or increase the hours of service for any consumer below or above the amount determined to be necessary under any assessment prepared by the department or an area agency on aging.
(6)(a) The authority, the area agencies on aging, or their contractors under this act may not be held vicariously liable for the action or inaction of any individual provider or prospective individual provider, whether or not that individual provider or prospective individual provider was included on the authority's referral registry or referred to a consumer or prospective consumer.
(b) The members of the board are immune from any liability resulting from implementation of this act.
(7) Nothing in this section affects the state's responsibility with respect to the state payroll system or unemployment insurance for individual providers.

NEW SECTION. **Sec. 7.** POWERS. In carrying out its duties under this act, the authority may:
(1) Make and execute contracts and all other instruments necessary or convenient for the performance of its duties or exercise of its powers, including contracts with public and private agencies, organizations, corporations, and individuals to pay them for services rendered or furnished;
(2) Offer and provide recruitment, training, and referral services to providers of long-term in-home care services other than individual providers and prospective individual providers, for a fee to be determined by the authority;
(3) Issue rules under the administrative procedure act, chapter 34.05 RCW, as necessary for the purpose and policies of this act;
(4) Establish offices, employ and discharge employees, agents, and contractors as necessary, and prescribe their duties and powers and fix their compensation, incur expenses, and create such liabilities as are reasonable and proper for the administration of this act;
(5) Solicit and accept for use any grant of money, services, or property from the federal government, the state, or any political subdivision or agency thereof, including federal matching funds under Title XIX of the federal social security act, and do all things necessary to cooperate with the federal government, the state, or any political subdivision or agency thereof in making an application for any grant;
(6) Coordinate its activities and cooperate with similar agencies in other states;
(7) Establish technical advisory committees to assist the board;
(8) Keep records and engage in research and the gathering of relevant statistics;

(9) Acquire, hold, or dispose of real or personal property or any interest therein, and construct, lease, or otherwise provide facilities for the activities conducted under this chapter, provided that the authority may not exercise any power of eminent domain;
(10) Sue and be sued in its own name;
(11) Delegate to the appropriate persons the power to execute contracts and other instruments on its behalf and delegate any of its powers and duties if consistent with the purposes of this chapter; and
(12) Do other acts necessary or convenient to execute the powers expressly granted to it.

NEW SECTION. **Sec. 8.** PERFORMANCE REVIEW. (1) The joint legislative audit and review committee will conduct a performance review of the authority every two years and submit the review to the legislature and the governor. The first review will be submitted before December 1, 2006.
(2) The performance review will include an evaluation of the health, welfare, and satisfaction with services provided of the consumers receiving long-term in-home care services from individual providers under this act, including the degree to which all required services have been delivered, the degree to which consumers receiving services from individual providers have ultimately required additional or more intensive services, such as home health care, or have been placed in other residential settings or nursing homes, the promptness of response to consumer complaints, and any other issue the committee deems relevant.
(3) The performance review will provide an explanation of the full cost of individual provider services, including the administrative costs of the authority, unemployment compensation, social security and medicare payroll taxes paid by the department, and area agency on aging home care oversight costs.
(4) The performance review will make recommendations to the legislature and the governor for any amendments to this act that will further ensure the well-being of consumers and prospective consumers under this act, and the most efficient means of delivering required services. In addition, the first performance review will include findings and recommendations regarding the appropriateness of the authority's assumption of responsibility for verification of hours worked by individual providers, payment of individual providers, and other duties.

NEW SECTION. **Sec. 9.** FUNDING. (1) The governor must submit a request for funds necessary to administer this act and to implement any collective bargaining agreement entered into under section 6 of this act or for legislation necessary to implement any such agreement within ten days of the date on which the agreement is ratified or, if the legislature is not in session, within ten days after the next legislative session convenes. The legislature must approve or reject the submission of the request for funds as a whole. If the legislature rejects or fails to act on the submission, any such agreement will be reopened solely for the purpose of renegotiating the funds necessary to implement the agreement.

(2) When any increase in individual provider wages or benefits is negotiated or agreed to by the authority, no increase in wages or benefits negotiated or agreed to under this act will take effect unless and until, before its implementation, the department has determined that the increase is consistent with federal law and federal financial participation in the provision of services under Title XIX of the federal social security act.

(3) After the expiration date of any collective bargaining agreement entered into under section 6 of this act, all of the terms and conditions specified in any such agreement remain in effect until the effective date of a subsequent agreement, not to exceed one year from the expiration date stated in the agreement.

Sec. 10. RCW 74.39A.030 and 1995 1st sp.s. c 18 s 2 are each amended to read as follows:

(1) To the extent of available funding, the department shall expand cost-effective options for home and community services for consumers for whom the state participates in the cost of their care.

(2) In expanding home and community services, the department shall: (a) Take full advantage of federal funding available under Title XVIII and Title XIX of the federal social security act, including home health, adult day care, waiver options, and state plan services; and (b) be authorized to use funds available under its community options program entry system waiver granted under section 1915(c) of the federal social security act to expand the availability of in-home, adult residential care, adult family homes, enhanced adult residential care, and assisted living services. By June 30, 1997, the department shall undertake to reduce the nursing home medicaid census by at least one thousand six hundred by assisting individuals who would otherwise require nursing facility services to obtain services of their choice, including assisted living services, enhanced adult residential care, and other home and community services. If a resident, or his or her legal representative, objects to a discharge decision initiated by the department, the resident shall not be discharged if the resident has been assessed and determined to require nursing facility services. In contracting with nursing homes and boarding homes for enhanced adult residential care placements, the department shall not require, by contract or through other means, structural modifications to existing building construction.

(3)(a) The department shall by rule establish payment rates for home and community services that support the provision of cost-effective care. <u>In the event of any conflict between any such rule and a collective bargaining agreement entered into under sections 6 and 9 of this act, the collective bargaining agreement prevails.</u>

(b) The department may authorize an enhanced adult residential care rate for nursing homes that temporarily or permanently convert their bed use for the purpose of providing enhanced adult residential care under chapter 70.38 RCW, when the department determines that payment of an enhanced rate is cost-effective and necessary to foster expansion of contracted enhanced adult residential care services. As an incentive for nursing homes to permanently convert a portion of its

nursing home bed capacity for the purpose of providing enhanced adult residential care, the department may authorize a supplemental add-on to the enhanced adult residential care rate.

(c) The department may authorize a supplemental assisted living services rate for up to four years for facilities that convert from nursing home use and do not retain rights to the converted nursing home beds under chapter 70.38 RCW, if the department determines that payment of a supplemental rate is cost-effective and necessary to foster expansion of contracted assisted living services.

Sec. 11. RCW 74.39A.095 and 2000 c 87 s 5 are each amended to read as follows:

(1) In carrying out case management responsibilities established under RCW 74.39A.090 for consumers who are receiving services under the medicaid personal care, community options programs entry system or chore services program through an individual provider, each area agency on aging shall provide ((~~adequate~~)) oversight of the care being provided to consumers receiving services under this section((~~. Such oversight shall~~)) to the extent of available funding. Case management responsibilities incorporate this oversight, and include, but ((~~is~~)) are not limited to:

(a) Verification that ((~~the~~)) any individual provider who has not been referred to a consumer by the authority established under this act has met any training requirements established by the department;

(b) Verification of a sample of worker time sheets;

(c) ((~~Home visits or telephone contacts sufficient to ensure that the plan of care is being appropriately implemented~~)) Monitoring the consumer's plan of care to ensure that it adequately meets the needs of the consumer, through activities such as home visits, telephone contacts, and responses to information received by the area agency on aging indicating that a consumer may be experiencing problems relating to his or her home care;

(d) Reassessment and reauthorization of services;

(e) Monitoring of individual provider performance. If, in the course of its case management activities, the area agency on aging identifies concerns regarding the care being provided by an individual provider who was referred by the authority, the area agency on aging must notify the authority regarding its concerns; and

(f) Conducting criminal background checks or verifying that criminal background checks have been conducted for any individual provider who has not been referred to a consumer by the authority.

(2) The area agency on aging case manager shall work with each consumer to develop a plan of care under this section that identifies and ensures coordination of health and long-term care services that meet the consumer's needs. In developing the plan, they shall utilize, and modify as needed, any comprehensive community service plan developed by the department as provided in RCW 74.39A.040. The plan of care shall include, at a minimum:

(a) The name and telephone number of the consumer's area agency on aging case manager, and a statement as to how the case manager can be contacted about any concerns related to the consumer's well-being or the adequacy of care provided;
(b) The name and telephone numbers of the consumer's primary health care provider, and other health or long-term care providers with whom the consumer has frequent contacts;
(c) A clear description of the roles and responsibilities of the area agency on aging case manager and the consumer receiving services under this section;
(d) The duties and tasks to be performed by the area agency on aging case manager and the consumer receiving services under this section;
(e) The type of in-home services authorized, and the number of hours of services to be provided;
(f) The terms of compensation of the individual provider;
(g) A statement that the individual provider has the ability and willingness to carry out his or her responsibilities relative to the plan of care; and
(h)(i) Except as provided in (h)(ii) of this subsection, a clear statement indicating that a consumer receiving services under this section has the right to waive any of the case management services offered by the area agency on aging under this section, and a clear indication of whether the consumer has, in fact, waived any of these services.
(ii) The consumer's right to waive case management services does not include the right to waive reassessment or reauthorization of services, or verification that services are being provided in accordance with the plan of care.
(3) Each area agency on aging shall retain a record of each waiver of services included in a plan of care under this section.
(4) Each consumer has the right to direct and participate in the development of their plan of care to the maximum practicable extent of their abilities and desires, and to be provided with the time and support necessary to facilitate that participation.
(5) A copy of the plan of care must be distributed to the consumer's primary care provider, individual provider, and other relevant providers with whom the consumer has frequent contact, as authorized by the consumer.
(6) The consumer's plan of care shall be an attachment to the contract between the department, or their designee, and the individual provider.
(7) If the department or area agency on aging case manager finds that an individual provider's inadequate performance or inability to deliver quality care is jeopardizing the health, safety, or well-being of a consumer receiving service under this section, the department or the area agency on aging may take action to terminate the contract between the department and the individual provider. If the department or the area agency on aging has a reasonable, good faith belief that the health, safety, or well-being of a consumer is in imminent jeopardy, the department or area agency on aging may

summarily suspend the contract pending a fair hearing. The consumer may request a fair hearing to contest the planned action of the case manager, as provided in chapter 34.05 RCW. When the department or area agency on aging terminates or summarily suspends a contract under this subsection, it must provide oral and written notice of the action taken to the authority. The department may by rule adopt guidelines for implementing this subsection.

(8) The department or area agency on aging may reject a request by a consumer receiving services under this section to have a family member or other person serve as his or her individual provider if the case manager has a reasonable, good faith belief that the family member or other person will be unable to appropriately meet the care needs of the consumer. The consumer may request a fair hearing to contest the decision of the case manager, as provided in chapter 34.05 RCW. The department may by rule adopt guidelines for implementing this subsection.

NEW SECTION. **Sec. 12.** In addition to the entities listed in RCW 41.56.020, this chapter applies to individual providers under sections 6 and 9 of this act.

NEW SECTION. **Sec. 13.** The authority established by this act is not subject to regulation for purposes of this chapter.

NEW SECTION. **Sec. 14.** The department must seek approval from the federal health care financing administration of any amendments to the existing state plan or waivers necessary to ensure federal financial participation in the provision of services to consumers under Title XIX of the federal social security act.

NEW SECTION. **Sec. 15.** CODIFICATION. Sections 1 through 9 of this act are each added to chapter 74.39A RCW. Section 12 of this act is added to chapter 41.56 RCW. Section 13 of this act is added to chapter 70.127 RCW. Section 14 of this act is added to chapter 74.09 RCW.

NEW SECTION. **Sec. 16.** CAPTIONS. Captions used in this act are not any part of the law.

NEW SECTION. **Sec. 17.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

Originally filed in Office of Secretary of State April 17, 2001.
Approved by the People of the state of Washington in the General Election on November 6, 2001.

APPENDIX 4: HCQA OUTCOME AND OUTPUT MEASURES (2004)

2004 Outcome Measures	HCQA Performance
1. Implementation of Referral Registry to begin July 2005: • The Referral Registry will be available statewide by July 2006; • The annual baseline number of providers recruited, screened, and added to the registry, will be determined by July 2006 and will increase by 15 percent in the first year of full operation, and increase annually thereafter for the next three years.	**HCQA substantially met this target.** • Four RWRCs opened in January 2005, six months ahead of schedule. • Eleven RWRCs were operating by July 2006 and all sites were open by September 2006. • 1,329 persons had been enrolled in the registry as of July 2006, of whom 1008 were active. These numbers provide a baseline for future enrollment targets. • Individual providers (IPs) and consumers who were no longer active were removed for a variety of reasons including being employed and no longer available, removal by request, and failing to update registry information.
2. Statewide, at least 75 percent of consumer-driven referral requests will result in a match. Of those, at least 30 percent will result in employment by July 2006.	**HCQA substantially met this target.** • 99 percent of consumer driven referrals result in a match. (A match is a list of prospective IPs that matches the consumer's needs and preferences.) • 34 percent of referral requests resulted in employment from 2/2005-2/2006. • 27 percent of referral requests resulted in employment from 2/2006-7/2006. This drop coincided with the opening of 7 new referral sites between 1/06 and 6/06. HCQA states that employment numbers fluctuate greatly when new sites open.

2004 Outcome Measures	HCQA Performance
3. At least 50 percent of providers will receive safety training by July 2005, and will increase by ten percent by July 2006 and annually thereafter for the next three years.	HCQA reports 13,418 IPs received safety training between December 2004 and July 2006, and 16,809 had been trained by September 2006. HCQA estimates that approximately 5,000 remain to be trained by December 2006. **JLARC cannot determine whether HCQA met the July 2005 target.** • JLARC has neither reliable numbers of IPs in July 2005, nor numbers of the online and self-study students who had completed the course at that time. • 1,137 persons taking safety training in the classroom had completed the course by July 2005, but most of the IPs hired by consumers prior to July 2005 have taken the course online or through self study books. **JLARC cannot determine whether the July 2006 goal was met.** • Of the approximately 32,500 IPs who provide at least one day of paid in-home care in a year, there are approximately 23,500 IPs working in any given month. • Because the identities of the IPs working in a given month change, it is not possible to say how many of those actually working in a given month had completed safety training. • In addition, some IPs who were trained may have quit working as an IP, and some will still be within their 120 day training period. However, by July 2006, 41 percent of the total number of those working in a year and about 58 percent of the total number of those working in a given month had completed safety training. By September 2006, the number trained represented approximately 72 percent of the number working in any given month.
4. 100 percent of complaints/concerns are responded to within one business day.	HCQA received 17 complaints and responded to 100 percent of complaints within one business day, **meeting this target**.
5. At least 80 percent of consumers who use the referral registry are satisfied with services as determined by an annual survey.	**JLARC cannot determine whether HCQA met this target.** • HCQA contacts each consumer who has hired an IP through the referral registry at 5, 30, and 90 days after employment. HCQA asks the consumer to rate his or her satisfaction with the registry on a scale of 1-5, where 5 is very satisfied. HCQA reports an overall rating of 4.67 out of 5. However, only about 30 percent of referrals result in employment, so JLARC cannot state that this rating represents 80 percent of the consumers using the registry. • HCQA is also surveying consumers, but the consumer survey was not yet complete at the time of this report.

2004 Outcome Measures	HCQA Performance
6. Reduce the percent of consumers who use the referral registry who have gone without a provider for three days or more by 10 percent between July 2005 and July 2006.	In 2003, before the registry was created, the Consumer survey indicated that 31 percent of consumers and 46 percent of family members indicated that the consumer had gone without a provider for more than three days. Because the consumer survey was not yet complete at the time of this report, **JLARC cannot determine whether HCQA met this target.**
7. Providers who care for someone other than a family member will experience an increased length of employment as determined by an annual survey.	**Baseline information** from the 2006 IP survey indicates the following total time that non-family providers had "done this work" as: 0-6 months = 31% 7-12 months = 31% Over 12 months = 38%
8. Baseline information on various cost efficiencies will be gathered during FY 2006. • RWRC operating costs • Cost ratio of consumers and providers using the Referral Registry	Total Costs: **FY03-FY06 $1,298,636.60.** (Annual amounts are under output measure # 11, below.) This figure includes significant one-time costs (the feasibility study and software development). Because RWRCs have been available statewide for less than one month, **it is too early to identify cost efficiencies**. Establishing cost ratios now would not fairly distribute start-up costs across all centers. Establishing **baseline** operating cost ratios costs will be important and more accurate when all RWRCs have some operating history.

2004 Output Measures	2006 Result
1. Number of IPs on the Referral Registry	• 1,329 total persons have been enrolled. • 1,008 current active (July 2006)
2. Number of consumers who use the Referral Registry	• 684
3. Number of Referral Requests	• 1384
4. Number of IPs employed following a referral	• 373
5. Number of matches made between consumers and IPs	• 7433
6. Number of consumers and IPs served by Referral Registry sites	• 8289
7. Number of training sessions held	2004 = 6 2005 = 65 2006 = 69 (projected) **Total = 140 (projected through 2006)**
8. Number of providers attending safety training	**Classroom:** **Online Total = 2,910** 2004 = 335 **Self Study Total = 8,742** 2005 = 1114 2006 = 317 **July 2006 Total = 12,418** **Total = 1766** **September 2006 Total = 16,809**
9. Number of complaints received	• RWRCs received 7 • HCQA headquarters received 10
10. Number of providers who are satisfied with HCQA services	**2006 IP telephone survey responses to this question were too low to be statistically significant**.
11. Dollar amount (costs) of Referral Registry	FY 2003 = $0.00 FY 2004 = $96,721.00 FY 2005 = $232,300.60 FY 2005 RR Grant = $235,475.00 FY 2006 = $175,361.00 FY 2006 RR Grant = $558,779.00 **Total = $1,298,636.60**

APPENDIX 5: THE COMPONENTS OF THE FULL COST ESTIMATE OF INDIVIDUAL PROVIDERS AND DATA CONFIDENCE

The full cost estimate of individual provider (IP) services developed by JLARC requires a lengthy, detailed, complex model. The spreadsheet-based model has many components, with detailed data (sub-components) for each component.

Figure 9 provides additional summary detail in those components for both IPs and agency providers, including:

- **Cost Component**: A summary area. Within each component, additional sub-components are included in the spreadsheet model
- **Percent of Total per Hour**: This is the total explained by each cost component.
- **Cumulative Percent**: This is the cumulative amount explained as each component is added to the previous component.
- **Confidence in Data Reliability**: Each estimate is based on different data sources. This is an estimate of how confident JLARC is of the reliability of those data sources.

Figure 9 – Summary Detail

Individual Providers				Agency Providers		
Cost Component	**Percent of Total per Hour**	**Cumulative Percent**	**Confidence in Data Reliability**	**Percent of Total per Hour**	**Cumulative Percent**	**Confidence in Data Reliability**
Base Cost per Hour	87.95%	87.95%	High. Based on collective bargaining agreement and standard tax rates.	90.30%	90.30%	High. Based on actual rate.
Health Benefit Cost/Hour	7.77%	95.72%	High. Based on DSHS Financial Services Administration data and checked against Office of Financial Management (OFM) and Social Services Payment System.	8.15%	98.45%	High. Based on actual weighted average for May 2006.
HCQA	0.87%	96.59%	High. Based on allotment including federal match and grants.	N/A	N/A	N/A
SSPS Variable Costs	0.04%	96.63%	High. Based on monthly cost.	0.04%	98.48%	High. Based on monthly cost.
Provider Training	0.82%	97.44%	Medium High. Based on Aging and Disability Services Administration (ADSA) reported expenditures for 2005 and 2006, inflated to 2007.	0.83%	99.32%	Medium High. Based on ADSA reported expenditures for 2005 and 2006, inflated to 2007.
OFM Collective Bargaining and Arbitration	0.02%	97.47%	Medium High. Based on budget documents and checked by OFM.	N/A	N/A	N/A
Background Checks	0.02%	97.49%	Medium. Based on fully loaded cost per check. If any costs omitted they are omitted both for IPs and APs.	0.02%	99.34%	Medium. Based on fully loaded cost per check. If any costs omitted, they are omitted both for IPs and APs.
Remaining State Administration and Overhead	2.51%	100.00%	Medium. Based on agency-reported expenditures and cost allocation methods developed for this study.	0.66%	100.00%	Medium. Based on agency-reported expenditures and cost allocation methods developed for this study.

Source: JLARC.