

Date: September 8, 1989
To: All Wisconsin Home Health Agencies
From: Larry Tainter, Director
Bureau of Quality Assurance
Subject: Home Health Agency Questions and Answers

On July 19, 1989, representatives of the Bureau of Quality Compliance attended a question and answer session with a large number of home health agencies in the Milwaukee area. Prior to the meeting, fourteen questions were sent to the Bureau. At the meeting additional questions were asked.

It is our intention to share the questions and answers with all Wisconsin home health agencies. We hope that this will be the beginning of routine dialogue with the home health industry regarding rule interpretations, policy/procedure notification and statute/rule change.

The following are the questions and answers from the Milwaukee meeting.

1. How much notice is required for discharge? Will it vary with the skill level and the number of hours being provided?

There is no specified timeframe for discharge of home health agency patients in federal regulations or HSS 133.09(3). Obviously the skill level and needs of the patient will play a role in the difficulty of placement of the patient, as will the assistance that the agency receiving the patient is willing to provide. Agencies should also be aware of HSS 133.11 requiring referrals for patients having needs the home health agency cannot meet.

The entire discharge process is a test of reasonableness. Timely notice to patients being discharged is necessary for a smooth transition. It seems reasonable to expect at least 15 days notice at discharge with 30 days being good business practice.

2. What rights does an agency have, and what is its liability if referral information is limited, incorrect, or incomplete?

Examples:

1. The agency is told the client is homebound and isn't.
2. The agency is told the family and/or client have been trained for care and aren't.
3. The client is sent home without the agency's knowledge.
4. The request for services or hours needed change before the admission and the agency is not notified.
5. No one informs the agency that another agency has cared for the client in the past.

Example 1: The receiving agency is responsible for appropriate and adequate assessment before accepting a patient.

Example 2: Assessment and evaluation of the patient, prior to accepting the case, should include home visits, if possible, to find out who are the caregivers in the house and their training. Previous caregivers should be consulted as well as the patient's physician.

Example 3: If the home health agency's patient is sent home from the hospital, and was never discharged from the home health agency to the hospital, then the home health agency has the responsibility for tracking the patient and their discharge from the hospital. If the patient was formally discharged from the home health agency to the hospital, then the hospital is responsible for the patient at the time of discharge. In this situation if a home health agency believes a hospital improperly discharged a patient, it should file a complaint with the Bureau of Quality Compliance.

Example 4: If an admission to an agency has not yet been made and the needs change so that the agency cannot meet them, then the accepting HHA should either not accept the patient, or if the patient is accepted, provide additional

services through a referral to another agency (see HSS 133.11) or through sharing of services with another agency (see HSS 133.12).

If the patient has been admitted to the home health agency, then the agency must provide additional services through a referral to another agency (see HSS 133.11) or through sharing of services with another agency (see HSS 133.12). If services needed are beyond the agency's ability to provide then the agency may recommend discharge of the patient under HSS 133.09(3).

Example 5: There is no requirement that an agency, accepting a patient, be told that another agency has cared for the patient in the past. However, an agency transferring a patient to another agency must provide a copy or abstract of the clinical record to the accepting agency as specified in HSS 133.21(4).

3. How much information is allowed to be shared under discharge or preadmission to another agency, etc.? We were told that any information related to care or the delivery of service is required. Can this include safety issues for staff?

Information required at time of transfer to another agency is a copy of the medical record or abstract as indicated in HSS 133.21(4). Safety information is not required under HSS 133, but information needed to provide safe, appropriate care to the patient should be included at time of transfer.

4. Are client's rights infringed upon if an agency shares its reason for discharge?

No. There are times that such information is important to make a judgement regarding the ability to provide care.

5. Please clarify how many visits may be missed before obtaining a doctor's order.

We assume that this question refers to the home health agency missing visits. If an agency misses visits, several issues must be considered.

- (a) Physician orders are not required to cover missed visits. However, the patient's physician should be contacted about the missed visits and a record of the contact should be made in the patient's progress notes.
- (b) Physician orders are needed to change the level or frequency of service provided to the patient.
- (c) Missed visits are a violation of HSS 133.20(4) (Physician's Orders) and federal regulation 405.1223(c) (Standard: Conformance with Physician's Orders).

6. If part of a visit is missed per client or family request are doctor's orders required?

Physician's orders are not needed to cover a missed visit. A missed visit is a missed visit and cannot be fixed by physician order. Several issues to bear in mind regarding this situation are:

- (a) A patient has a right to refuse treatment.
- (b) HSS 133.14(2)(b) requires the agency's registered nurse to regularly evaluate the patient's needs. If this evaluation indicates a change in service required, then physician orders are required and must be documented in the patient's progress notes.
- (c) If the missed visit is occasional, at the patient's or family's request, and has no health impact, then adjusted physician orders are not needed.

7. What is the agency's recourse when dealing with a physician who continually does not sign or return orders in a timely manner, even when the orders are sent in advance?

There are no specific code requirements to deal with physicians who habitually do not sign orders. Some suggestions for dealing with this problem are to meet with your physicians to explain that their lack of diligence jeopardizes your agency and appropriate patient care, approach your physicians through your medical director if your agency has one (all

agencies must have a physician on their professional advisory committee), or if the problem persists, refuse to accept patients from a non-compliant physician.

8. What can the agency do when the physician refuses to sign orders for frequent changes in service due to combined reasons such as:
1. The client does not want service for a day.
 2. The client's family wishes to provide service for a day.
 3. Staff is not available and the family is willing to accept responsibility for cares.

Examples 1 and 2 should be infrequent. If these situations will have a direct impact on patient care, inform the patient's physician and include the contact in the progress notes. This should be prospective activity. If not, then these situations would be considered missed visits.

Example 3 should be a very infrequent situation unless the family is willing and able to take responsibility for the care. This family responsibility should be reflected in the physician's orders. Agencies should not determine patient needs based upon staff availability. If an agency cannot meet patient needs, it should make appropriate referrals (see HSS 133.11), share services (see HSS 133.12) or discharge the patient (see HSS 133.09(3)).

9. When the physician changes the plan of care (i.e., meds) and neither he, the client, or the family notifies the agency of the change, is the agency responsible for that change on the plan of care? What about over-the-counter medications that the client changes at will?

When a home health agency accepts a patient, it must complete a recent drug history to identify the current medications being taken by the patient. This history should include all drugs ordered by the attending physician as well as all other medications being taken including over-the-counter medications. In either situation in this question, the home health agency should routinely ask the patient and his caregivers what prescribed and over-the-counter medications are being taken. Prescribed medications can be followed up with the physician if the agency is unaware they were ordered. Over-the-counter medications should be brought to the attention of the patient's physician in a timely manner. If serious potential disease or drug interactions are present, the physician should be immediately notified. (Any pharmacy can identify and classify these for the patient and agency.) If no serious potential interactions are involved, the over-the-counter medications should be brought to the attention of the physician on the 60-day review of the plan of treatment signed by the physician (see HSS 133.20(3)). All medications should be included on the medication list indicated in HSS 133.21(5)(f).

10. When sharing a case with another agency, is there a primary agency and if so how is that determined?

There is no HSS 133 requirement for a primary agency when cases are shared. There is some question as to how the federal Health Care Financing Administration (HCFA) looks at this issue. HCFA has indicated in the past that the agency providing Medicare skilled nursing services may need to be designated as the primary agency. The Bureau of Quality Compliance will further investigate this issue.

When case sharing, each agency should have a plan of treatment for the care each is providing. Coordination of services between the agencies is required by HSS 133.12.

11. Which agency would be responsible for coordination of service? Will sharing information be a breach of confidentiality? If one of the agencies can no longer services its hours, is the other agency committed to accept them?

When case sharing occurs, both agencies are responsible for coordination of services. Sharing of information needed to provide safe, effective health care would not be a breach of patient confidentiality. If one agency can no longer services its agreed upon hours with the patient, the case sharing agency is not responsible for providing additional hours. The agency not able to meet the services required would have the responsibility to make a proper referral or discharge.

12. At what point in the admission process is the agency committed to the case? We had difficulty when a client changed their mind about providing service when the agency did not have staff at the last minute. We were concerned because it was after our preadmission assessment.

Once a service agreement between the agency and patient is signed, the agency is required to provide the types of service arranged for in the service agreement (see HSS 133.09(2)). If the patient's condition changes and additional service is required, the agency could refer the patient to other agencies, set up a case sharing situation with another agency or discharge the patient.

13. Can agencies subcontract aides? In HSS 133.10 although it states directly provided, could the phrase (or arrange for home health aide services) indicate that subcontracting might be allowed?

HSS 133.10(1) allows for a home health agency to "arrange" (subcontract) for aides. However, skilled nursing services must be directly provided by the agency. The Bureau of Quality Compliance has granted a very limited number of patient specific waivers of HSS 133.10(1) to allow for contracting of skilled nursing between agencies in situations of extremely complex care requiring multiple hours of care. Such waiver requests should be directed in writing to:

Allan D. Stegemann, Chief
Facilities Regulation Section
Bureau of Quality Compliance
Division of Health
P.O. Box 309
Madison, WI 53701

14. How can an agency best handle the anger of clients being transferred from another agency? The anger is being directed at the agencies in the process of admission due to differences after assessment of needs and the time involved in arranging care. Many of these potential clients are unrealistic and expect care to continue without interruption.

The agency should follow the requirements in HSS 133.09(3). Additionally, the agency should keep open the lines of communication between transferring and receiving agency and the patient.

In the future the Bureau of Quality Compliance will attempt to routinely circulate answers to questions asked which are of interest to all licensed and certified agencies. If you have specific questions, please send your question in writing to the Bureau and a written response will be provided.

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