Chapter 246-335 WAC - In-Home Services
Rule updating topics
January 4, 2016

- Background Checks
    - Requiring background checks for key individuals every two years when renewing license.
    - Requiring background checks for employees annually or every two years..
    - Clarify the background check process.
    - Clarify when finger prints are required.
    - Require P&Ps around suitability assessments for non-disqualifying convictions / actions (example: old DUI).
    - The Federal "Rap-back" system is a mechanism that continuously checks existing employee finger prints records against incoming arrest and conviction information and reports back to the state agency that originally requested the background check. NQAC's HB 2080 was introduced in 2015 and will be reintroduced in the 2016 session.
    - Possible rule language: "Licensees are required to submit updated background checks for key individuals and direct-care employees when renewing their license. Licensees are not required to submit updated background checks for employees that are subject to a federal rap back program."
    - Clarify what type of background check is required for Home Care Aides? CNAs? BCCU? Watch?
    - Or, clarify what type of background checks are required for Home Care agencies? Home Healh? Hospice?
    - Clarify who pays for background checks?
    - Clarify expectations for agencies when they are waiting on a pending finger print background check.

- Create a table / Matrix.
- Clarify background check requirements for agencies going into long-term care facilities: Nursing Home? Assisted Living? AFH?
- Student background check requirements who are doing their clinical trials.
- What is the intent of the background check RCW?

- Client assessments
  - Initial and annual client/patient assessments - Who should do these assessments? Should they have any minimal credentials?

- "Clinical judgment"
  - "Clinical judgment" is a key component when determining if a nursing / medical task can be delegated.
  - Should we define "clinical judgement?"
  - Use Nursing Quality Assurance Commission's definition – NQAC does not have a definition but indicated it would like to add one in the future. NQAC provided a couple of definitions that they liked:
    - "Clinical judgment" means an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response.
    - "Clinical judgement" means clinical reasoning, which includes clinical decision-making, critical thinking and a global grasp of the situation, coupled with nursing skills acquired through a process of integrating formal and informal experiential knowledge and evidence-based guidelines.

- CPR
  - Clarification that classroom training can be on-line but demonstration of skills must be hands on.
  - Should the Heimlich maneuver also be required?
  - Should CPR be required for Home Care agencies?
  - Should CPR be required for Home Care agencies utilizing Nurse Delegation?
  - Consider adding a new definition for "CPR."

- CPR in relation to POLST (Physician Orders for Life-Sustaining Treatment paradigm).
- New patient and family educational Video regarding POLST: http://www.polst.org/new-patient-and-family-educational-video/
- The National POLST Paradigm is an approach to end-of-life planning that emphasizes patients' wishes about the care they receive. The POLST Paradigm – which stands for Physician Orders for Life Sustaining Treatment – is an approach to end-of-life planning emphasizing: (i) advance care planning conversations between patients, health care professionals and loved ones; (ii) shared decision-making between a patient and his/her health care professional about the care the patient would like to receive at the end of his/her life; and (iii) ensuring patient wishes are honored. As a result of these conversations, patient wishes may be documented in a POLST form, which translates the shared decisions into actionable medical orders. The POLST form assures patients that health care professionals will provide only the treatments that patients themselves wish to receive, and decreases the frequency of medical errors.
- Ask NQAC regarding Advisory Opinion for POLST
- Advanced directive vs POLST - The POLST form complements the Advance Directive and is not intended to replace it. An Advance Directive is necessary to appoint a legal health care representative and provide instructions for *future* life-sustaining treatments. The Advance Directive is recommended for all adults, regardless of their health status. A POLST form should accompany an Advance Directive when appropriate.
- What does POLST look like in Hospice vs Home Health?
- Require agencies to establish policies & procedures relevant to POLST and advanced directives.
- Require POLST and advanced directives to be clearly listed on plan of care.
- Plan of care should clearly specify if the patient SHOULD NOT receive CPR.
- BREE Collaborative - *The Dr. Robert Bree Collaborative (Bree) was established in 2011 by the Washington State Legislature "…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."*

- Delinquent Plan of Correction
  - Adding enforcement language for Plan of Corrections that are not submitted to the department by the date specified in the Statement of Deficiencies.
- Durable Medical Equipment warehouse inspections

- Should we add specific inspection requirements for DME equipment warehouses?
- Research current DME requirements (CMS; Health Care Authority WAC 182-543) and incorporate key ones into IHS WAC.
- **CMS** Ma**intenance Plan for All Equipment -** The maintenance plan should provide for **all** inventory, including supplies that are discontinued, obsolete, or not patient-ready. Separate the clean and dirty supplies and log completed repairs. Keep a tracking system or log of all your equipment by model, serial, or other identifying number to ensure recalled equipment can be located and to identify instances of theft. Show evidence that all equipment is maintained. Log equipment calibration and temperature checks for refrigerated items. Infection control issues of equipment being stored in warehouses – separation of clean and dirty.
- **42 CFR 424.57(c)**

- Electronic records
  - Adding language that clarifies that electronic communication must be kept confidential.
  - Must be able to print electronic records if requested.
  - Are voicemails records?
  - Issue – printed client / patient materials kept in caregiver's car.
  - Some agencies don't know how to make their texting / emailing secure.
  - Identify current laws.
  - Follow HIPPA requirements: http://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/
  - With respect to HIPAA and electronic medical records (EMR), these systems typically use data encryption to protect patient medical records stored on the EMR. Data encryption technology protects EMR while they are stored and while they are being transferred, ensuring that only the intended recipients are able to view them. There are other HIPAA data security systems that are typically installed on health care computer systems and networks, including firewalls to prevent unauthorized access, and electronic auditing systems which require users to identify themselves and which log specific records that are accessed by them. Many health care providers find it useful to have HIPAA data security audits of their systems performed on a regular basis. These examinations and reports, if addressed properly, can serve to ensure a high level of compliance and also to mitigate penalties for inadvertent problems.

- "Telemedicine" means health care services provided via "interactive audio and video technology, permitting real-time communication" for purposes of diagnosis, consultation or treatment. "Telemedicine" does not include health care services delivered without a video component. Therefore, telephone, facsimile, email, text or other health care related communications that do not include a video component will not trigger the new law's parity of coverage provisions.

- SSB 5175 – Telemedicine bill of 2015.

- An article that explains SSB 5175.

- Health Care Authority rules on Telemedicine (WAC 182-531-1730)

- Medicaid's views on Telemedicine

- Should we revise supervision requirements to allow Telemedicine or interactive audio and video technology in certain circumstances?

- DOH "Meaningful use" guidelines: http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PublicHealthMeaningfulUse

- CMS guidance from 2009 - Surveyors instead are to focus on how the EHR system is being used in the facility, and whether that use is consistent with the Medicare CoPs or CfCs. For example, are computer screens showing clinical record information left unattended and readily observable or accessible by other patients/residents or visitors? Are there documents publicly posting passwords, which would be evidence of noncompliance with both confidentiality and medical record authentication requirements? Is there evidence to support a complaint allegation that facility staff shared information obtained from an EHR with unauthorized individuals?

- In accordance with 45 CFR §164.306, Covered Entities, Business Associates and subcontractors must:

    - Ensure the confidentiality, integrity and availability of all electronic protected health information ("PHI") the Covered Entity or Business Associate creates, receives, maintains or transmits;

    - Protect against reasonably anticipated threats or hazards to the security or integrity of PHI;

    - Protect against any reasonably anticipated unauthorized use or disclosure of PHI;

    - Ensure that the workforce complies with these requirements; and

        - Modify security measures as needed and update documentation to ensure reasonable and appropriate protection of electronic PHI. To comply with the new Megarule, there must be EHR features in place to prohibit healthcare providers from improperly accessing and/or transferring electronic PHI of patients.

- Enforcement
    - Adding language that enforcement steps may be taken if applicable laws are not followed.
    - There is a long-standing perception in the Washington industry that "no Home Care agency has ever been shut down."
    - How can we strengthen in WAC the current enforcement capabilities in RCW?
    - When the department receives professional-based complaints about Home Care Aides / Certified Nursing Assistants, what mechanisms are in place to connect separately filed complaints and Red Flag a specific agency where these employees are working?
    - There is a Matrix for professions – use something similar for facilities? (Research and report back to group).
- Exempt workers
    - Exempt Workers are not under the Uniform Disciplinary Act.
    - Definition of Home Care Aide (20) – include in the definition that Home Care Aides must have a minimum credential of a Certified Home Care Aide or Certified Nursing Assistant.
    - Definition of Home Care Aide (20) – include in the definition that Home Care Aides must meet the minimum requirements according to "WAC XXX-XXX-XXX".
    - There is exemption language in RCW for long-term care workers. This has essentially created a group of workers that will forever be exempt from credentialing. Without a credential, there is no way to track complaints against these workers. Now that the law has been in effect for a few years, the legislature should re-evaluate if the exemptions are still appropriate. Possible 2017 legislation?
- Food safety
    - Adding language around safely preparing and storing food
    - Should we require a "food handlers" card?

- If we go the route of requiring food handlers cards, create a carve out for Home Health and Hospice when they do not prepare food.
- What about volunteers and food preparation?
- If "food handlers" card cannot be required, have employees complete the on-line class.
- What food safety components are included in Certified Home Care Aide training?
- What if the client doesn't want to replace refrigerator that isn't working properly?
- Agency's P&Ps – If an employee is preparing food for client / patient, the following is required …
- Hospice Care Centers?

- Hepatitis B testing
  - Requiring Hep B testing for Home Care agencies.
  - Occupational exposure is the main concern.
  - Look at OSHA requirements.
  - Taken from OSHA Hep B Fact Sheet – "An employer must develop an exposure control plan and implement use of universal precautions and control measures, such as engineering controls, work practice controls, and personal protective equipment to protect all workers with occupational exposure…The standard requires employers to offer the vaccination series to all workers who have occupational exposure. The vaccine and vaccination must be offered at no cost to the worker and at a reasonable time and place."
  - Requiring testing if employee cannot prove they've been vaccinated
  - Agencies should offer employees vaccination to employees.
  - If employee declines, they need to sign an appropriate form.
  - Clarifying steps to take if employee tests positive?
  - Costs to agencies?
  - Clarify requirements for final follow-up testing.
  - Large number of immigrant workers without Hep B.

- Home Health licensing
    - By definition, Home Health agencies provide two or more Home Health related services – should one of the two services include nursing services?
    - Is it ok to have a Home Health agency that does not provide general nursing services? For example: PT / OT only Home Health agency?
    - In general, the group agreed that Home Health agencies did not have to have nursing services as one of their services offered.
    - Some current Home Health providers were interested in pursuing a licensing exemption for businesses serving birth to three infants – not medically fragile. Most of the group disagreed and felt these infant services were indeed Home Health. People interested in pursuing such an exemption would need to seek a legislative amendment.
    - Questions were raised about School Districts providing home-based PT/OT and not having a Home Health license? (Research this and report back to group)
- Hours of operation
    - Clarify that the agency must have support services available for employees that are out in field caring for clients / patients
    - What type of support service are we talking about? Clinical support? Administrative?
    - Different support services defined for Home Care, Home Health, and Hospice.
- Hospice volunteers
    - Adding language that Hospice volunteers are mandatory reporters.
    - This is a state licensed only issue.
    - Do we have the authority in RCW?
    - RCW 74.34 – Abuse of Vulnerable Adults.
    - RCW 74.34.020 Definitions (16) "Permissive reporter" means any person, including, but not limited to, an employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults.
    - Or, can we match state requirements with Medicare standards?
- Key Individuals (Administrators, Direct Care Supervisors, Director of Clinical Care)

- Should minimum credentialing be required of agency Administrators, Direct Care Supervisors, and Directors of Clinical Care if they intend to provide hands-on backup care when employees are unable to provide client care? Example: Employee calls in sick and supervisor cannot find a replacement worker so they go and assist the client.
- Minimum credentialing should be required even in case of emergency.
- Minimum credentialing should be required if they intend / plan on providing back-up client care.
- Should supervisors hold and equal or greater credential to those that they supervise?

- NARs
  - Currently, Home Health agencies can hire an NAR and there is no requirement that they become a NAC – they can stay an NAR indefinitely.
  - Adding language that requires NARs to become NACs within "X" number of days after hire (similar to DSHS / Nursing facility rules – WAC 388-97-1660(3)(a)(i))
    - (3) The nursing home must ensure:
    - (a) Students in an DSHS-approved nursing assistant training program:
    - (i) Complete training and competency evaluation within four months of beginning work as a nursing assistant;
  - Does the Nursing RCW restrict us from requiring NARs to become NACs?
  - Linda Patterson of NQAC indicated there is no nursing related law that would prohibit us from pursuing an IHS rule requirement for NARs to become NACs within "X" days.
  - If we don't require a NAR to become a NAC, add training requirements in WAC.
  - Or, the Home Health agency must ensure the NAR is competent.

- Non-direct care worker (Discussion ended. Start February 3, 2016 workshop here)
  - Should we add language that agencies can employ non-credentialed individuals to provide clients / patients with hands-off services (e.g. house cleaning, yard maintenance)?
  - If so, clarify that these employees need to pass the same background checks as credentialed employees.

- Non-medical services in Home Health agencies
    - Clarifying that Home Health only agencies can provide non-medical services to patients (e.g. Home Health Aide services) without having a Home Care service category.
- Nursing Delegation in Home Care agencies
    - Adding language that Home Care agencies utilizing Nurse Delegation must contract (not hire) with an RN.
    - Nurse delegation (ND) – clarify how often the delegating RN should assess the patient?
    - Clarify what ND looks like in a Home Care agency vs. Home Health agency.
        - Most home health agencies that also do non-medical home care have been providing nurse delegation under their home health license. This needs to be clarified in rule that this is acceptable.
    - Make sure we reference the updated ND rules (WAC 246-840-910 thru 970).
    - Invite appropriate stakeholders to discuss ND issues (e.g. DSHS - Doris Barret; NQAC).
- Orientation classes
    - Requiring new applicants to complete a department hosted In-Home Services Orientation class prior to licensure.
    - Completion of an orientation class may assist new licensees in becoming more successful in their first year of operation.
    - Some applicants may choose to withdraw their application after they learn what is expected of them.
- Plan of Care (POC) for Home Care agencies
    - Adding “resuscitation status” on Home Care POCs.
- Policies and Procedures
    - Requiring new applicant to submit their completed P&Ps along with application and fee.
    - Historically, many applicants have not completed their P&Ps when DOH conducts their initial on-site licensing survey. This results in a significant delay in the licensing process and often requires a second on-site survey.
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- Professional Insurance limits
    - What should the new minimum insurance limits be?
- Range of Motion (ROM)
    - Clarifying what ROM activities are permissible in a Home Care setting.
    - Active vs passive.
    - Hands-on vs reminders.
    - Home exercise program developed by a Physical Therapist and Home Care Aide is reminding client.
- Restraints
    - Adding language regarding the use of client / patient restraints. Patients should be free from the use of unlawful restraints.
    - Side rails on beds?
- RN Director of Clinical Services
    - Should the Director of Clinical Services in a Home Health agency be required to be an RN?
- Skills verification
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- TB testing
    - Contact Local Health Jurisdiction (LHJ) annually to verify if testing is needed and document LHJ's response.
    - What type of testing is recommended?
    - Developing P&Ps around TB risk assessments.
- Definition of "Therapist" currently includes the following professionals: physical therapist, occupational therapist, respiratory therapist, and speech therapist.
    - Should we include additional therapists such as Acupuncture and Massage?

- Vital signs in Home Care agencies
    - Define what constitutes vital signs and clarify what Home Care agencies employees can and cannot do