TABLE E.2: Administrator Questionnaire Write-in Responses.

Question	Response	Frequency
AQ18	**Agency's Fiscal Intermediary**	
	• Palmetto Government Benefits Administrators	12
	• Wellmark	7
	• Blue Cross of California	7
	• Blue Cross and Blue Shield of Wisconsin	6
	• United Government Services of Wisconsin	6
	• Associated Hospital Service of Maine	4
AQ27_4	**Standardized Care Plans for Other Cardiac Disorders**	
	• Arrhythmias	2
	• CABG	2
	• Angina	1
	• CABG/Valve	1
	• Hypertension	1
	• All cardiac diagnoses including post-cardiac surgery	1
	• Ischemia	1
AQ27_15	**Other Standardized Care Plans**	
	• Anemia, PVD	1
	• 43 diagnoses, including pediatrics	1
	• Neurogenic bladder	1
	• Plan of care, CVA	1
	• Hospice	1
	• Safety	1
AQ27_16	**Other Standardized Care Plans**	
	• CABG, urostomy, HTN, postpartum & well newborn	1
	• Generic, cancer	1
	• MCH & high risk pregnancy, PIH, hyperbil., routine follow-up	1
AQ28_d	**Other Changes Due to Venipuncture Regulations**	
	• Total number of visits	1
	• Number of discharges	1
	• Burden on outpatient labs	1
	• Caseload	1
AQ28_e	**Other Changes Due to Venipuncture Regulations**	
	• Burden on patient/caregiver	1
	• Number of agency-wide home health aide visits	1
AQ28_f	**Other Changes Due to Venipuncture Regulations**	
	• Costs associated with venipuncture	1

TABLE E.2: Administrator Questionnaire Write-in Responses. (cont'd)

Question	Response	Frequency
AQ30	**Description of Nurse Productivity Standard for Post-Hospital Discharge Patients**	
	• A post-hospital discharge patient generally receives a SN visit 3x week for 3-4 weeks, then a SN visit 2x week for 3 weeks, then a SN visit 1x week for 3 weeks.	1
	• Do what client needs related to condition.	1
	• Frequency and duration of visits is based on: 1) physicians' orders, 2) assessment findings including clinical, function and educational needs, with consideration to social support systems and multidisciplinary conferencing.	1
	• 4x1, 3x1, 2x2, 1x3.	1
	• Depends on patient condition, minimum 3x3.	1
AQ32	**Description of Nurse Productivity Standard for CHF Patients**	
	• We use clinical pathways to guide us in our treatment of the CHF patients. However, the visit may exceed the number on the clinical pathway depending on the patient condition and situation.	1
	• The critical pathway suggests once a day for 3 days, twice a week for 3 weeks, and once a week for 6 weeks. The admission RN makes the final decision based on her assessment and client's condition.	1
	• SN daily x 3d, 3x week for 2 weeks, 1x week for 3 weeks.	1
	• Frequency and duration of visits is based on: 1) physicians' orders, 2) assessment findings including clinical, function, and educational needs, with consideration to social support systems and multidisciplinary conferencing.	1
	• 3 x week x 3 weeks - but really depends on patient need and physician orders.	1
	• 4x1, 3x1, 2x2, 1x3	1
	• Individualized care plan.	1
AQ34	**Description of Nurse Productivity Standard for Diabetic Patients**	
	• We use clinical pathways to guide us in the treatment of the CHF patients. However, the visit may exceed the number on the clinical pathway depending on the patient condition and situation.	1
	• SN once a day for 4 days, every other day for 6 days; as necessary to complete instruction. The RN makes the decision based on her assessment and client's condition.	1
	• Newly diagnosed vs. long time diabetic vs. exacerbation or complication.	1
	• Frequency and duration of visits is based on: 1) physicians' orders, 2) assessment findings including clinical, function and educational needs, with consideration to social support systems and multi-disciplinary conferencing.	1
	• 4x1, 3x1, 2x2, 1x3	1
	• Individualized care plan.	1

TABLE E.2: Administrator Questionnaire Write-in Responses. (cont'd)

Question	Response	Frequency
AQ40	**Description of Standard for Home Health Aide Assignment**	
	• After being hired, the CNA's clinical skills will be checked off using a competency skills checklist. The CNA will not be assigned patients until the competency checklist has been completed.	1
	• We use the OASIS & comprehensive assessment data.	1
	• Aides are assigned by the RN based on the assessment and client's condition, availability of a caretaker, consistency of care and condition of the environment (home).	1
	• Based on need for hands-on personal care/availability of alternative caregiver, based on qualifying criteria as outlined in HIM-II (206.2).	1
	• These clients would be offered an aide unless they had an able and willing caregiver and refused aide services.	1
	• If patient requires assistance with personal care & family not able to help.	1
	• All home health aide assignments are made after evaluation of need and eligibility criteria. If a need exists but client is not eligible, referral for social services is made.	1
	• At least 75% of what needed to be done for the patient is hands-on personal care. Comes from Medicare standards.	1
	• Need for personal care and insurance coverage, also available caregiver is considered.	1
	• Case-by-case aide assignment is based on level of patient need and capability of the caregiver.	1
	• Individualized care plan.	1
AQ42	**Description of Standard for Home Health Aide Assignment to CHF Patients**	
	• Aides are assigned by the RN based on the assessment and client's condition, availability of a caretaker, consistency of care and condition of the environment (home).	1
	• These clients would be offered an aide unless they had a willing and able caregiver and refused an aide.	1
	• All home health aide assignments are made after evaluation of need and eligibility criteria. If a need exists but client is not eligible, referral for social services is made.	1
	• Need for personal care and insurance coverage, also available caregiver in home is considered.	1
	• Individualized care plan.	1
AQ44	**Description of Standard for Home Health Aide Assignment to Diabetic Patients**	
	• Aides are assigned by the RN based on the assessment and client's condition, availability of a caretaker, consistency of care and condition of the environment (home).	1
	• These clients would be offered an aide unless they had a willing and able caregiver and refused an aide.	1
	• All home health aide assignments are made after evaluation of need and eligibility criteria. If a need exists but client is not eligible, referral for social services is made.	1
	• Individualized care plan.	1

TABLE E.2: Administrator Questionnaire Write-in Responses. (cont'd)

Question	Response	Frequency
AQ45	**Procedures Performed by Home Health Aides**	
	• None	8
	• Only personal care, catheter care, and no invasive care.	1
	• Tap water enemas.	1
	• Range of motion, ostomy care and ostomy dressing changes.	1
	• Reinforcing dressings, application of simple unsterile dressings.	1
	• Clean dressing changes, blood pressure, temperature, pulse, enemas.	1
	• Catheter services, medication reminders (no hands-on meds), occasional blood pressures & assistance with ostomy care.	1
	• Glucometer checks, vital sign checks, simple dressing changes, ostomy changes, enemas, medication reminders.	1
	• Medication administration under the direction of a Registered Nurse and simple dressings.	1
	• Simple medication administration. Under specific direction of the RN, checking vital signs.	1
	• Delegated tasks such as ACE wraps, simple dressing changes, range of motion exercises, etc.	1
	• Medication assistance - refuse to open pill boxes, simple dressing changes (non-sterile), Foley catheter care (not insertion), range of motion - agency does very little delegation even though it is covered in state practice act.	1
	• The State Nurse Practice Act does not allow any nursing procedures to be performed by home care aides.	1
	• Assistance with IADLs (laundry, essential shopping, and meal prep). Assistance with plan of care: i.e., assist patient with home exercise programs, often instruction received from the physical therapist or nurse.	1
	• See attached home health aide information.	1
	• Monitor vital signs, including blood pressure.	1
	• Temperatures, fleet enema, assist with colostomy care, assist with Foley catheter care, I & O.	1
	• Reinforce wound dressings; temperature, pulse, and respiration.	1
	• Medication reminders, simple dressing changes, established ostomy care.	1
	• Enemas, range of motion, simple dressing changes, ostomy care.	1
	• Non-sterile wound care, accuchecks.	1
	• Personal care, can't administer medications, delegated to do routine wound, rashes - ointment - can give patients their meds to take but cannot administer them, trying to get more of a scope of what is allowed and what is not.	1
	• Simple wound dressing changes.	1
	• Basic wound care if delegated by an RN, insertion of rectal suppositories (laxative) if delegated by an RN.	1
	• 1) Change a clean dressing, 2) administer 'Fleets' enema, 3) apply topical creams and ointments, 4) change bags on an established colostomy, 5) assist with medications (i.e., can open container, but not pour. Also can remind client to take meds). All of the above require delegation from an RN.	1
	• Home exercise programs, non-sterile wound dressings.	1
	• Simple dressing changes, blood pressures, use of restraints, ostomy/Foley care.	1
	• Assistance with wound care (simple), assistance with rehab exercises, assistance with oral medications (reminder to take).	1
	• Basic personal care, activity of daily living assistance, remind patient to take medications, therapeutic communication.	1
	• Simple wound care dressings, vital signs, home exercise programs under PT supervision.	1
	• Simple dressing changes, catheter care, occasional exercises.	1
	• Simple dressing changes, range of motion exercises, weights.	1
	• Simple dressing changes.	1
	• Bowel program, sterile & non sterile procedures, invasive procedures, care of broken skin, reinforcement of health teaching.	1

TABLE E.2: Administrator Questionnaire Write-in Responses. (cont'd)

Question	Response	Frequency
AQ45 (cont'd)	**Procedures Performed by Home Health Aides**	
	• In our agency we elected to allow our aides only to perform home care aide duties. We do not delegate skilled procedures.	1
AQ48_4	**Other Staff Who Complete HCFA-485**	
	• Recertification Nurse & Admitting Nurse	1
	• Outcomes manager from hospital	1
AQ50	**Key Patient Factors Used to Negotiate Visits**	
	• N/A; at this time we are not required to negotiate visits for Medicare clients.	2
	• Acuity level, caregiver support, level of education of the patient and caregiver.	1
	• Severity of illness, what doctor dictates, level of ADLs, patient needs PT.	1
	• Individual patient need.	1
	• Patient status, teachable caregiver.	1
	• 1) Multiplicity of co-morbid diagnoses, 2) fragility and stability of patient, 3) amount of caregiver support available.	1
	• Skilled need, availability of alternative caregiver.	1
	• Severity of illness, complexity of care.	1
	• Skilled care required, presence of social supports.	1
	• Acuity, need (ability to learn), support systems, ability to receive care (or not) outside home.	1
	• Patient's functional status, skilled care needs, availability (or lack of) caregivers.	1
	• Acuity, homebound status, physicians' orders.	1
	• Complexity of task, availability of support (family/friends), client family able to learn treatment, stability/instability of medical condition.	1
	• Visits are negotiated in accordance with severity of illness, learning abilities and degree of family/caregiver support.	1
	• Patient status, severity of illness, level of care required. Availability of other family caregivers.	1
	• Medical conditions, knowledge deficits, caregiver support.	1
	• 1) Physicians' orders, 2) clinical assessment findings, including clerical functions, educational needs taking into account support systems and multidisciplinary case conferencing.	1
	• Medical diagnosis, skilled care needs, home environment, self care deficits, community resources, psychological status, mental status, support systems.	1
	• Condition on assessment and reassessment, ongoing process.	1
	• Patient status, goals, need for service.	1
	• Diagnosis, patient's condition and frequency of changes, treatments ordered, availability of caregiver.	1
	• Needs identified based upon physical assessment, acuity and patient diagnosis.	1
	• Presence/absence of a caregiver, functional ability, safety and environmental needs.	1
	• 1) Medical necessity, 2) skilled need, 3) psycho-social issues/family dynamics.	1
	• Patient medical condition, physician's orders.	1
	• Acuity, environment, procedures.	1
	• Skilled need, caregiver support, learning needs, complexity of care, psychosocial situation.	1
	• The patient's condition which requires skilled service, degree of complexity of the care needed, willing/capable caregiver available, physician's orders, degree of homebound status.	1
	• 1) Acuity, 2) diagnosis and severity of symptoms, 3) complexity of care required, 4) required skilled interventions, 5) desired outcomes expressed by the patient.	1

TABLE E.2: Administrator Questionnaire Write-in Responses. (cont'd)

Question	Response	Frequency
AQ50 (cont'd)	**Key Patient Factors Used to Negotiate Visits**	
	• Physician orders, skilled need, location of patient in county (remoteness of area).	1
	• Physician orders, patient needs.	1
	• Homebound status, medical necessity, level of care, caregiver availability skill.	1
	• Severity and symptomatology of the patient; onset of illness; willingness and ability of the patient and/or caregiver to learn; predisposing factors; new diagnosis or change in medication regime.	1
	• Patients' mental status, caregiver availability. Patients' condition: complex needs, recent changes, new onset. History of frequent hospitalizations/exacer-bations.	1
	• Severity of illness, able caregiver present in home, ability to perform ADLs, complexity of wound care or procedure.	1
	• Severity of diagnosis, no able caregiver in home, degree of patient incapacitation, exacerbations and complications.	1
	• The number of visits is not negotiated, it is based on the needs of the patient.	1
	• Complexity of case, new diagnosis, visits allowed by individual policy.	1
	• Eligibility, patient condition & needs, availability of caregiver.	1
	• Diagnosis, patient's knowledge, social environment, willing/able caregivers, ability to learn, prognosis.	1
AQ52_r and AQ52_s		
	• Helping Hands	1
	• Medication Patient Assistance Program	1
	• St. Vincent DePaul	1
	•	
AQ61_3	**Discharge Policy for Admission to Inpatient Facility - Hours**	
	• 24	10
	• 0	4
	• 23	1
	• 25	1
AQ61_3	**Discharge Policy for Admission to Inpatient Facility - Days**	
	• 14	4
	• 1	2
	• 0	1
	• 3	1
	• 10	1
	• 15	1
	• 30	1
AQ68	**Date of Change in Agency Ownership or Merger**	
	• 01/01/99	2
	• 10/01/97	1
	• 01/01/98	1
	• 02/01/98	1
	• 05/01/98	1
	• 11/01/98	1

TABLE E.2: Administrator Questionnaire Write-in Responses. (cont'd)

AQ45 Attachment	Procedures Performed by Home Health Aides	

HHA INFORMATION

WHAT IS A HOME HEALTH AIDE?

A Home Health Aide is an individual with nurses aide training. _____ employs and utilizes Home Health Aides who are "certified." This means that they have taken a training course and have passed a written and practical examination and possess certification through the _____ State Board of Nursing. Certified Home Health Aides practice under the instruction and supervision of a registered nurse (RN), Physical Therapist (PT) and/or speech therapist (ST).

HOW MUCH TIME WILL THE AIDE SPEND WITH ME?

The primary function of the Home Health Aide is to perform or assist personal care. Personal care is bathing, dressing, turning and positioning, assisting with transfers from bed to chair, helping to carry out home exercise programs left by a therapist - anything that requires "hands on" assistance.

Because levels of ability and/or disability vary so widely, the nurse or therapist will determine the amount of time appropriate for each patient on an individual basis. It may take 1 hour to assist personal care for someone who requires moderate assistance and 2 hours to provide personal care for someone who is bedbound, incontinent and in need of feeding.

The Home Health Aide will stay in the home as instructed by the supervisor in order to complete the assigned care.

WHAT TYPES OF THINGS CAN A HOME HEALTH AIDE DO FOR ME?

* bathe or assist bathing, shampooing, dressing
* assist use of the bedpan, urinal or commode
* assist transfer (bed to chair, sit to stand, stand to sit, chair to bed; may use mechanical devices to assist with transfers)
* make observation of changes in physical or mental condition (and report changes to the nurse)
* meal planning and preparation, shopping, light housekeeping
* assess temperature, pulse and respiration
* assist with oral medications, which have been prepared by the nurse or a family member (which are ordinarily self-administered, as ordered by the physician)
* assist with following home exercise programs initiated by therapists
* assist with braces and prostheses as directed by the nurse or therapist
* assist with following medical recommendations of rest, exercise and physical activity
* assist with use of medical and rehabilitation equipment

TABLE E.2: Administrator Questionnaire Write-in Responses. (cont'd)

DOESN'T THE HOME HEALTH AIDE ALSO DO HOUSEWORK AND SHOPPING?

At least 75% of the Home Health Aide's time in the home should be spent doing personal, or "hands on" care. In addition, the Home Health Aide may clean the patient's immediate living areas, usually the bedroom, or prepare a meal or do the patient's personal laundry.

Because the time allowed to do these other tasks is limited, it is anticipated that patients and family members will discuss these needs with the nurse on the first visit. For those tasks beyond the ordinary ability of the Home Health Aide, the nurse will make alternative suggestions.

ARE THERE THINGS THAT A HOME HEALTH AIDE CANNOT DO?

Yes! A Home Health Aide cannot:

- change a sterile dressing or one that requires application of medication
- give an enema or irrigate a colostomy
- apply heat, in any form
- irrigate or change foley catheter
- perform vaginal irrigations
- give injections
- drive the patient or family members in an automobile
- lift the entire weight of the patient
- massage a limb
- clip finger or toe nails
- perform general housecleaning
- shave a patient with a straight or safety razor - they may only use an electric razor

HOW LONG WILL THE AIDE BE PROVIDED?

When the skilled care stops, the Home Health Aide also stops. This means that when the Visiting Nurse, Physical Therapist, Occupational Therapist and Speech Therapist announce their last visit, the Home Health Aide will stop at the same time.

If, for any reason, the Home Health Aide continues after the last skilled visit, you need to call our Home Health Aide Coordinator at (XXX) XXX-XXXX to inform us. All insurers pay for the Aide only in conjunction with skilled care.

WHAT IF THE PATIENT NEEDS CONTINUED HELP AFTER DISCHARGE FROM HOME CARE?

We can assist you with phone numbers for sources of care on a private pay basis.

WE WOULD BE HAPPY TO DISCUSS ANY SPECIAL NEEDS YOU MAY HAVE OR TO FURTHER EXPLAIN THE ROLE OF THE HOME HEALTH AIDE. CALL US BETWEEN 8:00AM - 4:30PM, MONDAY THROUGH FRIDAY.