Agenda: Home Care and Assisted Living Program Advisory Council

Monday, September 10, 2018
2:00 pm – 4:00 pm

Location: Wilder Center
451 Lexington Pkwy N.
St. Paul, MN 55104
Auditorium A

1. Welcome and introductions – Cathy Griffin (10 min)
2. Annual Charter Review - Cathy Griffin (15 min)
3. Program and Department Updates – Jeri Cummins (20 min)
    a. HCALP Continuous Improvement Project
    b. Health Regulation Redesign
4. Survey Forms – Cindy Vargas (30 min)
5. Annual Recommendations for Legislature – Council (40 min)
6. Closing (5 min)

Future FY19 Work Group Meetings

None scheduled

Future FY19 Quarterly Advisory Council Meetings

September 10, 2018 (Mon)	Council Meeting	2-4 pm	Wilder Center, St. Paul - Auditorium A
December 3, 2018 (Mon)	Council Meeting	2-4 pm	Wilder Center, St. Paul - Auditorium A
March 4, 2019 (Mon)	Council Meeting	2-4 pm	Wilder Center, St. Paul - Auditorium A
June 3, 2019 (Mon)	Council Meeting	2-4 pm	Wilder Center, St. Paul - Auditorium A

Minnesota Department of Health
Home Care and Assisted Living Program
PO Box 3879, St. Paul, MN 55101
651-201-5273
health.homecare@state.mn.us

09/10/2018

To obtain this information in a different format, call: 651-201-5273.

Home Care and Assisted Living Program
Advisory Council Charter

~~05 31 2017~~ 9/10/18

Background	In 2013, the Minnesota Legislature enacted sweeping changes to the licensing of home care providers in Minnesota. While the licensing structure became simpler, the requirements to be a licensed home care provider are now stronger along with specific requirements for regulation and enforcement.
Purpose	By developing strong working relationships with members and through regular analysis of data leading to respectful discussions, we plan to create a model of licensed home care that respects providers and protects the people they serve.
Structure	Some structure is mandated by statute and some decided by council members: • By statute: o Meets quarterly o Meetings are open meetings as described in Chapter 13D o Members may be compensated for authorized expenses • By agreement: o Quarterly meetings are two hours long o Ad hoc work groups meet as needed between quarterly meetings o Meetings are in person, by phone or other electronic means o Standards for what constitutes a day spent on council activities to make daily payments o Members may be removed if they miss three consecutive meetings
Scope	Each member represents a type of home care stakeholder. In their Council work, members use their personal experience but also are aware about the group of stakeholders they represent. The Council provides information, guidance and recommendations to MDH about regulations for licensed home care providers.
Authority	The Licensed Home Care Advisory Council is a recommending body. At the commissioner's request, the Council provides information, guidance and recommendations to MDH about regulations for licensed home care providers on topics that include: • Standards of practice • Appropriateness of certain disciplinary actions • Enforcement criteria • How to inform licensed providers and home care consumers • Training specifications • Recognizing trends and opportunities including technology and telehealth • Creating license modifications and exemptions • Recommendations for studies using data in section 62U.04, Subd. 4 • Review balance in state government special revenue fund • Make annual recommendations to legislature by January 15 • Other duties and topics as directed by the Commissioner
Boundaries	There are certain parameters that limit MDH's ability to change elements about, or related to, home care licensing and regulatory oversight. Some of them are: • Current state statutes and administrative rules related to the licensing, delivery or payment of home care services o Council may recommend revisions • Available resources within MDH o Council may recommend how to allocate resources

	• Competing priorities of the legislature and MDH leadership such as: o Council may recommend different priorities
Membership	Representation of the Council is mandated by Minn. Statute 144A.4799 which describes an eight person council, appointed by the commissioner of health including: • Three public members who: o Are currently receiving home care services or o Have family members receiving home care services or who have family members who received home care services within five years of their application date • Three Minnesota licensed home care providers representing: o Basic and comprehensive licensure o Managerial officials, administrators, supervising RNs or unlicensed personnel • One member from the Minnesota Board of Nursing • One member representing the ombudsman for long-term care Minn. Stat 144A.4799 refers us to use Minn. Stat. 15.059 to organize and administer the council: • Four year terms beginning on first Monday in January • Half of members with election of governor and remainder one year later • Members may serve until successors are appointed and qualified
Roles	**Members:** Prepare for and participate in scheduled meetings. Be a communication vehicle for the stakeholders they represent. Openly share their experiences with council members to help improve the efficiency and effectiveness of home care licensing and regulation. Alert the council about important trends. Recommend agenda items for meetings. **MDH Key Staff:** Schedule, notify about, prepare for, facilitate and participate in meetings. Develop agendas based on council priorities, hot topics and current trends. Assist to locate subject matter experts if needed. Document key outcomes and next steps from meetings. Provide forms for members to request reimbursement of expenses and process the forms timely. (MDH key staff who must attend: Program Manager, at least one survey supervisor, at least one licensing specialist, at least one staff for administrative support.) **Internal and External Subject Matter Experts (SMEs):** Provide adequate information on designated topics to allow Members to make informed recommendations. **Guests:** May attend all council meetings and numbers will vary based on location and agenda topics. If Council Members approve, guests may provide input on agenda topics. **Sponsors:** Provide authority and advice as needed. (Assistant Commissioner, Division Director, Assistant Division Directors)
Timeline	The Licensed Home Care Advisory Council is an ongoing group. We will review the Charter annually at the start of the calendar year.
Expected Outcomes	We expect the Council will: • Make thoughtful recommendations to achieve the best outcomes for licensed home care providers and the people they serve • Develop strong working relationships with council members and MDH staff that will foster innovative solutions to strengthen home care licensure and regulatory functions • Value the contributions of each council member and understand that we need to listen to each other and respectfully allow for the discussion of differences • Consider objective facts and available data when making recommendations • Be accountable to the people of Minnesota through open communication, transparency, timeliness and a desire for continuous quality improvement

Dear HCALP Surveyors,

We are very pleased to inform you that the first batch of revised survey forms are available and **ready for you to pilot**. Many things have changed. We hope you find the changes support your work through the new organization of content and plain language wording.

Project goals

- More efficient survey process
- Clear communication of license requirements
- Improved provider self-audit opportunities (resulting in more prepared providers)
- Improved new surveyor training
- Meet MDH branding and accessibility requirements
- Professional presentation of materials

Changes include

- New organization of content
- Plain language (whenever possible)
- Purpose statements and/or instructions at the start of many documents to help providers and surveyors understand how to use the forms
- Active links to the statutes (if using the form on-line) and supporting url lists (if using a printed version of the document – in progress)
- Form numbering system for easy searching in the pool

What surveyors should do now

- **Review** the forms
- **Start using** the new versions on your next survey
- **Ask questions** as needed
- **Provide feedback weekly** to Cindy. She will provide a feedback form for you to use.

Find the new forms here

P:_Standards & Templates\New Survey Forms_SURVEYOR PDFs_2018

What's next

The project team will continue its work on the remaining forms. As new forms become available we will communicate with the survey teams.

Over the next six weeks (September 1 – October 15) we will collect your feedback. Let us know what works, what doesn't work. Ideas/comments are actively sought and welcome.

At the end of the six-week feedback period we will make revisions and roll out the new forms, including for providers to use for self-audit purposes. The forms will be posted on the website and communications will be made with providers via govdelivery.com, Home Care Matters calls, advisory council meetings and through surveyor efforts on-site.

Documents ready to pilot

Entrance Conference Documents

- Introduction Letter_License Survey_F5023
- Introduction Letter_Temporary License Survey_F5024
- Entrance Conference Form_Comprehensive_F5065
- Current Client Roster_BASIC_F5064
- Current Client Roster_COMP_F5060
- Discharged/Deceased Client Roster_F5061
- Employee List (sample form)_F5066 (NEW FORM)

During the Survey Documents

- CLIA Application and Waiver Instructions_F5050
- Client Observation and Record Review_Comprehensive_F5022
- Consent for Home Visit_F5026
- Employee, Volunteer and Individual Contractor Record Review_F5021
- Medication Administration Observation and Drug Storage_F5028
- Notes Form_Handwritten_F5063
- Notes Form_Fillable_F5062
- Treatment Observation Form_F5027

Exit Conference Documents

- Correction Order Documentation Guidelines_F5040
- Exit Conference Attendance Sheet_F5068
- Exit Conference Guidelines_F5067
- Process for Requesting a Reconsideration_F4123
- Provider Resources (3 versions: electronic, print, horizontal)_F6060, F6061, F6062

After the Survey Documents

- JH_Provider Questionnaire_F5030-JH
- JC_Provider Questionnaire_F5030-JC

Other Provider Documents

- Statement of Home Care Services_Basic_F4031
- Statement of Home Care Services_COMP_F4032

Documents under development

- Guide to Survey Process for Licensed Home Care Providers_F5020
- Guide to the Initial Survey Process for Temporary Licensees_F5019
- Entrance Conference_Guidance Document_Comprehensive_F5066 (NEW)
- Dementia Training Requirements_F4122 (NEW)
- Training Requirements for Unlicensed Personnel_F4110 (NEW)
- Orientation Requirements_F4120 (NEW)
- Annual Training Requirements_F4121 (NEW)
- Service Plan for Home Care Clients_F4102 (NEW SAMPLE FORM)
- Requirements of a Home Care Service Plan_F4100 (NEW)
- Guidelines for Completing the Service Plan_F4101 (NEW)

Home Care Survey Introductory Letter

FOR BASIC AND COMPREHENSIVE LICENSEES

My name is _____, RN. I am a nurse with the Minnesota Department of Health (MDH). The purpose of my visit is to complete the licensing survey for your home care license and review the quality of care clients receive.

During the survey I will observe and interview staff, clients and client representatives (if applicable). I will also review records, including those for:

- Clients
- Employees
- Operational and/or administrative policies and procedures

I will need access to these records. You can provide the records electronically or on paper. We will discuss this at the beginning of the survey.

The information provided by your staff is a very important part of my evaluation. I want all staff to feel comfortable talking to me. Be sure to ask me any questions you may have. If I say something you don't understand, feel free to ask me to explain. I will explain the results of my visit after I am done with the observations, interviews, record reviews and home visits.

If you have any questions or comments about my visit, feel free to contact the Home Care and Assisted Living Program manager:

Cathy Griffin
Cathy.Griffin@state.mn.us
651-201-3708

MDH has a website where information for home care providers is posted. We encourage you to visit the website for information designed to help providers meet licensing requirements and improve the quality of care for the clients.

Website: http://www.health.state.mn.us/divs/fpc/homecare/index.html

Thank-you for taking the time to help with the evaluation of your home care services.

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Health Regulation Division
P.O. Box 3879
St. Paul, MN 55101-3879
Phone 651-201-5273 | Fax 651-215-9697
www.health.state.mn.us/divs/fpc/homecare/

To obtain this information in a different format, call 651-201-5273. Printed on recycled paper.

Home Care Survey Introductory Letter

FOR TEMPORARY LICENSEES

My name is _____, RN. I am a nurse with the Minnesota Department of Health (MDH). The purpose of my visit is to complete the initial licensing survey for your temporary home care license and review the quality of care clients receive.

During the survey I will observe and interview staff, clients and client representatives (if applicable). I will also review records, including those for:

- Clients
- Employees
- Operational and/or administrative policies and procedures

I will need access to these records. You can provide the records electronically or on paper. We will discuss this at the beginning of the survey.

The information provided by your staff is a very important part of my evaluation. I want all staff to feel comfortable talking to me. Be sure to ask me any questions you may have. If I say something you don't understand, feel free to ask me to explain. I will explain the results of my visit after I am done with the observations, interviews, record reviews and home visits.

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DEPARTMENT OF HEALTH

Entrance Conference Form

COMPREHENSIVE HOME CARE PROVIDERS

Purpose

This form is for use by

- Minnesota Department of Health (MDH) home care surveyors on survey;
- Licensed home care providers to conduct self-audits and prepare for surveys.
- Applicants for home care licensure

At the time of survey, surveyors will ask for the information requested in this document, including the provider policies, procedures and reports listed on the last page. Have this information readily available.

Statute references (with links to the Revisor's website) occur throughout the document. (e.g., 144A.479). Click on the link and scroll to the noted subdivision for more information about the requirements.

See the *Entrance Conference Guidance Document (MDH form HCALP-F5066)* for additional information about what surveyors will review. (NOTE: This is a new document that is still in development.)

At the start of a survey, the surveyor(s) will

- Request a meeting with the licensee or designee;
- Provide an introductory letter, explain the purpose of the survey and give an overview of the process;
- Provide the licensee with a copy of the *Guide to the Survey Process for Licensed Home Care Providers (MDH form HCALP-F5020).* (NOTE: This is document is still in development.)

Provider Information

Provider name: _____ HFID: _____

Date/Time: _____ Surveyor name: _____

License effective and expiration dates: _____

Conference attendees: _____

Email of agent: _____

Administrator name: _____

Housing with services director name: _____

Provider is familiar with current home care laws and regulations ☐ Yes ☐ No
(144A.472 subdivisions 1, 2, and 3)

Provider holds the integrated license: HCBS designation ☐ Yes ☐ No

Current license is displayed in provider's place of business/branch offices ☐ Yes ☐ No

Nurse/Licensed Health Professional Information

Director of nursing (DON) name: _____

DON's work cell #: _____ DON's hours/days: _____

RN(s)' previous experience: _____

Other nurse name(s): _____

Nursing hours: _____ Nursing days of the week:_____

PT/OT/Speech therapist name (if applicable): _____

How many licensed staff work for this licensee? _____

Explain on-call nurse system: _____

Locations / Type of establishment

Services under this license are provided: ☐ Not in HWS ☐ In HWS

Special programs or units for residents with dementia: ☐ Yes ☐ No

Provider advertises as providing specialized care for residents with dementia, Alzheimer's disease or related disorders: ☐ Yes ☐ No

Obtain schedule of home visits during the survey (if applicable): _____

_____

Housing with services locations

At time of survey, providers should have available (if applicable):

- The total census for each HWS location;
- Special access codes for locked units;
- Branch office address(s).

Services and client admission

Home care services offered: _____

_____

Provide a copy of the admission packet, including:

☐ Home care bill of rights (Statute: 144A.4791, Subd. 1 (a)(b)(c))
☐ Written complaint notice (Statute: 144A.4791, Subd. 11)
☐ Statement of services given to clients (Statute: 144A.4791, Subd. 3)
☐ Website and advertising information (Statute: 144A.4791, Subd. 2)
☐ All nursing assessment forms

Assessment, service plan and service provision

Nursing assessments: Describe your assessment procedures. Include information about the initial assessment, reassessments/changes in condition, individual abuse prevention plans, falls, physical device/safety (e.g. bed rails). (Statutes: 144A.4791, Subd. 8; 144A.479, Subd. 6; and 144A.44 Subd. 1(2))

_____

_____

Service plan: Describe your procedure for development and maintenance of the service plan. (Statute: 144A.4791, Subd. 9)

_____

_____

Medication management services: Describe your medication management services. (Statute: 144A.4792, Subd. 1 through Subd. 23)

_____

_____

RN medication assessment process: Describe your medication management assessment process**.** (Statute: 144A.4792, Subd. 2, 3, 4, 5)

_____

_____

Medication administration system: Describe your medication administration system including times, PRN procedures, medication security and storage. (Statute: 144A.4792, Subd. 5, 7, 9, 19, 22, 23)

_____

_____

Medication management services for clients who will be away from home: Describe your protocols. (Statute: 144A.4792, Subd. 10)

_____

_____

Prescribed medication: Describe your system for how prescribed orders are communicated to the registered nurse, including when received by fax. (Statute: 144A.4792, Subd. 11 through Subd. 16)

_____

_____

Treatment or therapy services: Identify the client treatment and therapy services you provide. (Statute: 144A.4793 Subd. 2)

_____

_____

Development of client treatment or therapy plans: Describe your individualized treatment or therapy management plans. (Statute: 144A.4793, Subd. 3, 6)

_____

_____

Documentation of treatment and therapy plan and services in client record: Describe how/what you document in the client record regarding treatment/therapy plans. (Statute: 144A.4793, Subd. 4, 5)

_____

_____

Client record documentation system: Describe your client record documentation system, whether electronic, paper, or both. Explain how records are maintained and secured and where information is located. (Statutes: 144A.4794, Subd. 2, 3; 144A.474, Subd. 5, 6)

_____

_____

Staff orientation, training and supervision

All staff

Orientation and training of unlicensed personnel and professional staff:
Describe who trains staff. (Statute: 144A.4796, Subd. 1,2) _____

_____

Describe how competencies (written and demonstrated) are documented and tracked. (Statute: 144A.479, Subd. 7)

_____

_____

Describe your system for completing annual training. When is it done: monthly, yearly, or anniversary hire date? (Statute: 144A.4795, Subd. 3, 7 (a)(b)(c))

_____

_____

Describe your system for completing annual performance reviews. (Statute: 144A.479, Subd. 7 (4))

_____

_____

Training for dementia, Alzheimer's disease or related disorders:
Describe your system for completing the required training at hire date and annually. (Statutes: 144A.4796 Subd. 5 for all providers; 144D.065 for providers serving clients in housing with services establishments with and without special unit or advertising)

_____

_____

Notice of services for dementia, Alzheimer's disease or related disorders:
Describe your training program for the above. (Statute: 144A.4791 Subd. 2)

_____

_____

Unlicensed personnel (ULP): training and supervision

Treatment and therapy services: Describe your system for training and competency evaluations. (Statutes: 144A.4793, Subd. 4 and 144A.4795, Subd. 3, 7(a)(b)(c))

_____

_____

Medication administration: Describe the training and supervision process for ULPs.(Statute: 144A.4792, Subd. 7, and 10 (b))

_____

_____

Staff communications

ULP communications: Describe your agency's system for how ULPs communicate with each other regarding changes in clients' conditions or events that occurred on their shifts. Describe how ULPs communicate to the RN or LPN.

_____

_____

Nursing staff communications: Describe your agency's system for how nursing staff communicate to ULP regarding changes in clients' condition, medications, treatments, etc.

_____

_____

Staffing patterns

Contracted staff: Describe your ULP and licensed nursing staffing schedule, if applicable. (Statute: 144A.479, Subd. 7)

_____

_____

Staffing patterns: Describe your staffing schedule.

Days: _____

Evenings: _____

Nights: _____

Complaints and investigations

Client complaint procedure: Describe your client complaint procedure. Provide your written client complaint form. (Statute: 144A.4791 Subd. 11 (c))

_____

_____

Investigating client complaints: Describe your system for investigating and documenting client complaints. (Statute: 144A.479 Subd. 11 (a) (b))

_____

_____

Management of client unusual occurrences/incidents: Describe your investigative procedures and implementation of interventions for incidents such as falls, medication errors, elopement, etc. Describe how you document these incidents. (Statutes: 144A.4794, Subd. 3 and 144A.479, Subd.6)

_____

_____

Tuberculosis (TB) Prevention and Control Program

Facility risk assessment completion date: _____/_____/_____ Level: _____

Describe your employee, regularly scheduled volunteer, and contracted staff TB screening process, to include:

- TB policy and procedures;
- Staff TB history and symptom screens and baseline screenings at hire date;
- TB training records.

(Statute: 144A.4798, Subd. 1)

Quality management activities

Describe your agency's quality management plan and provide documentation for current year. (144A.479, Subd. 3)

_____

_____

Provide these required documents at start of survey

Reports and documents

- ☐ Current client roster (may use MDH form HCALP-F5060)
- ☐ Discharged/deceased client roster (may use MDH form HCALP-F5061)
- ☐ List of current employees, titles, and their hire dates.
- ☐ List of all licensed staff and evidence of current licensure
- ☐ Documentation of incidents, accidents and medication errors for the past six months.
- ☐ Abuse/neglect reports for the past six months. (MAARC)
- ☐ Any complaints for the past three to six months.
- ☐ 24-hour report book or communication book, if applicable
- ☐ Unlicensed personnel daily assignment work/shift forms
- ☐ Admission information (See page 2, Services and client admission)
- ☐ For HWS with special programs or units or that advertise as providing specialized care for residents with dementia, Alzheimer's disease or related disorders, a copy of your public disclosure statement as required in Statute 325F.72
- ☐ CLIA waiver (if applicable)
- ☐ Current year's quality management plan
- ☐ Medication administration book and treatment provision documentation/book. (Provide when requested.)

Provider policies and procedures

- ☐ Training of unlicensed personnel training on:
  - Documentation requirements
  - Medication administration
  - Delegated tasks
  - Treatments and therapies (Statute: 144A.4793, Subd. 1 and 2)
  - Training on dementia and related disorders
- ☐ Content of employee records
- ☐ Disaster and emergency plan (for business and for individual clients)
- ☐ Quality management plan and activities
- ☐ Orientation and annual training (including curriculum)
- ☐ Content of client records
- ☐ Vulnerable adult reporting / Reporting of maltreatment of minors (if serving minors)
- ☐ Handling of complaints from clients and/or client representatives

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DEPARTMENT OF HEALTH

Current Client Roster

BASIC LICENSED HOME CARE PROVIDER

Provider Name: _____ HFID: _____ Date: _____

List all <u>current clients</u>. Check services or events pertaining to the client. Use additional sheets if needed. See back for definitions.

Name of Client Room # / Unit	Start of Services	Primary Diagnosis	Recent (3 mo) Hospitalization	Falls (3 mo)	ADL Assistance	Medication Reminders	Standby Assistance	Treatment Reminders	Modified Diet	Laundry	Housekeeping	Meal Preparation	Shopping	Other

144A.43 Definitions

Subd. 3a. Hands-on assistance. "Hands-on assistance" means physical help by another person without which the client is not able to perform the activity.
(Note: Hands-on assistance is a comprehensive level service. Basic providers cannot provide hands-on assistance.)

Subd. 24. Reminder. "Reminder" means providing a verbal or visual reminder to a client.

Subd. 30. Standby assistance. "Standby assistance" means the presence of another person within arm's reach to minimize the risk of injury while performing daily activities through physical intervention or cuing.

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DEPARTMENT OF HEALTH

Current Client Roster

COMPREHENSIVE HOME CARE PROVIDER

Provider Name: _____ HFID: _____ Date: _____

List all current clients. Check services or events pertaining to the client. Use additional pages as needed. See definitions on back.

										Medication Administration					**Treatments and Therapies**									
Name of Client Room # / Unit	Start of Services	Primary Diagnosis	Basic Service Only	Memory Care	Recent (3 mo) Hospitalization	Falls (3 mo)	Bed Rails or Restraints	Skilled or Medicare Certified Care	Hospice	Nebulizer	Psychotropic Medications	Med-Admin	Med-Set-ups	Insulin	Dialysis	Oxygen	Ventilator	C- pap or Bi-pap	Tube Feed	PT/OT/ST	Blood Glucose Monitoring	Catheter	Wound Care	Other Treatments

144A.43 Definitions

Subd. 2c. Dietary supplement. "Dietary supplement" means a product taken by mouth that contains a dietary ingredient intended to supplement the diet. Dietary ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissue, glandulars, or metabolites.

Subd. 10. Medication. "Medication" means a prescription or over-the-counter drug. For purposes of this chapter only, medication includes dietary supplements.

Subd. 11. Medication administration. "Medication administration" means performing a set of tasks to ensure a client takes medications, and includes the following:
(1) checking the client's medication record;
(2) preparing the medication as necessary;
(3) administering the medication to the client;
(4) documenting the administration or reason for not administering the medication; and
(5) reporting to a nurse any concerns about the medication, the client, or the client's refusal to take the medication.

Subd. 12. Medication management. "Medication management" means the provision of any of the following medication-related services to a client:
(1) performing medication setup;
(2) administering medication;
(3) storing and securing medications;
(4) documenting medication activities;
(5) verifying and monitoring effectiveness of systems to ensure safe handling and administration;
(6) coordinating refills;
(7) handling and implementing changes to prescriptions;
(8) communicating with the pharmacy about the client's medications; and
(9) coordinating and communicating with the prescriber.

Subd. 16. Over-the-counter drug. "Over-the-counter drug" means a drug that is not required by federal law to bear the symbol "Rx only."

Subd. 35. Treatment or therapy. "Treatment" or "therapy" means the provision of care, other than medications, ordered or prescribed by a licensed health professional provided to a client to cure, rehabilitate, or ease symptoms.

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DEPARTMENT OF HEALTH

Discharged/Deceased Client Roster

LICENSED HOME CARE PROVIDER

Provider Name: _____ HFID: _____ Date: _____

List all <u>discharged or deceased</u> clients for the <u>past six months</u>.

Name of Client	Diagnosis	Date Started Services	Date of Discharge/Death	Place death occurred: Nursing home, assisted living, hospital, home (if applicable)	Discharged to: Nursing home, assisted living, hospital, home (if applicable)	Was service termination notice given? Yes or No

DEPARTMENT OF HEALTH

Employee List (sample form)

FOR LICENSED HOME CARE PROVIDERS

Purpose

Current employee names, titles and hire dates must be given to Minnesota Department of Health surveyors upon request. Providers may use this form or their own.

Employee Name	Title	Hire Date

Clinical Laboratory Improvement Amendment Information

Overview of Requirements

The Clinical Laboratory Improvement Amendment (CLIA), a federal government program, requires a CLIA certificate when providers conduct any tests, including waived tests, on materials taken from the human body (saliva, serum, blood, urine, tissues, etc.) to provide health information for the diagnosis, prevention, or treatment of disease or impairment, or assessment of a person's health. The type of CLIA certificate required depends upon the level of complexity of the tests.

Application Process

Complete the application and email or mail it to the Minnesota Department of Health. Approximately two weeks after the application is processed, an invoice for $150 will be mailed to the provider/laboratory. The certificate will be mailed after payment is received and posted by CLIA. **Do not send payment with the application.**

CLIA Application for Certification

Certificates must be renewed every two years. Providers must update the CLIA Program at the Minnesota Department of Health when there are changes (such as the named laboratory director).

Certificates of Waiver

Some providers conducting tests will need a certificate of waiver. Examples of waived tests include blood glucose, fecal occult blood, streptococcus, influenza, mononucleosis, urine pregnancy, cholesterol tests and INR. Providers should review the information on the CLIA website to determine the level of certificate, if any, that is required for their agency.

Send completed applications to

Email: Health.clia@state.mn.us

OR

CLIA Program
Minnesota Department of Health
3333 West Division Street Suite 212
St. Cloud, MN 56301

Questions?

CLIA hotline: 651-201-4120
Email: Health.clia@state.mn.us

06/21/2018

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DEPARTMENT OF HEALTH

Client Observation and Record Review

COMPREHENSIVE HOME CARE PROVIDER

Purpose

The *Client Observation and Record Review* is used by Minnesota Department of Health (MDH) surveyors to document evidence of:

- Observations of client care and services;
- Medication management services;
- Treatment and therapy services;
- All nursing assessments; and
- Client and/or family interviews (utilizing the *Home Visit Client/Family Interview*).

Providers may use this document to self-audit. Statute references (with links to the Revisor's website) occur throughout (e.g., 144A.4792, Subd. 1). Click on the link and scroll to the noted subdivision for information about the requirements.

Provider Information

Provider name: _____ HFID: _____

Date/Time of survey: _____

Client Information

Name: _____ Identifier: _____

Diagnoses: _____

Start of care: _____ Service plan date: _____

Surveyor

Surveyor name(s): _____

Discharged Client Record Review

☐ Discharge summary (144A. 4794 Subd. 3 (14);

☐ Disposition of medications (144A. 4792 Subd. 22 (c)

Client Daily Life Review

Caregiver observed: _____ (name and identifier)

Position/title: _____

Observations of staff and client services are made throughout the survey. Interviews of staff and clients are conducted to evaluate and validate surveyor observations and findings. Areas reviewed include but are not limited to:

- ☐ Staff knowledge and implementation of the client's service plan and the client's individualized vulnerable adult or minor abuse prevention plan.
- ☐ Client is free from physical and verbal abuse.
- ☐ Client with care needs including but not limited to: durable medical equipment, tube feedings, pressure ulcers, blood glucose checks, insulin, oxygen, dialysis, hospice care and falls.
- ☐ Care and services are provided in accordance with accepted medical and nursing standards.
- ☐ Current standards of practice for infection control are followed, including but not limited to appropriate hand hygiene, handling and transporting linen to prevent spread of infection and the use of protective gloves when appropriate.
- ☐ Client is treated with courtesy and respect and client's rights are not violated.
- ☐ Staff listens and is responsive to client requests. (Note staff interaction with both communicative and non-communicative clients.)
- ☐ Medication administration and/or assistance with self-administration of medications.
- ☐ Client appears clean and neat.
- ☐ Client is free from physical and/or chemical restraints.
- ☐ Other observations/interviews as deemed necessary (e.g., behaviors).

Client Record Review

Client records are reviewed to determine if documentation standards are met related to evaluation and assessments and the services the client is receiving.

- ☐ Individual abuse prevention plan is current and includes:
  - ☐ An individualized assessment of client's susceptibility to abuse by other individuals;
  - ☐ Assessment of the client's risk of abusing other vulnerable adults or minors; and
  - ☐ Statements of the specific measures to be taken to minimize the risk of abuse to the client and other vulnerable adults or minors.

  Date of most current IAPP: _____ (144A.479, Subd. 6 (b))
- ☐ Registered nurse initial assessment is within 5 days of starting services. Date: _____ (144A.4791, Subd. 8 (a))
- ☐ Reassessment is within 14 days of starting services. Date: _____ (144A.4791, Subd. 8 (b))
- ☐ Ongoing client monitoring at least every 90 days. Dates: _____, _____, _____ or with a change in client's condition. Date(s) _____, _____ (144A.4791, Subd. 8 (c))
- ☐ Service plan completed within 14 days of admission and revised as needed. Date(s) _____, _____ (144A.4791, Subd. 9 (a) (b) (c) (d) (e) (f))
- ☐ All services are provided and documented (ADLs, IADLs, medications and treatments) as noted in the client's service plan. (144A.4791, Subd. 9 (c) and 144A.4794, Subd. 3)

☐ Client-specific written instructions are present for delegated nursing procedures. (144A.4792, Subd. 7; and 144A.4793, Subd. 4) Date: _____

☐ Documentation of client's receipt (date and signature) and review of:
- ☐ Minnesota home care bill of rights _____ (144A.479, Subd. 1)
- ☐ Statement of home care services _____ (144A.479, Subd. 3)

☐ Written complaint notice _____ (144A.4791, Subd. 11 (a) (b) (c))

☐ Documentation of complaints received and resolution, if applicable.

☐ Client records are kept confidential and are secure. (144A.4794 Subd. 1 (b))

☐ Entries in the client's record are current, authenticated and legible. (144A.4794 Subd. 1 (a))

☐ Significant changes or incident(s) and the actions taken in response are documented, (e.g. client falls, post-hospital, ER visits, any client deterioration) (144A.4791, Subd. 8 (c))

Medication Management

(144A.4792)

Surveyors review client's record for compliance related to medication administration including all dietary supplements (Subd. 2 (c)), over-the-counter (Subd. 16) and prescribed medications (Subd. 22 and 151.01 Subd. 16 (a)) taken by the client. ☐Registered nurse developed and implemented an individual medication management plan prior to provision of services. Medication plan is current and updated with any changes.

Assessment date: _____ (Subd. 2)

☐ Medication orders are renewed at least every twelve months. (Subd. 3)

☐ Individual medication management plan included descriptions of:
- ☐ Medication management services provided by nurse and ULP (included PRN).
- ☐ Type of medication storage system, based on client needs.
- ☐ Specific written instructions for client's medication administration.
- ☐ Person responsible for monitoring medication supplies and refills.
- ☐ Medication management tasks that may be delegated to ULPs.
- ☐ Procedures for staff to notify an RN when problems arose.
- ☐ Any client-specific requirements (e.g., parameters: blood sugar, blood pressure, pulse, etc.)

Individual medication management plan date: _____ (Subd. 5)

☐ If delegated, employee record shows RN instructed ULP in proper methods, ULP demonstrated competency and instructions are written and specific to client. (Includes PRN medications) (Subd. 7)

☐ Medication administration records are complete; medications are administered as ordered and documented correctly, or reason not administered is documented. (Includes PRN effectiveness) (Subd. 8)

☐ Medication set-up and administration is documented. (Subd. 9)

☐ Documentation of medication administration was completed for client who was away from home. (Subd. 10 (a) (b))

☐ Prescriber's orders are written and dated for medications administered and orders are complete. (Subd. 13)

☐ Verbal orders are received only by a nurse or pharmacist, are entered into the client record and recorded and forwarded for signature. (Subd. 15)

☐ Electronically transmitted orders are recorded, communicated to the registered nurse and placed in client record. (Subd. 16)

Treatment and Therapy Management Services

(144A.4793, Subd. 1-6)

Client's record (including the service plan and treatment administration records) is reviewed for all prescribed treatments and therapies administered by the provider's employee(s).

Examples of treatments and therapies include but are not limited to CPAP, O2, pulse oximetry, blood glucose checks, tube feedings, TED hose, splints, P.T./O.T. exercises, and wound care. Surveyors will also review maintenance procedures for equipment used in treatments and therapies.

Individual treatment and therapy management plan

☐ RN or appropriate licensed health professional developed treatment plan (before services were provided). Date: _____

☐ Plan is current and updated with any changes. Date: _____

Plan includes the following items:

- ☐ Written client instructions for each treatment or therapy.
- ☐ A list of the treatment or therapy tasks delegated to ULPs.
- ☐ Procedures to notify an RN or other licensed professional when there are problems with treatments or therapies.
- ☐ Documentation of all treatments or therapies administered, or reason not administered.
- ☐ Verified as administered and monitored by RN to prevent complications or adverse reactions.

☐ Prescriber's orders are written, complete and dated for treatments or therapies administered.

☐ Service plan includes a written statement of treatments and therapies provided.

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DEPARTMENT OF HEALTH

CONSENT FOR HOME VISIT

HOME CARE LICENSE SURVEY

Client Name: _____

Client Address: _____

Provider Name: _____

I consent to Minnesota Department of Health (MDH) personnel to conduct a home visit to assess the effectiveness and quality of the home care services I am receiving and to ensure that those services satisfy State requirements.

I understand that consent for this visit is voluntary and that the visit will be performed only if I grant permission. I also understand that refusal to consent to a home visit will have no effect on the level and nature of the services I am receiving.

I understand I am not legally required to provide any information about myself. I understand that my name, address and telephone number are private information, which will be disclosed only to certain MDH employees and, if necessary, employees of the Attorney General or Office of Administrative Hearings.

Client/representative signature: _____

Printed name: _____

Date of consent: _____

Verbal consent obtained from: _____

Date of consent: _____

Relationship to client (if not client): _____

Reason verbal consent obtained: _____

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Employee, Volunteer, Individual Contractor and Temporary Staff Record Review

COMPREHENSIVE HOME CARE PROVIDER

Purpose

Minnesota Department of Health (MDH) surveyors use this form to verify that the following individuals have the required professional credentials and have completed the required training, orientation and competency testing:

- Unlicensed personnel (ULP)
- Professional/licensed personnel
- Individual contractors
- Temporary staff
- Volunteers

Providers may use this document to self-audit. Statute references (with links to the Revisor's website) occur throughout (e.g., 144A.479). Click on the link and scroll to the noted subdivision for more information about the requirements.

Minnesota statutes 144A.479, Subd. 7 and 144A.4795 require that the following items be documented in the record for each paid employee (including temporary staff), regularly scheduled volunteer and individual contractor:

1) Evidence of licensure/certification/registration, if required;
2) Completion of orientation, annual training, infection control training, competency testing;
3) Current job description, including qualifications, responsibilities and identification of staff providing supervision;
4) Annual performance reviews which identify areas of improvement needed and training needs;
5) For individuals providing home care services, verification of required health screenings;
6) Completed and passed background study.

Provider Information

Provider Name: _____ HFID: _____

Date/Time of Survey: _____

Employee/Volunteer/Individual Contractor/Temp Staff Information

Name: _____ Identifier: _____

Title/Position: _____ Start Date: _____

Surveyor

Surveyor Name: _____

Record Review: All Employees, Volunteers, Individual Contractors, Temporary Staff

Credentials

- ☐ Current license or certification: Type _____; Dated _____
- ☐ Currently registered on MDH nursing assistant registry; Dated _____

Orientation (144A.4796, Subd. 1, 2, 3, 4 and 5)

- ☐ Orientation to home care regulations (Subd. 2 (a) and (b)) (Must be completed prior to providing home care services to clients.) Dated _____
  - ☐ Overview of home care statutes
  - ☐ Review of provider's home care services policies and procedures
  - ☐ Handling emergencies and using emergency services
  - ☐ Reporting maltreatment of vulnerable adults or minors
  - ☐ Home care bill of rights
  - ☐ Handling of clients' complaints, reporting of complaints, where to report
  - ☐ Consumer advocacy services
  - ☐ Review of types of home care services the employee will provide and provider's scope of license
  - ☐ Hearing loss training (optional)
- ☐ Orientation to each specific client and services provided (144A.4796, Subd. 4)
- ☐ If serving clients not in housing with services, training in working with clients who have dementia, Alzheimer's disease or related disorders, if applicable. (144A.4796 Subd. 5)
- ☐ If serving clients in housing with services, initial dementia care training in the specified topics as required in 144D.065 (a) b) c) (d).

Annual Training (144A.4796, Subd. 6)

- ☐ Last annual training dates _____, _____, _____
  - ☐ At least eight hours for every 12 months of employment, in the following topics:
  - ☐ Reporting maltreatment of vulnerable adults or minors
  - ☐ Home care bill of rights
  - ☐ Infection control techniques
  - ☐ Review of provider's home care services policies and procedures
- ☐ If serving clients in housing with services, at least two hours for every 12 months of employment of training in working with clients who have dementia, Alzheimer's disease or related disorders (144D.065 (a) b) c) (d))

Other requirements

- ☐ Current job description – Dated _____
- ☐ Annual performance reviews completed on _____, _____
- ☐ TB screening and training (144A.4798, Subd. 1)
  - ☐ TB history and symptom screen completed on _____
  - ☐ Baseline screening (TST x 2, serum or CDC accepted standard) on _____
  - ☐ TB training (at hire) completed on _____
- ☐ Background study (144A.476 Subd. 2) completed on _____

Record Review: Unlicensed Personnel (ULP) Only

ULP training and competency testing

☐ Training and competency in the 22 areas required in 144A.4795, subd. 7 (b) and (c)

- ULPs currently listed on the MDH nursing assistant registry (NAR) are assumed to be competent in these requirements. NAR expiration date: _____
- See *Training Requirements for Unlicensed Personnel (HCALP-F4110) (Under development)*

Supervision of ULP

☐ ULP was supervised within 30 days of performing delegated tasks on _____ (144A.4795, Subd 3 (b))

☐ If ULP administers medications, the ULP has been trained and has demonstrated competency to the RN on all route procedures.

☐ Planned or unplanned times away:

- ☐ ULP has been trained in preparing medications and has demonstrated competency to the RN. (144A.4792, Subd. 10 (b))
- ☐ RN has specific written procedures related to administration and documentation of medications for leaves of absence.

☐ If ULP performs delegated tasks (including but not limited to monitoring blood glucose; administration of tube feedings; assistance with CPAP, oxygen, compression stockings; prescribed exercises; assistance with eating program), confirm that:

- ☐ RN or other licensed health professional has instructed ULP in proper methods;
- ☐ ULP has demonstrated competency to RN or other licensed health professional;
- ☐ RN or other licensed health professional has appropriately delegated tasks. (144A.4793 Subd. 4)

Record Review: Professional Staff Only

Does this employee train unlicensed personnel? ☐ Yes ☐ No

☐ If yes, verify that employee has training and experience in home care services delivery.

Surveyor sign off

Requirements reviewed: (Surveyor initials) _____

The surveyor will document concerns and follow up in notes.

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DEPARTMENT OF HEALTH

Medication Administration Observation and Drug Storage

COMPREHENSIVE LICENSED HOME CARE PROVIDER

Provider Name: _____ HFID: _____

Date: _____ Surveyor Name: _____

When possible, the surveyor will observe medication administration to verify that staff administers medications using the proper technique and medications are administered as ordered. If possible, the surveyor will observe at least 10 medications being administered, by three or more different staff, by three or more different routes, at three or more medication times.

Date / Time	Name of Staff Person Observed / Title	Client Name	Drug, Dosage, Route	Observation Notes	Prescriber's Order? Yes or No

Observation Findings

During observation of medication administration, did you identify problems such as:

- ☐ Incorrect medication administered to client;
- ☐ Incorrect medication dose administered to client;
- ☐ Medication administered without a prescriber's order;
- ☐ Medication not administered as ordered before, after, or with food/antacids;
- ☐ Medications administered without adequate fluid as manufacturer specified, such as laxatives;
- ☐ Failed to check pulse and/or blood pressure prior to administering medications when ordered;
- ☐ Medication administered after date of expiration on label;
- ☐ Medication administered to client via wrong route;
- ☐ Prior to medication administration gastrostomy tube placement not checked;
- ☐ Gastrostomy tube not flushed with required amount of water before and after medication administration as prescribed;
- ☐ Improper technique used for intravenous/intramuscular/subcutaneous injections;
- ☐ Insulin suspensions: Failed to "mix" the suspension without creating air bubbles;
- ☐ Failed to "shake" a drug product that is labeled "shake well."
- ☐ IM/SQ injection sites not rotated;
- ☐ Transdermal patch sites not rotated;
- ☐ Inhaler medication not administered according to prescriber's orders/manufacturer's guidelines;
- ☐ Multiple eye drops administered without adequate time sequence between drops;
- ☐ Staff did not observe the complete medication administration.
- ☐ Other (describe): _____

1. Was the observed medication preparation or administration in accordance with the prescriber's orders, accepted professional standards, and/or manufacturer's specifications? ☐ Yes ☐ No

Drug Storage and Labeling

- ☐ System is in place, with written policies and procedures, that addresses requesting and receiving prescriptions, preparing and giving medications, verifying medications are administered as prescribed, documenting medication management, control of medications, storing of medications, monitoring medication use, resolving medication errors, communicating with the prescriber, pharmacist or client, educating clients about medications and disposition of medications.
- ☐ Drugs and biologicals are stored in locked compartments under proper temperature controls and permit only authorized staff to have access to keys. Documentation of refrigerator temperature logs are maintained.
- ☐ When controlled substances are being managed, there are policies and procedures that identify how the provider will ensure security and accountability for the overall management, control and disposition of these substances. Over the counter drugs that are retained in general stock supply are kept in the original labeled container.
- ☐ Prescription drugs are kept in their original containers bearing a prescription label and not used or saved for the use of another client.

2. Are all drugs and biologicals stored and labeled properly? ☐ Yes ☐ No

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DEPARTMENT OF HEALTH
HOME CARE & ASSISTED LIVING PROGRAM

Provider Name: _____ HFID: _____

Surveyor Name/ID: _____

Care Area(s)/Activity: _____

Enter the time, source, and documentation.

Date and Time	Source and Documentation

Date and Time	Source and Documentation

DEPARTMENT OF HEALTH

Provider Name: _____

HFID: _____ Date: _____

Surveyor Name: _____

Treatment Observation Form

LICENSED HOME CARE PROVIDER

Instructions

When possible, the surveyor will observe clients receiving at least three different treatments such as (but not limited to) blood glucose checks, tube feedings, pressure ulcer treatments, oxygen therapy, etc. to verify that staff is competent and use proper technique in performing the treatment.

Date and Time	Name and Title of Staff Person Observed	Client Name	Treatment	Observation Notes

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HCALP-F5027
08/30/2018

Exit Conference

GUIDELINES FOR SURVEYORS

Protocols

1) Have all personnel (MDH and provider) sign the *Exit Conference Attendance Form.*
2) Introduce team members.
3) Thank staff for courtesies extended (i.e. coffee, assistance, copies, etc.).
4) State: "This has been a survey from (date) _____ to (date) _____. During the course of the survey, we have gathered information related to your clients and the care they are receiving, medications, treatments and personnel training and competency."

Review the following with provider

1) Explain the preliminary findings, including statute numbers.
2) Inform that:
    a. You will leave them with a draft of the preliminary findings.
    b. The findings may change after supervisory review.
    c. The provider can submit additional information, if they wish.
    d. When survey results (2567) are received, the required date of correction will be indicated by each order.
    e. A revisit can occur at any time following the required date of correction.
    f. If this is a revisit, there is no correction time period, unless there are new orders. They will receive a 2567 if they have orders and the 2567B if they have corrected some or all orders.
    g. Surveys are emailed within 30 days to the authorized agent on file.
3) Remind the agent to notify us of any changes and to check both the inbox and junk mail folders to ensure receipt of survey documents.
4) Invite provider, again, to submit additional information.

Leave with provider

- *Draft of Preliminary Findings (including client identifiers)*
- *Process for Requesting a Reconsideration*
- *Resources for Home Care Providers* (which includes the MDH TB guidelines document)

DEPARTMENT OF HEALTH

Exit Conference Attendance

LICENSED HOME CARE PROVIDER SURVEY

Instructions

Complete this form at the start of the survey exit conference.

Provider/Licensee Information

Provider Name: _____

HFID: _____ Survey Exit Date:_____

Surveyors

Surveyor Name: _____Title: _____

Surveyor Name: _____Title: _____

Surveyor Name: _____Title: _____

Provider/Licensee Staff Members in Attendance

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

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HCALP-F5068
09/04/2018

Correction Order Documentation Guidelines

BASIC AND COMPREHENSIVE LICENSED HOME CARE PROVIDERS

Minnesota Home Care Statute Reference

144A.474 SURVEYS AND INVESTIGATIONS, Subd. 8. Correction Orders
(c) By the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.

Documentation Guidelines

Licensed home care providers must take action to correct violations found at survey. The correction order documentation should include the following:

a. Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.

b. Identify how the area(s) of noncompliance was corrected for all of the provider's clients/employees that may be affected by the noncompliance.

c. Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

The provider is not required to send correction order documentation to the Minnesota Department of Health, however the provider must document in the provider's records any actions taken to comply with the correction orders and must make these records available upon request by the commissioner.

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Process for Requesting a Reconsideration

FOR LICENSED HOME CARE PROVIDERS

Statute

144A.474, Subdivision 12

Overview

Following a home care license survey, licensed home care providers may challenge the correction order(s) and request that the Minnesota Department of Health (MDH) reconsider its findings. Providers may challenge the level and/or the scope and any fine assessed. During the review, the correction orders are not stayed, but MDH will post information on its website that the licensee has requested a reconsideration and that a review is pending.

Process

- Correction orders are emailed to the agent on record.
- The request for reconsideration (with supporting documentation) must be received by MDH within 15 calendar days of the correction order receipt date. The receipt date is the date the orders are emailed to the provider.
- The request must include a list of the order(s) being challenged and the reasons the provider disagrees with MDH's findings.
- The reconsideration may be conducted in person, by phone, by electronic form, or in writing.
- MDH will respond in writing to the provider within 60 days of the request.
- The response will identify MDH's decision regarding each citation challenged by the provider.

Additional information

- The reconsideration will be reviewed by someone other than the surveyor, investigator or supervisor that participated in issuing the order.
- If the findings are changed by MDH, the website will be updated to reflect the change.
- The correction order reconsideration process does not apply to temporary licensees.

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HCALP-F4123
08/30/2018

Resources for Home Care Providers

This document provides links to websites with valuable information for home care providers. You can find this same information (with active links) on the Home Care and Assisted Living Program website: health.state.mn.us/divs/fpc/homecare/providers/resources.html

Minnesota Department of Health (MDH)

MDH Home Page
health.state.mn.us/index.html

Home Care and Assisted Living Program Home Page
health.state.mn.us/divs/fpc/homecare/index.html

Home Care Laws
health.state.mn.us/divs/fpc/homecare/laws/index.html

Frequently Asked Questions: Home Care Providers
health.state.mn.us/divs/fpc/homecare/providers/faq.html

Federal Certification Process for Home Health Agencies
health.state.mn.us/divs/fpc/profinfo/lic/hhamedicare

Tuberculosis Information
health.state.mn.us/tb

Infection Prevention and Control Guidelines
health.state.mn.us/divs/idepc/dtopics/infectioncontrol/guidelines.html

Regulations for TB Control in MN Health Care Settings (pdf)
health.state.mn.us/divs/idepc/diseases/tb/rules/tbregsmanual.pdf

Nursing Assistant Registry
health.state.mn.us/divs/fpc/profinfo/narinfo/index.html

Drug Diversion
http://www.health.state.mn.us/patientsafety/drugdiversion/index.html

Disaster Planning and Emergency Preparedness
http://www.health.state.mn.us/divs/fpc/homecare/providers/emergency.html

Basic Home Care Provider: Survey Forms
health.state.mn.us/divs/fpc/homecare/surveyforms/basicsurveyforms.html

Comprehensive Home Care Provider: Survey Forms
health.state.mn.us/divs/fpc/homecare/surveyforms/compsurveyforms.html

MDH Official Notices and Updates

service.govdelivery.com/accounts/MNMDH/subscriber/new?topic

Minnesota Department of Human Services

Department of Human Services (DHS) Home Page
mn.gov/dhs

NetStudy 2.0: Background Studies
mn.gov/dhs/general-public/background-studies

DHS Provider Enrollment
dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_000221

Minnesota Health Care Programs Provider Manual
dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000094

Ombudsman for Long Term Care
mn.gov/dhs/people-we-serve/seniors/services/ombudsman

CountyLink
dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=Countylink_Home

TrainLink: DHS Training Opportunities
dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_007128

Publications and Documents

Minnesota Home Care Laws
Bound copy:
mnbookstore.com/laws-rule-extracts/health-care/home-care-licensure-laws-97.html
Digital copy:
mnbookstore.com/laws-rule-extracts/health-care/home-care-laws-digital-file-14539.html

Minnesota Board of Nursing

MN Board of Nursing Home Page
mn.gov/boards/nursing

Federal Government Agencies

Centers for Medicare and Medicaid Services (CMS)
cms.gov

Consumer Organizations and Associations*

Minnesota Board on Aging
mnaging.net

Senior Linkage Line
seniorlinkageline.com

Minnesota Falls Prevention
mnfallsprevention.org

Minnesota Help
minnesotahelp.info

Provider Advocacy Organizations*

Care Providers of Minnesota
careproviders.org

Leading Age Minnesota
leadingagemn.org

Minnesota Home Care Association
mnhomecare.site-ym.com

*The Minnesota Department of Health does not endorse any of these organizations.

Questions? Contact Us

Home Care and Assisted Living Program
Health Regulation Division
Minnesota Department of Health
PO Box 3879
St. Paul, MN 55101-3879
651-201-5273
health.homecare@state.mn.us
health.state.mn.us

06/26/2018

To obtain this information in a different format, call: 651-201-5273.
To report issues with this document: health.homecare@state.mn.us

DEPARTMENT OF HEALTH
HOME CARE & ASSISTED LIVING PROGRAM

Home Care Provider Post Survey Questionnaire

We are interested in your opinions regarding the Minnesota Department of Health (MDH) home care provider survey. Please give us your feedback by completing this questionnaire. The information will be used as part of our internal quality improvement process. The completed form can be submitted by folding and securing the document, adding a stamp and sending to MDH. You may also fax this document to 651-215-9697. Completion of this form is optional.

Please circle your responses:

4 = Strongly Agree
3 = Agree
2 = Disagree
1 = Strongly Disagree
0 = No Opinion or not Applicable

1. There was effective communication between the reviewer and the provider. 4 3 2 1 0

   Comment

2. Staff of the agency were treated in a professional manner. 4 3 2 1 0

   Comment

3. Education and/or information provided was beneficial. 4 3 2 1 0

   Comment

4. Additional comments? (e.g., strengths, improvement needed, suggestions for further educational topics, other)

Date(s) of survey (optional): _____

Signature, title (optional): _____

Thank you!

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Health Regulation Division
P.O. Box 3879
St. Paul, MN 55101
Phone 651-201-5273 | Fax 651-215-9697
www.health.state.mn.us/divs/fpc/homecare/

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Return to:
Jeri Cummins, Supervisor
Health Regulation Division
Home Care and Assisted Living Program
P.O. Box 3879
St. Paul, MN 55101

DEPARTMENT OF HEALTH
HOME CARE & ASSISTED LIVING PROGRAM

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Return to:
Jonathan Hill, Supervisor
Health Regulation Division
Home Care and Assisted Living Program
P.O. Box 3879
St. Paul, MN 55101

DEPARTMENT OF HEALTH

Statement of Home Care Services: Comprehensive Home Care Provider

Home Care Provider Name: _____

Below is a list of all services that *may* be provided with a comprehensive home care license. **Each service offered by this provider is indicated by a check in the box next to the service.**

- ☐ Advanced practice, registered or licensed practical nurse services
- ☐ Physical/occupational therapy, speech-language pathologist or respiratory therapy services
- ☐ Social worker, dietician or nutritionist services
- ☐ Medication management services
- ☐ Delegated tasks to unlicensed personnel
- ☐ Hands-on assistance with transfers and mobility
- ☐ Providing eating assistance for clients with complicating eating problems
- ☐ Complex or Specialty Healthcare Services – Describe:_____
- ☐ Assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing
- ☐ Standby assistance within arm's reach for safety while performing daily activities
- ☐ Verbal or visual reminders to take regularly scheduled medication
- ☐ Verbal or visual reminders to the client to perform regularly scheduled treatments and exercises
- ☐ Preparing modified diets ordered by a licensed health professional

I have received a copy of this *Statement of Home Care Services*:

Client Signature: _____ Date: _____

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Statement of Home Care Services: Basic Home Care Provider

Home Care Provider Name: _____

These services *may* be provided with a basic home care license. **Each service offered by this provider is indicated by a check in the box next to the service.**

☐ Assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing
☐ Standby assistance within arm's reach for safety while performing daily activities
☐ Verbal or visual reminders to take regularly scheduled medication
☐ Verbal or visual reminders to the client to perform regularly scheduled treatments and exercises
☐ Preparing modified diets ordered by a licensed health professional

The services listed below are comprehensive home care services and **may not** be provided with a basic home care license.

- Advanced practice, registered or licensed practical nurse services
- Physical/occupational therapy, speech-language pathologist or respiratory therapy services
- Social worker, dietician or nutritionist services
- Medication management services
- Delegated tasks to unlicensed personnel
- Hands-on assistance with transfers and mobility
- Providing eating assistance for clients with complicating eating problems
- Complex or specialty healthcare services

I have received a copy of this *Statement of Home Care Services*:

Client Signature: _____ Date: _____

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