Q&A CoP INTERPRETIVE GUIDELINES

HOME HEALTH

FOR PROVIDERS. BY PROVIDERS.

QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI):

Q: Can a member of the governing body be the QAPI Coordinator?

A: There is no standard that prohibits a governing body member to be the QAPI Coordinator. However there must be documentation that verifies the governing body is responsible for the following:

- An ongoing program for quality improvement and patient safety is defined, implemented, and maintained
- The agency-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness
- Clear expectations for patient safety are established, implemented, and maintained
- Any findings of fraud or waste are appropriately addressed

ADMINISTRATION:

Q: New requirements for Administrator: If they are a Registered Nurse (RN), do they need to have a four-year degree?

A: Individuals hired after the implementation date will be required to be a physician, an RN or have an undergraduate degree in addition to experience in health service administration, with at least one year of supervisory or administrative experience in home health care or a related healthcare program. The interpretive guidelines define an undergraduate degree as a bachelor's or associate's degree.

Q: Is the Clinical Manager the same as Director of Nursing (DON)? What exactly is the Clinical Manager role? Can it be the Nursing Supervisor? Does this title have to be used exactly? Would ACHC expect to see the title of the DON change?

A: The Clinical Manager role has been expanded to include additional disciplines and additional duties. An agency may have more than one Clinical Manager to provide oversight of all patient care services and personnel. At a minimum, oversight must include the following: Making patient and personnel assignments, coordinating patient care, coordinating referrals, ensuring that patient needs are continually assessed, and ensuring the development, implementation, and updates of the individualized plan of care. This position replaces the standard for the supervising physician or RN. Changing the existing titles from Director of Nursing to Clinical Manager is recommended.

Q: Per the new guidelines, how long does the RN have to be licensed as an RN before they are qualified to be a clinical manager?

A: The CoPs have no experience requirements to be the clinical manager. ACHC requires a minimum of two years of home care experience and at least one year of supervisory experience. State regulations may also have specific experience requirements.

Q: Is it acceptable for the Administrator and the Clinical Manager to be the same person?

A: There is no guidance at this time that prohibits an individual from acting as both the Administrator and the Clinical Manager. However, the Administrator or pre-designated person, which could be the Clinical Manager, must be available during all operating hours.

PLAN OF CARE

Q: Will we have to send out an updated plan of care for signature to the primary physician with each new verbal order? When every new physician order is created, does the plan of care (485) need to be updated and re-sent to the physician for signature?

A: No. It is not necessary for the physician to sign an updated plan of care until the patient is recertified to continue care and the plan of care is updated to reflect all current ongoing orders including any verbal orders received during the 60-day period. Verbal orders must be documented and maintained in the medical record.

Q: Is the plan of care the required document to be provided to the patient in order to fulfill the regulation which requires written information provided to the patient?

A: No. The regulations do not specify what documents are to be utilized to provide the patient and caregiver with the written information.

The interpretive guidelines state the information is to be provided to the patient and caregiver no later than the next visit after the plan of care have been approved by the physician and should be updated as the plan of care changes. The information should also avoid medical terminology and should be written in plain language.

Q: How often and which changes need to be communicated to other physicians ordering services to the plan of care?

A: Revisions to the plan of care, due to a change in patient health status and/or needs that suggest that outcomes are not being met, should be communicated to the patient, caregiver and representative (if any) as well as to the physician responsible for the plan of care and to all other relevant physician(s) as it pertains to change.

Q: Please explain the new requirement that the assessment includes the patient's strengths, goals, and care preferences.

A: The intent in identifying patient strengths is to empower the patient to take an active role in his or her care. The home health agency must ask the patient to identify her or his own strengths and must also independently identify the patient's strengths to inform the plan of care and to set realistic patient goals and measurable outcomes. Examples of patient strengths identified by home health agency through observation and by patient self-identification may include: awareness of disease status, knowledge of medications, motivation and readiness for change, motivation/ability to perform self-care and/or implement a therapeutic exercise program, understanding of a dietary regimen for disease management, vocational interests/hobbies, interpersonal relationships and supports, and financial stability.

The intent of assessing patient care preferences is to engage the patient to the greatest degree possible to take an active role in their home care rather than placing the patient in a passive recipient role by informing the patient what will be done for them and when.

A patient goal is defined as a patient-specific objective, adapted to each patient based on the medical diagnosis, physician's orders, comprehensive assessment, patient input, and the specific treatments provided by the agency.

Q: In a therapy-only case, can the Registered Nurse complete the start of care and is an order required?

A: Yes, the Registered Nurse can complete the start of care in a therapy-only case and an order is required.

Q: Can you clarify what supplies are to be included on the plan of care?

A: All supplies that are ordered by the physician that will be billed for should be included on the plan of care.

Q: Is the DME section to reflect the DME the patient is currently using or what is anticipated the patient will need?

A: The plan of care should reflect any DME the patient is currently using as well as any DME ordered by the physician that will be used in the provision of care.

Q: If a patient has more than one hospital risk, does each risk have to be addressed individually in the plan of care or can a statement such as "educate on hospital risk be sufficient"?

A: No. The requirement is that all necessary interventions to address the underlying risk factors applicable to hospital re-admission and emergency department visits are identified. A blanket statement such as "educate on hospital risk" is not likely to be specific enough to address the underlying risk factors.

EMERGENCY PREPAREDNESS

Q: Do we have to do both drills every year?

A: Yes. Facilities are required to participate in a full-scale exercise that is community-based or an individual facility-based exercise when a community-based exercise is not accessible AND conduct an additional exercise that may include a second full-scale community or facility-based exercise or a tabletop exercise (as described in the regulations). So yes, a facility is required to conduct two tests annually. If the facility experienced an emergency and had to activate its emergency plan between November 15, 2017, and December 31, 2017, that would satisfy one of the annual testing requirements and would exempt the facility from engaging in a community or facility-based exercise for one year following the date of the actual emergency event.

Q: What are some examples of community-based, facility-based and table-top agencies?

A: The training and exercise requirements of the regulation call for individual-facility and/or full-scale community-based exercises, the below are some examples of exercise considerations:

- Earthquakes
- Tornados
- Hurricane
- Flooding
- Fires
- Cyber Security Attack
- Single-Facility Disaster (power outage)
- Medical Surge (i.e., community disaster leading to influx of patients)
- Infectious Disease Outbreak
- Active Shooter

Q: What is the difference between a full-scale community-based exercise and a facility-based exercise?

A: A community-based exercise is a multi-agency, multijurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and "boots on the ground" response (for example, firefighters decontaminating mock victims).

A facility-based exercise is a testing of the emergency preparedness drill that is specific to the facility. Facility-based includes, but is not limited to, hazards specific to a facility based on the geographic location, Patient/Resident/Client population, facility type, and potential surrounding community assets (i.e., rural area versus a large metropolitan area).

Q: If we activate our emergency plan, are we exempt from conducting another drill for the remainder of the year?

A: No. If a facility activates their emergency plan due to a disaster, the facility is exempt from one full-scale/individual-based exercise for that year. However, the secondary requirement for a table-top exercise or exercise of choice still applies. Facilities must demonstrate completion of two exercises per annual year.

Q: If we have reached out to our community emergency preparedness officials and no one has allowed us to participate in a community-based drill, what should we do?

A: Document your attempts to participate in a community-based drill and then complete a facility-based drill.

HOME HEALTH AIDES

Q: Can the home health aide competency be assessed on a pseudo patient or must it be on a real patient?

A: No. The following skills must be evaluated by observing the aide's performance while carrying out the task with a patient.

- Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff
- Reading and recording temperature, pulse, and respiration
- Appropriate and safe techniques in performing personal hygiene and grooming tasks that include:
  - Bed bath
  - Sponge, tub, and shower bath
  - Hair shampooing in sink, tub, and bed
  - Nail and skin care
  - Oral hygiene
  - Toileting and elimination
- Safe transfer techniques and ambulation
- Normal range of motion and positioning

Q: Do home health agencies need to complete another competency evaluation on aides hired prior to January 13, 2018?

A: No. Home health aides who successfully completed a competency evaluation prior to January 13, 2018, do not need to repeat the portion of the competency evaluation required to be done while providing services to a patient. All home health aides who receive a competency evaluation after January 13, 2018, must have these skills tested while the aide is providing care to a patient.

Q: What additional training must the home health agency provide to home health aides and how can this be accomplished?

A: For home health aides who met the qualification requirements for home health aides prior to January 13, 2018, agencies can provide in-service training of the following content:

- Communication skills in regard to the aide's ability to read, write, and verbally report clinical information to patient, representative, and caregivers, as well as to other home health agency staff
- Recognizing and reporting changes in skill condition

The agency must maintain documentation that the additional training was provided.

Q: Will all home health aides need to be competency assessed in tub, sponge, and shower bath as well as bed bath?

A: Yes. The verbiage changed in the Federal Register from "or" to "and" regarding the competency assessment for sponge, tub, and shower bath.

Q: Can an RN or LPN/LVN be used to provide patient care in lieu of an aide?

A: Yes. It is within the scope of practice for an RN or LPN/LVN to perform personal care services. If an LPN/LVN is providing personal care services, written instructions are still required and the LVN/LPN would be required to be supervised in accordance with state regulations and/or accrediting organization requirements.

Q: In the situation of therapy-only cases (PT only) can we follow the CoP requirements or follow the state requirement? Our state does not allow for a therapist to supervise a home health aide.

A: A home health agency must always follow the more stringent regulation and if the state does not allow for a PT to supervise the home health aide, then you must follow the state requirements.

Q: What skills are to be assessed during the annual on-site visit of the home health aide?

A: The standard does not specify what skills are to be assessed during the annual on-site visit.

OTHER

Q: If a home health agency is still using paper visits notes, can the information be maintained via scan or should the hard copies be maintained?

A: The CoPs do not address whether patient information is maintained electronically or on paper.