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# PROGRAM INSTRUCTION (PI)

**EOEA- PI 14-03**
REF: EOEA-PI-01-22
EOEA-PI-00-60
EOEA-PI-00-40

**TO:** Aging Service Access Points
Area Agencies on Aging

**CC:** Interested Parties

**FROM:** Ann L. Hartstein

**DATE:** May 1, 2014
**RE:** Coordination and Reimbursement of Home Health Services Protocol

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## Purpose:

With the increased focus on Community First, Aging Service Access Points (ASAPs) are supporting consumers with many complex care needs and multiple chronic conditions. This Program Instruction is to address Initial Assessment, Care Planning, Communication, Supervision, and payment from ASAPs when authorizing services by Certified and non-Certified Agencies who provide home health care. This PI includes a listing of Health Services indicators (Attachment A) that may be utilized by ASAP interdisciplinary care management staff when determining when a referral for a skilled services assessment is needed.
This PI replaces PI 00-40, PI-00-60, and PI 01-22.

## Background and Program Implications:

Personal Care (PC) services provide physical assistance and verbal cuing with personal care tasks such as bathing, dressing, grooming, ambulation, and transfers. PC services are provided to consumers who, based on an assessment performed by an ASAP RN, need assistance with these types of services.

The ASAP RN assesses the consumer's overall functional and clinical status, the type and amount of care needed, the consumer's environment, and current support systems, both formal and informal, in determining the appropriateness for PC.

Consumers with conditions/diagnoses that may not be appropriate for PC services include, but are not limited to: consumers with extensive paralysis or total immobility, consumers who cannot transfer more than 50% of their body weight or require assist of two or use of a mechanical lift, open wounds, certain types of fractures including, but not limited to those casted to immobilize, unstable medical conditions, and those that require special skin care. Refer to the Homemaker Standards and Personal Care Guidelines for a more comprehensive listing.

When the ASAP RN determines a consumer is not appropriate for a Personal Care Homemaker (PCHM) level of care, the ASAP RN may authorize a home health aide to provide these services. ASAPs provide payment for Home Health Services as defined by PI 09-13 Home Care Program Service Descriptions, Attachment A. These services include Skilled Nursing (SN), Home Health Aide (HHA), Physical Therapy (PT), Speech Therapy (ST) and Occupational Therapy (OT) to eligible consumers from both federally certified home health and non-certified home care agencies.

## Required Actions:

The ASAP Care Manager and RN will determine a need for Home Health Service via an interdisciplinary conversation based on the ASAP RN's comprehensive in home person centered assessment with the consumer. Each ASAP should develop its own process for interdisciplinary communication between the ASAP RN and ASAP CM on HHA level cases. After the home assessment, the ASAP will communicate with the provider RN regarding this assessment and the needs identified. A consumer's need for HH services is based solely on his or her unique situation and individual needs, whether the condition is acute, terminal, chronic or stable or expected to extend over a long period of time.

### I. Establishing the Plan of Care That Includes Home Health Aide Service

- The provider agency will be required to conduct an initial assessment by an RN to establish the plan of care for the home health aide service. This will be a reimbursable visit.

- The ASAP interdisciplinary team will develop a service plan encompassing the IADL's, homemaking, meal prep etc. while the provider RN will be writing the care plan encompassing the consumer's personal care needs.

- ASAPs must work with provider agencies to ensure a mutually agreed upon communication method to share care plans and provide updates on the consumer's status. In addition, the provider agency will forward a copy of the care plan to the ASAP.

- In Complex Care cases, (deemed so either at the request of the ASAP or by service plans greater than 42 hours/week) there will be a documented communication between the ASAP RN and the provider RN to discuss assessment findings and the plan of care.

- The ASAP is required to do a home visit and reassessment when a consumer experiences a significant change in health or functional status per RFR 9.1.5.8.

- The ASAP RN and provider RN will assume joint responsibility to communicate with each other regarding the consumer's health and/or functional changes. Service Plans and any changes to the service plan remain the responsibility of the ASAP. The provider RN will update the care plan as needed to reflect HHA service changes. Visits for these purposes are not reimbursable.

- The ASAP shall comply with the required Home Care Program reassessment schedule based on the consumers' program enrollment and risk level in home care.

- When the only service provided by the ASAP is a HHA level of care, the ASAP RN shall visit the consumer annually to assess the level of care need is still appropriate for the consumer. The ASAP must convey to the provider RN any changes the ASAP interdisciplinary team notes.

- When an ASAP consumer continues on HHA service for a period of a year, the provider agency will be required to conduct an annual assessment, update the plan of care and communicate this to the ASAP RN via documentation of the care plan. This is considered to be a reimbursable visit.

- In some cases the consumer who requires HHA services, also requires skilled oversight of their care needs. The ASAP shall authorize Skilled Nursing Services in addition to home health aide services as appropriate.

- The ASAP will evaluate the consumer's potential to qualify for skilled services that could be billed to another Third Party. See Attachment A for indicators for referral for skilled services.

## II. Supervision of the Home Health Aide Service

- An agency providing a HHA level of care must perform an in-home review of the care plan at least quarterly to ensure the level of service is reviewed, updated if necessary and meeting the service needs of the consumer.

- The agency providing HHA level of care must perform quarterly in home supervision of the aide on a representative sample of consumers.

### Effective Date:

This PI is effective May 1, 2014.

### Contact:

Please contact Mary DeRoo, Director of Home and Community Programs, 617-222-7468, Mary.deroo@state.ma.us for any questions about this PI.

# Attachment A

The ASAP Interdisciplinary Care Management Team should consider the following listing of Skilled Nursing, Physical Therapy, and Occupational Therapy indicators for referral for a skilled services assessment or visit when determining the consumers service plan.
Based upon the Interdisciplinary Care management Team's consumer needs assessment, a referral to a Certified Home Health Agency shall be considered if the indicators below are identified:

1. Poly pharmacy Issues or Medications that may need reconciling, or need for medication pre-fill. Often indicated by:
   - Multiple medications and difficult administration techniques,
   - Presence of Hi-Risk medications, multiple medications, or difficult administration, techniques combined with perceived lack of knowledge about medication use,
   - Inability to adhere to dosage schedule,
   - Hand and muscle coordination issues for example, inability to open a vial or box,
   - Family caregiver misunderstanding of medication use.

2. A marked change in functional capacity, as indicated by:
   - Inability to transfer more than 50% of body weight,
   - Decline in level of endurance,
   - Increased incidence of falls,
   - Change in ambulation ability,
   - Inability to perform ADL/IADL tasks which may indicate a possible need for adaptive equipment and thus a referral to OT.

3. Non Compliance with nutrition plan, as indicated by:
   - Lack of appetite and/or disinterest in food,
   - Not following a prescribed diet and/or under/over-eating,
   - Difficulty chewing or Difficulty swallowing,
   - Unintended weight loss/gain.

4. Complaints related to chronic pain, shortness of breath or pain on exertion effecting ADLs and/or quality of life.

5. A change in behavior or cognition:
   - Gradual or acute changes in the areas of memory, perception, communication, orientation, calculation, comprehension, problem solving, thought processes, language, and attention,
   - Safety concerns secondary to poor judgment/inability to protect oneself from hazards.

6. Elimination issues, such as:
   - Urinary/bowel incontinence,
   - Changes in output,
   - Discomfort/Pain,
   - Inability to manage catheter care,
   - Frequent UTI's with or without urinary catheter.

7. Skin breakdown, rashes or bruises related to decreased mobility, incontinence, inability to transfer or poor hygiene.

8. Frequent hospitalizations/emergency room visits,

9. Recent diagnosis of terminal illness that may be combined with:
   - Expressed desire to not seek acute care,
   - Verbalization by patient/caregiver the desire to live final days at home.