

## GENERAL

**Q:** Since the new CoPs are finalized, is it OK to go ahead and make the changes?

**A:** An agency can start to make changes as long as the changes are in compliance with the current CoPs and ACHC Standards.

**Q:** When will you release your revised standards based on the new CoPs? We are looking for any tools to help us organize our preparation. Can ACHC provide checklists lined up with the standards?

**A:** Once our standard revisions have been approved by CMS, we will release them to the public. All ACHC materials will be updated to reflect the new CoPs once CMS has approved our standards and a State Operations Manual has been published.

**Q:** If I am due for an ACHC survey before January 13, 2018, what CoPs and standards will I be surveyed to?

**A:** All surveys before the CoP implementation date will be held accountable to the current version of the CoPs.

**Q:** I am wondering how much this affects our agency. We do not bill Medicare but have HMO Medicaid patients. Does this include us?

**A:** The Medicare CoPs are applicable to all agencies that are Medicare-certified home health agencies or are required by state law to abide by the CoPs.

## QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

**Q:** Will QAPI replace our current Performance Improvement projects?

**A:** Yes, ACHC's Performance Improvement standards will be replaced by the QAPI CoP.

**Q:** Does the Performance Improvement Program that ACHC has in place currently cover all of the new Medicare CoP requirements for Quality Improvement?

**A:** Yes. ACHC has added detail to include the CoP requirements.

## ADMINISTRATION

**Q:** New requirements for Administrator: If they are a Registered Nurse (RN), do they need to have a 4-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 healthcare or a related health care program.

## ADMINISTRATION (CONTINUED)

**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:** The new CoPs outline the responsibilities of the new Clinical Manager role; however, there is nothing regarding the qualifications for this position. Are we to assume they are the same as they were for the Supervising RN?

**A:** The qualifications for this role are found in §484.115 Personnel Qualifications. A Clinical Manager is a licensed physician, Physical Therapist, Speech-Language Pathologist, Occupational Therapist, Audiologist, Social Worker, or Registered Nurse.

**Q:** Is it acceptable for the owner to be the Administrator and the Governing Board? When the owner sometimes wears multiple hats, how does a small agency satisfy this new CoP?

**A:** There is no guidance at this time that prohibits an individual from acting as both the Administrator and as a member of the Governing Board.

## PATIENT RIGHTS

**Q:** What do you feel is the best/most expedient way to meet the requirement that a patient's "legal" representative, defined by the new CoPs as virtually anybody, be provided with the Notice of Rights prior to touching a patient – especially when many states define surrogate decision-makers when patients are unable to make healthcare decisions for themselves?

**A:** Your first step would be to determine if your state has surrogate decision-maker requirements for when a patient is unable to make their own healthcare decisions and has not established a health care power of attorney or an appointed guardian. In the absence of state requirements, you should develop a policy and procedure to define legal representative.

**Q:** Does the Clinical Manager's or the overall Administrator's information need to be on the Patient Rights?

**A:** CoP §484.50 requires only that the agency Administrator's name and contact information be on the Patient Rights. CoP §484.60 *Care Planning, Coordination of Services and Quality of Care* requires that the patient receive, in writing, the Clinical Manager's name and contact information.

**Q:** Describe ACHC's plan to revise discharge requirements to align with the discharge requirements in the CoPs.

**A:** ACHC has expanded the requirements to include the new CoP requirements for discharging a patient.

## 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 (CoP §485) need to be updated and re-sent to the physician for signature? Has there been any additional clarification on how best to operationalize the sending of updated care plans?

**A:** The current standard requires that any revision to the plan of care due to a change in patient health status be communicated to the patient, representative, caregiver, and all physicians issuing orders for the home health aide plan of care. We are currently waiting on additional guidance.

**Q:** Please clarify the new requirement of timing an order. Do we time it next to our signature/date when we are inputting the order? Or is it timed when we note the signed order is returned by the physician?

**A:** CMS' response is that it is necessary and appropriate to proactively record the time of day that each verbal order is received by a home health agency clinician from a physician.

**Q:** What other clinical record items need a time stamp beside ALL physician orders and clinical notes? What are the verbal order requirements with this new CoP? Do agencies now have to have field staff complete their visit note on the day of the visit to ensure DATE/TIME of the actual visit matches the note? Is this an ACHC requirement?

**A:** The standard requires that a nurse acting in accordance with state licensure requirements or other qualified practitioner responsible for furnishing or supervising the ordered services in accordance with state law and agency policies must document the orders in the patient's clinical record and must sign, date, and time the order. Verbal orders must be authenticated and dated by the physician in accordance with acceptable state laws and regulations as well as agency policies. The CoP §484.110 also requires that all entries in the clinical record be timed. CMS' comment from the proposed CoPs is that all entries should be timed based on when the care actually occurred, not when the clinician completed the clinical note.

**Q:** Regarding discharges, if a patient can be discharged when the home health agency and physician agree that care plan goals are met, what documentation would be required? Does that mean contact with the physician prior to discharge?

**A:** The clinical record should contain documentation to support the established goals have been met. The discharge summary is also required. Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the home health agency plan of care, and the patient's primary care practitioner or other healthcare professional who will be responsible for providing care and services to the patient after discharge from the home health agency (if any).

**Q:** Is first initial and last name and title OK?

**A:** CMS states, "Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry." ACHC is currently waiting on further qualification once the State Operations Manual is revised and published.

## EMERGENCY PREPAREDNESS

**Q:** Will ACHC provide detailed information on Emergency Preparedness standards?

**A:** ACHC has issued a series of "Did You Know?" emails on Emergency Preparedness and will provide more education including a webinar on Emergency Preparedness in the next few months.

**Q:** By testing the emergency plan, do you mean having drills, or a written test for staff?

**A:** The expectation is that two exercises are completed before November 15, 2017 - one community- or facility-based exercise and then either a second community- or facility-based exercise or a tabletop exercise. The tabletop test must include a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

## INFECTION CONTROL

**Q:** If a clinician uses a bucket with a clean/dirty section for transporting supplies in and out of a patient's home, do they need to use a barrier and are they in compliance with infection control standards?

**A:** The use of a barrier is determined by agency policy and procedure.

## HOME HEALTH AIDES

**Q:** The standards include a patient-driven choice for home health aide services. How will the home health aide care plan be developed and supervised?

**A:** The home health aide plan of care continues to be developed by an RN or other appropriate skilled professional based on the personal care needs of the patient and the skills of the home health aide. Supervision requirements remain the same as well; an RN or other skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions, must make an on-site visit to the patient's home no less frequently than every 14 days.

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

**A:** Per the standard, required skills must be evaluated by observing a home health aide's performance of the task with an actual patient.

**Q:** Does an agency have to provide training to ALL home health aides who are hired?

**A:** All home health aides must receive at least 12 hours of in-service training during each 12-month period. The in-service training may be offered by any organization and must be supervised by an RN.

**Q:** Is it true that with the new CoPs we cannot hire a home health aide who has neither worked in the past 24 months nor attended home health aide training in the past 24 months?

**A:** A home health aide or nurse aide is not considered to have completed a program if, since the individual's most recent

## HOME HEALTH AIDES (CONTINUED)

completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services furnished by the individual as described in §409.40 of this chapter were for compensation. If there has been a 24-month lapse in furnishing services for compensation, the individual must complete another program, as specified in paragraph (a)(1) of this section, before providing services.

**Q:** Does the annual observation have to be completed in the patient home while staff are providing care or can it be done during a skills fair or annual competency evaluation?

**A:** An RN or other appropriate skilled professional must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each home health aide while he or she is performing care.

**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.

## OTHER

**Q:** Is there a need for a PAC meeting in 2017?

**A:** Since the implementation date has been delayed until January 13, 2018, you must remain in compliance with current CoPs and have a PAC in 2017. You also need to check state requirements, and if your state continues to require a PAC and/or meeting, then you must continue to have a PAC.

**Q:** I have heard that 60-day Medicare episodes will turn into 30-day episodes with the CoP revisions. Any comments on this?

**A:** This is not addressed in the new CoPs.

**Q:** Are the CoPs or other regulations addressing the issue of Nurse Practitioners (NPs) or other advanced practitioners signing home care orders?

**A:** No, the CoPs do not address the role of the NPs or other advanced practitioners signing orders.

**Q:** Will ACHC require an annual agency evaluation?

**A:** Although the agency evaluation has been removed from the CoPs, ACHC is maintaining it as a requirement.

**Q:** Is the quarterly clinical record review requirement going to be retained by ACHC, and will ACHC expect the agency to conduct the quarterly record review as it stands now?

**A:** Yes, the expectation is that all disciplines are involved in the quarterly record review.