Strange Questions for the Home Health Agency Attorney

By Robert N. Swidler

Health care attorneys who represent a mix of providers will find their home health agency (HHA) clients generate some of the oddest, most challenging patient care-related questions. The change in the locus of care from an institutional setting, which is more or less under the control of the provider, to a patient's home has far-reaching implications. Home health nurses and aides witness conduct and circumstances that institutional or office staff would be unlikely to see. And home health staff are more apt to be drawn into personal and business relationships that rarely ensnare hospital or physician office staff.

To be sure, experienced home health care agency administrators and care staff are familiar with that setting, and rarely need to seek legal counsel's help. But when they do, their questions can be quite strange.

This article provides a few examples of the strange questions that may be posed by home health agency administrators or staff to the HHA's counsel, and guidance in addressing those questions.

It is assumed for this article the client is a Medicare-participating "home health agency" under the Centers for Medicare and Medicaid Services (CMS) regulations subject to the conditions of participation in 42 C.F.R. Part 484—Home Health Services, and also a "certified home health agency" (CHHA) as defined by NYS Public Health Law § 3602.3 subject to the minimum standards in 10 N.Y.C.R.R. Part 763.

Having noted that, few of these questions can be answered by reference to regulatory standards.

1. The Love Affair

Q ***We just learned one of the home health aides has become romantically involved with the patient's adult son, who lives with the patient. They are seeing each other after work. In fact, we heard she plans to move into the patient's home. Can we let her do that? Do we have to transfer the aide from caring for this patient, or more drastically, terminate her employment?***

A Nothing in the CMS or DOH home care regulations directly prohibit a home health aide from entering into a romantic or sexual relationship with a patient's family member—or for that matter, even with the patient. Moreover, nothing in those sources expressly prohibit an aide from moving into the patient's home. So the HHA is not compelled by regulation to terminate the aide's care of the patient or the aide's employment.

If the caregiver were a licensed professional like a registered nurse or physical therapist, professional conduct principles might be implicated—especially if the relationship were with the patient.[1] If so, the HHA would also face exposure since CMS regulations provide "the HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA."[2] But the home health aide, while a "paraprofessional," is not a licensed professional subject to Education Department sanctions for unprofessional conduct.

Nonetheless, it would be legally and ethically perilous to permit an aide to care for a patient while romantically involved with a family member, and even worse for the aide to move into the home.

For one thing, it would become difficult to reliably distinguish the aide's reimbursable care-giving time from non-reimbursable personal time. That same blurring of work time and personal time creates exposure to the HHA for labor law violations. Also, if the aide moved into the home, the payor (including a governmental payor) could take the position the care constitutes non-reimburseable family care-giving. The situation therefore invites either actual fraud, abuse or noncompliance, accusations of fraud, abuse or noncompliance, or at least payment disputes.

Even more problematic, the aide's emotional involvement with the family would jeopardize her care-giving objectivity, and compromise her loyalty to her employer. Thus it might lead her to provide a level of care, or extra services, that another objective aide would not provide. The personal relationship could also lead the aide to expect or demand gifts or favors that another aide would not seek. Indeed, the relationship would likely inhibit a patient from asserting complaints or grievances relating to the aide's conduct or care.

Finally, if the patient were ever harmed as a result of negligent care by the aide, one can easily envision the plaintiff's attorney highlighting the aide's personal relationship with a family member, and contending the HHA violated some standard of care by permitting the aide to continue to serve the patient. Whether the argument is logical or not, it provides the opportunity for a salacious presentation that could harm the HHA's defense.

For these and other reasons, the HHA should not allow the aide to continue to serve the patient. It would also be helpful for the HHA to have a policy that states that an aide cannot continue to serve a patient if he or she is romantically involved with a family member. The HHA, with a clear statement in the employee code of conduct or handbook prohibiting such conduct, will be on firmer ground when responding to this situation and less likely to face a complaint by the employee to a regulatory agency, or a lawsuit.

The HHA should also provide materials upon admission to patients and the family members who live with them that explain the need to preserve boundaries in the relationship. Such materials may not prevent a romantic relationship, but it should reduce the risk of a complaint by the patient in the event the HHA feels compelled to transfer the patient's care to another aide.

Finally, the HHA needs to consider whether it is sufficient to terminate the aide's care of the patient, or whether it should terminate the aide's employment. Obviously the terms of employment policies and collective bargaining agreements might bear on this decision and on the process that must be afforded in implementing it. But all other things being equal, it appears to this author that the reassignment of the aide from the care of the patient is an appropriate response to a romantic relationship with a family member.

2. The Drug-Dealing Son

***Q** Our home health aide told us she has seen the patient's adult son dealing drugs in an adjacent room on more than one occasion. Are we required, or even permitted to report this illegal activity to the police? What if the patient is pleading with us not to do so? Also, now the aide is reluctant to return to the home—especially if we report the illegal activity. Can we stop providing services as a result of this?*

A Neither the aide, nor the RN supervising the aide, nor the HHA have a legal obligation to report this criminal conduct to the police. While agencies, RNs or aides are required to report certain offenses, such as child abuse[3] and in some cases health care fraud,[4] they have no general responsibility to act as police informants.

As to whether the HHA or aide are *permitted* to report the conduct to a law-enforcement HHA, it is clear they can do so. To be sure, the HHA and aide are obligated under HIPAA[5] and DOH regulations[6] to maintain the confidentiality of patient health information. But their knowledge of drug-dealing by the son is not patient health information by any reasonable construction of those requirements.[7]

Interestingly, HIPAA specifically authorizes a covered entity to disclose to law enforcement personnel protected health information that the entity "believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity."[8] That exception would not be available here since the conduct is not occurring on the premises of the covered entity. While the policy rationale for the exception seems applicable to this case, it is likely the drafters of the exception gave little consideration to criminal conduct in the home care setting. In any event, there is no need to rely upon the exception in this case; again, the information about the son's drug dealing is not protected health information (unlike, for example, illegal drug use by a patient, which would be protected health information).

Accordingly, the home health agency is free to exercise its own judgment regarding whether to report the conduct or not. A key factor that weighs in favor of reporting is that drug dealing on the premises has a high potential to attract violence, and therefore endangers both the aide and the patient. If reporting were apt to stop that conduct, it would be an attractive option. Simple civic virtue also weighs in favor of reporting this offense.

But the countervailing considerations are obvious and significant: Reporting could itself expose the aide, or possibly the patient, to retaliatory violence. Moreover, if the patient knew and tolerated her son's activity, or was complicit in the activity, reporting would likely destroy the therapeutic relationship.

Another option is to notify the patient, or perhaps the son directly, that unless the activity ceases, the HHA will withdraw from the case. Significantly, DOH regulations strictly limit the ability of a home health agency to discharge a patient.[9] Indeed, home health agencies are far more constrained in this regard than are other health care providers, such as physicians and hospitals. But this situation does seem to fall solidly within one of the permissible bases for discharge: DOH regulation 10 N.Y.C.R.R. § 763.5(h) provides that discharge is appropriate, among other instances, when "(2) conditions in the home imminently threaten the safety of the personnel providing services or jeopardize the HHA's ability to provide care as described in [§ 763.5(b)(2)(ii) and (iii)]." The referenced clauses then provides an HHA is not required to admit a patient (and therefore can discharge a patient):

> (ii) when conditions are known to exist in or around the home that would imminently threaten the safety of personnel, including but not limited to . . . (b) presence of weapons, criminal activity or contraband material which creates in personnel

a reasonable concern for personal safety.

So in this case the HHA would have a clear legal basis to discharge the patient if the activity persists. But should it do so? Taking that step would penalize, and maybe even jeopardize, the innocent patient for the transgressions of her son. While this raises more of an ethical question than a legal one, it is suggested here the HHA cannot ask its aides to risk their lives to serve the HHA's patients. The discharge could be made with a referral to adult protective services, which may be in a better position to address the broader circumstances in this home.

There is no simple or one-size-fits-all answer to the case of the drug-dealing son, and the specific facts of the case can be very important. Evidence of a teenager selling one marijuana cigarette to a friend warrants a different response than evidence of routine transactions involving large amounts of cocaine and larger sums of cash. Certainly evidence of violent criminal conduct by a family member, such as rape or murder, would drive a decision to call the police.

3. The Accusation of Theft

Q*A patient phoned us to complain she is missing valuable jewelry. She suspects our aide stole it. The aide has worked for us a long time and we think she is honest and trustworthy. We interviewed her and she denied taking anything and seemed quite credible. We think either the patient misplaced the jewelry, or someone else stole it. What are our further obligations, if any?*

Unfortunately, most home health agencies are familiar with accusations of theft and experienced in responding to them. Such accusations are common, in part because thefts by home health agency staff do occur. But they are common also because the home care patient population includes elderly and infirm persons who may be forgetful, who may misplace items, and who may be suspicious of strangers in their homes. Determining the truth when confronted with one party's accusation and another's denial is exceedingly difficult in any setting, including this one.

It should be noted at the outset that home health agencies are required to take steps to prevent thefts by aides. Aide training programs must include components on respect for patient property.[10] Also, home health agencies are required to conduct criminal history background checks on home health aides and other caregiving staff,[11] in addition to the usual interviews, reference checks and Medicare/Medicaid exclusion checking. Finally, agencies will typically offer staff guidance on ways to reduce the risk of accusations of theft.[12]

When an accusation occurs, it must be regarded from a regulatory standpoint as a patient complaint or grievance. Agencies are required to develop and implement a patient complaint procedure, which must include documenting the receipt, investigation and resolution of complaints, reviewing and responding to complaints, describing the investigation and findings and decisions, and providing an appeals process.[13] The patient must also be informed of his or her right to complain about "lack of respect for property" to the DOH Office of Health System Management.[14] And as discussed further below, the patient should also be informed of the right to report the alleged theft to the police.

So in this instance the HHA must follow that procedure by, among other things, investigating the allegation of theft. Ordinarily such investigation would include an interview with the patient, with the aide, and with any other relevant witnesses.

If the HHA finds evidence that the aide committed the theft, several issues arise. First, the HHA needs to decide what to do about the aide. While the HHA is under no regulatory obligation to terminate the aide's employment, it would probably seek to do so, absent unusual extenuating or mitigating circumstances. Such an employee is a threat to patients and ultimately to the HHA. Any such termination would have to be pursued in accordance with the process prescribed by the employment handbook or collective bargaining agreement.

Second, the HHA needs to consider what reporting obligations it has, if any. Currently, home health agencies have no obligation to report thefts or incidents to any state agency. A bill introduced in the NYS Assembly by Health Chair Dick Gottfriend would require incident reporting by home care services agencies, but the list of reportable incidents would not include theft.[15]

However, the HHA could, and probably should, report its evidence of a crime to the police. Alternatively, or additionally, it could encourage the patient to report the crime to the police. This is different from the case described previously where an aide witnessed criminal conduct by a patient's son: In this instance the HHA placed the aide in the patient's home, and should assume some responsibility for remedying the problem by making the report.

Which raises the last issue—compensating the patient. Here again, there is no regulatory obligation to compensate the patient. The question of civil legal liability is a closer one: The HHA is unlikely to have vicarious liability for the employee's theft under the doctrine of *respondeat superior*. As the Court of Appeals explained,

> The doctrine of respondeat superior renders an employer vicariously liable for torts committed by an employee acting within the scope of the employment. Pursuant to this doctrine, the employer may be liable when the employee acts negligently or intentionally, so long as the tortious conduct is generally foreseeable and a natural incident of the employment (citation omitted). If, however, an employee for purposes of his own departs from the line of his duty so that for the time being his acts constitute an abandonment of his service, the master is not liable.

RJC Realty v. Republic Ins. Co., 2 N.Y.3d 158 (2004), *citing Judith M. v. Sisters of Charity Hosp.*, 93 N.Y.2d 932 (1999). However, a plaintiff's lawyer could try to circumvent that barrier by asserting a claim based on negligent hiring, training or supervision. In any event, the HHA may feel an ethical obligation, or at least public-relations interest, in compensating the patient.

In any event, in the hypothetical above, the HHA firmly concluded the aide is not a thief. In that instance, the HHA has no obligation to, and should not, terminate the aide, report the theft to the police or any other HHA, or compensate the patient. It might, however, still encourage the patient to report the matter to the police. That way the police will conduct their own professional investigation, which will hopefully confirm the HHA's findings and put the matter to rest. It may also be a precondition to the patient's ability to file an insurance claim on the missing items.

4. Smoking in Bed

Q ***The aide is telling us she sees evidence the patient smokes in bed when the aide is not there: cigarette butts on the floor, even burn holes in his bedspread. It's clear the patient has fallen asleep while smoking several times. The aide has counseled the patient not to do this but he persists. The patient lives in an apartment building and the aide is quite fearful the patient will cause a fire, and so are we. What can we do?***

A Agencies and home health aides understand they cannot be overly judgmental; that often they must turn a blind eye to patient lifestyles, conduct and choices that are disturbing to them. But this conduct is beyond the pale: It poses a significant danger to the lives of many people.

Once again, regulations provide no directly applicable mandates, standards or guidance. Even so, the HHA would be well advised to become more aggressive in stopping this conduct, primarily to protect its patient and the other building tenants, but also to protect itself: If the building were to burn down with loss of life, and it appeared the HHA, while aware of the danger, limited itself to counseling the patient, the legal, financial, public relations and emotional consequences could be terrible.

Initially it could insist the patient enter into a Patient Conduct Contract obligating the patient not to smoke in bed. The ability of agencies to compel patients to enter into such contracts, and the right of an HHA to discharge a patient based on breach of such contract, is a complex topic beyond the scope of this article. But the fact is such contracts often resolve HHA-patient tensions by clarifying and formalizing mutual expectations clearly.

The HHA might also assist the patient in installing technological safeguards to reduce the risk, e.g., smoke detectors, safer cigarettes, fire-resistant bedspreads and floor coverings, and so on.

But if the patient's dangerous conduct continues, the HHA could and should notify the fire department and/or police. While HIPAA obligates the HHA to protect the confidentiality of patient health information, this does not appear to be patient health information (although that conclusion is subject to debate). In any event, HIPAA allows a covered entity to make a disclosure the entity regards "is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public."[16] A disclosure to the fire department in this situation would fit that exception.

5. Sexual Harassment

Q ***The patient, a 60-year-old man with capacity, tends to make lewd comments to aides, expose himself inappropriately, and ask for sexual activity. More than one aide has refused to return due to this conduct. We warned the patient, but his conduct continues. Any advice?***

A Initially, the home health agency should try to resolve this case the way it was advised to resolve the last case: by insisting that the patient enter into a Patient Conduct Contract. The contract should define the problematic conduct, prohibit the patient from engaging in it, and provide for discharge in the event of the patient's breach of the contract. It should also include basic procedural protections for the patient, such as the right to notice of an alleged breach, and the opportunity to respond and, if appropriate, correct the breach before being discharged.

The Patient Conduct Contract should be viewed not as a way to provide legal support for an eventual discharge, but as a way to try to improve conduct to avert a discharge. Indeed, if the repugnant conduct persists, it is

not clear the HHA can rely solely on the breach of contract as its basis for discharge; it may still need to identify an independent regulatory basis for the discharge.

That may not be easy. The regulation, 10 N.Y.C.R.R. § 763.5(b), permits an HHA to discharge a patient in these circumstances (and others not relevant here):

> (ii) when conditions are known to exist in or around the home that would imminently threaten the safety of personnel, including but not limited to:
>
> (a) actual or likely physical assault which the individual threatening such assault has the ability to carry out
>
> (b) presence of weapons, criminal activity or contraband material which creates in personnel a reasonable concern for personal safety; or
>
> (c) continuing severe verbal threats which the individual making the threats has the ability to carry out and which create in personnel a reasonable concern for personal safety;
>
> (iii) when the HHA has valid reason to believe that HHA personnel will be subjected to continuing and severe verbal abuse which will jeopardize the HHA's ability to secure sufficient personnel resources or to provide care that meets the needs of the patient; . . .

An argument could be made that sexual harassment satisfies one or more of these standards. Notably, the introductory clause makes it clear a discharge is permitted in cases "including but not limited to" the ones described. Moreover such harassment may constitute the "criminal activity" referred to in (ii)(b). Still, there is no clear unequivocal clause that allows an HHA to discharge a patient for sexually harassing aides. There ought to be one.

In any event, the HHA and aide should recognize their caregiver relationship with the patient does not preclude them from making a criminal complaint, or filing a civil lawsuit, against the patient. Of course, that would be quite drastic and would destroy the therapeutic relationship; but it may suffice for the HHA and aide to simply warn the patient that they intend to take such step unless his abuse stops. In the case described here, they probably should do so.

Indeed, the HHA faces legal liability under Title VII of the Civil Rights Act of 1964 if it knowingly allows its employees to be exposed to sexual harassment, even by non-employees like customers—or patients. Such conduct might give rise to a "hostile-work-environment"-type claim under EEOC guidelines on sexual harassment.[17] As a result, the HHA may find itself in one of the many "damned-if -you-do-damned-if-you don't" situations in health care: The HHA could face liability if it discharges the patient (for violating the discharge regulations) and could face liability if it sends aides into a hostile work environment.

Amplifying the problem for the HHA, a lawyer for the patient might contend the patient's propensity to sexually harass aides is an uncontrollable mental disorder and a "disability" within the meaning of the Americans with Disability Act, and discharging the patient on account of that disability would constitute discrimination in public accommodations on the basis of disability in violation of Title III of the ADA.[18] The HHA's counsel should not find it too difficult to defeat that legally weak claim, but HHA counsel also should not be too surprised to encounter it: The author has encountered that argument by lawyers to counter steps to discharge patients for similarly offensive conduct.

With no easy answer at hand, the HHA needs to do what it can to control this patient's conduct. One effective, albeit expensive solution, would be to send a security guard, or simply an escort, along with the aide. Another interesting idea is to seek the patient's agreement to videotape the provision of care, which might inhibit the offensive conduct.

6. The Bigoted Patient

***Q** A new patient, an 80-year-old woman, insists we assign her only white aides, and says she will refuse care by any non-white aide. We could accommodate her, but we think it would be wrong to agree to do so, and we question whether we are even allowed to accommodate her. Are we?*

A This is easy to answer from a legal standpoint: The home health agency needs to just say "No." The HHA is prohibited by federal[19] and state[20] law from discriminating on the basis of race in the terms and conditions of employment. That prohibition encompasses race discrimination in the assignment of aides to patients. It is paramount to any right the patient may have in decisions about his or her care.

In fact, the Federal Equal Employment Opportunity Commission (EEOC), in revised guidelines on race discrimination issued in 2006, described a similar case as an example of prohibited race discrimination:

> **EXAMPLE 6—YIELDING TO CUSTOMERS' RACIAL PREFERENCES**
> The employer is a home care agency that hires out aides to provide personal, in-home assistance to elderly, disabled, and ill persons. It has a mostly White clientele. Many of its clients have expressed a desire for White home care aides. Gladys, an African American aide at another agency, applies for a job opening with the employer because it pays more than her current job. She is well qualified and has received excellent performance reviews in her current position. The employer wants to hire Gladys but ultimately decides not to because it believes its clientele would not be comfortable with an African American aide. The employer has violated Title VII because customer preference is not a defense to race discrimination.[21]

Although the example posits a discriminatory impact on a specific employee, the EEOC or Human Rights Division, given evidence of overt race discrimination in the assignment of aides, would not find it difficult to find such a link.

Accordingly, the home health agency that accedes this patient's request would face liability in a civil rights lawsuit by the reassigned or unassigned aides, as well as regulatory sanctions from the EEOC and New York State Division of Human Rights.

Accordingly, the HHA needs to decline the request, even if it has the staff to accommodate the request, and even if the patient refuses admission for that reason.

A closer question, though outside the scope of the case described, is whether the HHA could accommodate a request by this patient for a female aide, or honor her rejection of a male aide. The civil rights laws cited above also prohibit discrimination on the basis of sex. However, the laws also include the exception for "bona fide occupational qualifications" (BFOQ). As Title VII states:

> Notwithstanding any other provision of this subchapter . . . it shall not be an unlawful practice for an employer to hire and employ employees . . . on the basis of his religion, sex or national origin in those certain instances where religion, sex or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise.[22]

The question of whether discrimination based on sex is permissible as a BFOQ in employment that involves intimate contact between employees and others, like hospitals, bathrooms and prisons, is the subject of several court decisions.[23] Courts have tended to look at whether the discrimination is necessary to reduce the danger of physical and sexual assault, the invasion of privacy or assault to modesty, and the frustration of rehabilitative goals.[24]

For now, until the evolving law settles and points to a different result, it would seem this home health agency could honor a reasonable request by this patient for a female aide based on the BFOQ exception, with low risk of civil or regulatory liability.

7. Elder Neglect

***Q** Patient, a dual Medicare/Medicaid client, is largely confined to her bed, and lives with an adult daughter who is clearly dysfunctional herself. There is almost no food in the house, and the place is never cleaned and is itself a health hazard. We sought the daughter's help with some basic but critical tasks, but she is uncooperative. At what point is the daughter's conduct considered "elder abuse" and are we required to report it, and to whom?*

A Elder abuse and neglect is widely recognized as a serious problem both nationally and in this state. However, few New York state laws or regulations address it specifically. In fact, there is no specific definition of "elder abuse" in New York law; instead it is encompassed by the more general definitions of abuse in N.Y. Social Services Law § 473, which relates to the adult protective services operated by local social services districts.

Section 473 separately defines "physical abuse," "sexual abuse," "emotional abuse," "active neglect," "passive neglect," "self-neglect," and financial exploitation." The categories relevant to address this question, "active neglect," and "passive neglect," are defined as follows:

> (d) "Active neglect" means willful failure by the caregiver to fulfill the caretaking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health related services.

(e) "Passive neglect" means non-willful failure of a caregiver to fulfill caretaking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment or denial of food or health related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services.

It is not clear in this case whether the daughter is a "caregiver," and therefore responsible for the active or passive neglect of her mother. That would be a key issue if the question was the daughter's criminal or civil liability. But from the HHA's standpoint, it is not necessary to resolve the daughter's caregiver status for it to answer the question about its reporting obligation.

The HHA does not have an obligation to make a report of third-party "elder abuse" to any agency. Unlike many other states, New York does not have a law that mandates professionals or other caregivers to report elder abuse in the community, akin to the child abuse reporting law.[25] This state's main foray into mandating elder abuse reporting is to require certain persons to report the abuse or neglect of residential care facility residents.[26]

But while HHAs and aides are not legally required to report abuse or neglect of elderly patients, they certainly can do so, and should do so when warranted. Specifically, a report should be made to the Adult Protective Services office of the local social services district if the HHA or aide identifies an "endangered adult," a category that would include an adult who may be the subject of abuse or neglect. Persons making such reports are protected from liability for doing so.[27]

Another operational challenge with legal implications in this case is developing a lawful package of services for this patient. Medicaid will cover housekeeping and laundry services and home-delivered meals for people who require such support services based on a medical need. However Medicaid, in reviewing the care plan, will expect family members to provide support to the extent of their ability. This appears to be a case in which the daughter has proven herself unable to much provide much support, but it may be a challenge to convince Medicaid she is truly unable, and not just unwilling. Moreover, it may prove even more difficult to find a way to provide such home health care assistance to the client, without taking on the housekeeping, laundry, home-delivered meals, and other tasks for the daughter as well—which would raise Medicaid fraud and abuse concerns.

8. The Off-Hours Errands

Q ***We learned the patient is paying our home health aide some money "on the side" to run private errands for the patient after hours: e.g., to buy lottery tickets, cash checks, pick up a visiting relative at the bus station. Are there any legal concerns about her doing that?***

A No law or regulation precludes the HHA from permitting its staff to "moonlight;" i.e., to take on assignments from the patient after hours. But it is a practice fraught with risk for the patient, the employee and the HHA, and it should be prohibited or discouraged by HHA as a matter of employment policy.

The concerns here are similar to those raised by the romantic relationship in the first example: It creates these risks, among others:

- The aide could easily drift into providing such private errands, or discussing or engaging in follow-up activities relating to such errands, during a reimbursable home health aide visit. If so, the HHA could be led to submit improper bills Medicare, Medicaid or other payors, exposing it to charges of fraud or abuse.
- Conversely, the Labor Department and/or Tax Department could regard the aide's after-hours work for the same patient as overtime, subjecting the HHA to liability for overtime pay, withholding, and regulatory violations.
- If the aide or patient were injured, or their property harmed, in the course of such activity, the HHA would be exposed to uninsured claims against it.

Probably the greatest concern is that permitting such activity invites either the aide or the patient to pressure the other party to enter into such private arrangements. A clear prohibition at the start will head off the potential for exploitation.[28]

Conclusion

This article offers only a few examples of the unique problems that can arise when health care is delivered in the patient's home. Home health care agencies and caregivers face challenges, and reap rewards, that differ greatly from those faced by their colleagues in hospitals, nursing homes and doctors offices. Legal counsel to home health care agencies do as well.

Endnotes

1. *See* 8 N.Y.C.R.R. Part 29—Rules of the Board of Regents: Unprofessional Conduct.

2. 42 C.F.R. § 484.12(c).
3. N.Y. Social Services Law § 413 (persons and officials required to report cases of suspected child abuse or maltreatment).
4. 42 U.S.C. § 1320a-7b(a)(2) (provider's duty to disclose improper payments).
5. 45 C.F.R. § 164.501.
6. 10 N.Y.C.R.R. § 763.2(a)(10).
7. *See* 45 C.F.R. § 164.501 (definition of "health information").
8. 45 C.F.R. § 164.512(f)(5).
9. 10 N.Y.C.R.R. § 763.5.
10. *See* 42 C.F.R. § 484.36(a)(viii).
11. *See* 10 N.Y.C.R.R. 400.23, which for CHHAs is referred to in 10 N.Y.C.R.R. 763.13(b) .
12. For example, the Eddy Home Care "Professional Code of Conduct of Home Health Aides" (hereinafter "Eddy HHA Code") states "When the Home Health Aide prepares to care for a patient and finds money or jewelry in the patient's clothing or area, the patient will be told: 'I wanted to make sure you knew this because our HHA wants to protect employees from any accusations relating to theft.'"
13. 10 N.Y.C.R.R. § 763.11(a)(8).
14. 10 N.Y.C.R.R. § 763.11(a)(7).
15. Assembly Bill 3792-A (2008) (A. Gottfried)
16. 45 C.F.R. § 164.512(j)(1)(A).
17. *See* 29 C.F.R. § 1604.11.
18. 45 C.F.R. Part 84. http://www.hhs.gov/ocr/discrimdisab.html.
19. *E.g.,* Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e *et seq*.
20. N.Y. Executive Law § 296 (part of NY Executive Law Article 15—Human Rights Law).
21. EEOC Compliance Manual Section 15, *available at* http://www.eeoc.gov/policy/docs/race-color.html.
22. 42 U.S.C. § 2000e-2(e).
23. *E.g., Slivka v. Camden-Clark Mem. Hosp.*, 594 S.E.2d 616 (S. Ct., W.Va. 2004) (remanding for reconsideration of whether a hospital's policy of selecting only female nurses for the obstetrics unit is legal as BFOQ)
24. *See generally*, S. McGowan, The Bona Fide Body: Title VII's Last Bastion of Intentional Sex Discrimination, *Columbia Journal of Gender and Law*, Vol. 12, 2003.
25. N.Y. Social Services Law § 413 (persons and officials required to report cases of suspected child abuse or maltreatment).
26. N.Y. Public Health Law § 2803-d.
27. N.Y. Social Services Law § 473-b.
28. *See* Eddy HHA Code ("Home Health Aides may not work privately for a patient while an Eddy Home Care employee") .

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