HCAF
Home Care Association of Florida
RESOURCES, EDUCATION, ADVOCACY

January 9, 2024

Jeremy Roberts
Health Quality Assurance Rules Coordinator
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Sent electronically to jeremy.roberts@ahca.myflorida.com

Dear Mr. Roberts,

I am writing on behalf of the Home Care Association of Florida (HCAF) to express our appreciation for the efforts of the Agency for Health Care Administration (AHCA) in enhancing care for medically fragile children through the proposed Rule 59A-8.0099 – Home Health Aides for Medically Fragile Children.

HCAF represents Florida's more than 2,300 licensed home health agencies, including providers that participate in the Medicaid program. While recognizing the potential impact of this program, we have identified several concerns based on provider feedback that, in our view, require careful consideration and clarification.

Concerns & Recommendations

1. **Increased Training and Staffing Costs:** The 86-hour training requirement, while comprehensive, raises financial concerns for smaller agencies, potentially impacting staffing costs and access to care. We recommend phasing in the training or providing financial incentives to ensure program viability and accessibility.

2. **Supervisory Burden:** Mandatory registered nurse (RN) supervisory visits every 30 days present logistical challenges, especially for geographically dispersed agencies. Exploring alternative models such as telehealth or tiered supervision based on child complexity could enhance efficiency while maintaining essential oversight.

3. **Liability and Risk Management:** Expanding caregiving roles to family members requires robust risk management. We recommend mandatory liability insurance for home health aides for medically fragile children and robust risk protocols for participating agencies to mitigate potential risks and ensure safety.

4. **Operational Challenges:** Integrating the program with existing services requires clear guidance from AHCA. Streamlining RN supervision and medication administration with home health aide for medically fragile children services, along with considering efficiency for less complex cases, will facilitate a smooth transition.

5. **Impact on Existing Staff and Families:** Introducing home health aides for medically fragile children may affect existing home health aides and families, potentially leading to concerns about continuity of care. Strategies to address these concerns, including additional training for existing staff, are essential. AHCA should also explore effective communication strategies to navigate the transition for both staff and families.

6. **Emergency Respiratory Management:** Further clarification is sought regarding the standard of care outlined in Section 13(b)1. Specifically, does the training curriculum include procedures such as calling 911 in emergencies? Providing clear guidance on the expected protocols will enhance the preparedness of home health aides for medically fragile children in critical situations. Additionally, we have observed that training requirements in the rule specifically address ventilator care, while the statute refers only to "respiratory procedures." Please provide clarification on the interpretation of the rule's language compared to the statutory language.

7. **Assisting With Prescribed Medical Equipment:** Confirmation is needed regarding whether home health aides for medically fragile children are permitted to perform circuit changes for ventilators, as outlined in Section 5. Clarity on this matter will help define the scope of responsibilities and ensure adherence to best practices.

8. **Measuring and Preparing Special Diets:** Section 11 mentions measuring and preparing special diets, but it should explicitly state the exclusion of responsibilities related to IV/TPN nutrition. This clarification ensures that the scope of responsibilities is well-defined, minimizing potential confusion and errors.

9. **Validation Period:** Clarification is sought on the duration of active validation mentioned in Section 5(c). Specifically, does the validation remain active for the full 12 months or only 10 months? Understanding the validation period is crucial for agencies to plan revalidation processes effectively.

10. **Data Reporting and Program Assessment:** Enhanced details on the e-blast submission process mentioned in Section 7(a) would ensure a streamlined and effective data submission process. Additionally, providing more specific parameters for identifying additional support for home health aides, as mentioned in Section 7(b)(5), will contribute to more meaningful data collection.

11. **Penalties for Late Submission:** To ensure transparency and fairness, clarity on the process and criteria for imposing fines, as outlined in Section 7(c), is essential. A well-defined approach will facilitate compliance and minimize uncertainties for home health agencies.

12. **Specificity of Education and Training:** It is crucial that the education and training provided are specific and mandated by the state. While we understand that the state does not typically dictate training programs for licensed individuals, the unique situation of unlicensed personnel caring for medically fragile children necessitates clear guidelines. Without state-mandated best practices, agencies may be exposed to litigation risks if caregivers deviate from trained protocols, posing potential threats to patients, caregivers, and the agency.

    We believe additional clarification is necessary on the development and approval process for training curricula, the specific requirements relating to training for non-English speaking caregivers, and the statute's requirement that training be offered in "various formats" and "during various times of the day." We ask the state to consider providing financial support to assist agencies in meeting these requirements.

13. **Emergency Preparedness and Critical Thinking Skills:** Unlicensed personnel lack the training and critical thinking skills acquired through practice, especially in emergencies. While agencies can provide training, the absence of a state-mandated foundation increases the risk of emergencies. It is imperative to establish best practices for unlicensed personnel to safeguard the well-being of patients, caregivers, and agencies.

14. **Inclusion Criteria for Medically Complex Children:** The criteria for including medically complex children should be clearly defined to distinguish them from non-medically complex cases. There is a concern that the inclusion of non-medically complex cases might dilute the focus on the specific needs of medically fragile children. Ensuring that this program targets patients with unique medical complexities is crucial.

15. **Timeline for Staffing Transition:** A defined timeline or reasonable timeframe should be established for agencies to transition to this model. Without limitations, agencies may opt for this option indefinitely, potentially diminishing the incentive to seek licensed nursing staff. To ensure the best care for the child, controlling and monitoring the program to prevent abuse and encourage ongoing efforts to find licensed nursing staff is essential.

Similarly, if a home health aide for medically fragile children no longer wants or is able to provide care, could you confirm that hours no longer being serviced by the home health aide for medically fragile children could resume being provided by skilled nursing or other qualified agency caregivers, with no reduction in authorized hours?

In summary, while we recognize the potential of the proposed rule to improve care for medically fragile children, addressing these concerns and incorporating our recommendations will contribute to its feasibility and success. We appreciate AHCA's dedication to this initiative and are committed to collaborating in the implementation of a program that ensures safe, high-quality care.

Thank you for your time and consideration.

Sincerely,

Bobby Lolley, RN
Executive Director