**Section 245.200 Services – Home Health**

a) Each home health agency shall provide skilled nursing service and at least one other home health service on a part-time or intermittent basis. The agency staff shall directly provide basic skilled nursing service. The agency staff may provide other home health services directly or through a contractual purchase of services. Additional skilled specialty nursing services and use of additional nursing staff to meet changes in caseload may be provided by contract. All services shall be provided in accordance with the orders of the patient's health care professional, under a plan of treatment established by the health care professional, and under the supervision of agency staff.

b) The agency shall state in writing what services will be provided directly and what services will be provided under contractual arrangements.

c) Services provided under contractual arrangements shall be through a written agreement that includes, but is not limited to, the following:

1) A detailed description of the services to be provided;

2) Provision for adherence to all applicable agency policies and personnel requirements, including requirements for initial health evaluations and employee health policies;

3) Designation of full responsibility for agency control over contracted services;

4) Procedures for submitting clinical and progress notes;

5) Charges for contracted services;

6) Statement of responsibility of liability and insurance coverage;

7) Period of time in effect;

8) Date and signatures of appropriate authorities; and

9) Provision for termination of services.

d) Acceptance of Patients. Patient acceptance and discharge policies shall include, but not be limited to, the following:

1) Persons shall be accepted for health services on a part-time or intermittent basis in accordance with a plan of treatment established by the patient's health care professional. This plan shall be promulgated in writing within 14 days after acceptance and signed by the health care professional within 30 days after the start of the care date.

2) Prior to acceptance of a patient, the agency shall inform the person of the agency's charges for the various services that it offers.

3) No person shall be refused service because of age, race, color, sex, marital status, national origin or source of payment. An agency is not required to accept a patient whose source of payment is less than the cost of services.

4) Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing and social needs can be met adequately by the agency in the patient's place of residence.

5) When services are to be terminated by the home health agency, the patient is to be notified three working days in advance of the date of termination, stating the reason for termination. This information shall be documented in the clinical record. When any continuing care is indicated, a plan shall be developed or a referral made.

6) Services shall not be terminated until the RN, or the appropriate therapist, or both, in consultation with the patient's health care professional, consider termination appropriate or arrangements are made for continuing care.

e) Plan of Treatment

Skilled nursing and other home health services shall be in accordance with a plan based on the patient's diagnosis and an assessment of the patient's immediate and long-range needs and resources. The plan of treatment is established in consultation with the home health services team, which includes the patient's health care professional, pertinent members of the agency staff, the patient, and members of the patient's family. The plan of treatment shall include:

1) Diagnoses;

2) Functional limitations and rehabilitation potential;

3) Expected outcomes for the patient;

4) The patient's health care professional regimen of:

A) Medications;

B) Treatments;

C) Activity;

D) Diet;

E) Specific procedures considered essential for the health and safety of the patient;

F) Mental status;

G) Frequency of visits;

H) Equipment required;

I) Instructions for timely discharge or referral; and

J) Assessed need for influenza and pneumococcal vaccination;

5) The patient's health care professional signature and date.

f) Consultation with the patient's health care professional on any modifications in the plan of treatment deemed necessary shall be documented, and the patient's health care professional's signature shall be obtained within 30 days after any modification of the medical plan of treatment.

1) The home health services team shall review the plan every 60 days, or more often if the patient's condition warrants.

2) An updated plan of treatment shall be given to the patient's health care professional for review, for any necessary revisions, and for signature every 60 days, or more often as indicated.

g) Patient Care Plan

1) Home health services from members of the agency staff, as well as those under contractual arrangements, shall be provided in accordance with the plan of treatment and the patient care plan. The patient care plan shall be written by appropriate members of the home health services team based upon the plan of treatment and an assessment of the patient's needs, resources, family and environment. An RN shall make the initial assessment. An assessment by other members of the health services team shall be made on orders of the patient's health care professional or by request of an RN. If the patient's health care professional has ordered only therapy services, the appropriate therapist (physical therapist, speech-language pathologist or occupational therapist) may perform the initial assessment.

2) The patient care plan shall be updated as often as the patient's condition indicates. The plan shall be maintained as a permanent part of the patient's record. The patient care plan shall indicate:

A) Patient problems;

B) Patient's goals, family's goals, and service goals;

C) Service approaches to modify or eliminate problems;

D) The staff responsible for each element of service;

E) Anticipated outcome of the service approach with an estimated time frame for completion; and

F) Potential for discharge from service.

h) Clinical Records

1) Each patient shall have a clinical record identifiable for home health services and maintained by the agency in accordance with accepted professional standards. Clinical records shall contain:

A) Appropriate identifying information for the patient, household members and caretakers, medical history, and current findings;

B) A plan of treatment signed by the patient's health care professional;

C) A patient care plan developed by the home health services team in accordance with the patient's health care professional's plan of treatment;

D) A noted medication list with dates reviewed and revised and date sent to the patient's health care professional;

E) Initial and periodic patient assessments by the RN that include documentation of the patient's functional status and eligibility for service;

F) Assessments made by other members of the home health services team;

G) Signed and dated clinical notes for each contact that are written the day of service and incorporated into the patient's clinical record at least weekly;

H) Reports on all patient home health care conferences;

I) Reports of contacts with the patient's health care professional by patient and staff;

J) Indication of supervision of home health services by the supervising nurse, an RN, or other members of the home health services team;

K) Written and signed confirmation of the patient's health care professional's interim verbal orders;

L) A discharge summary giving a brief review of service, patient status, reason for discharge, and plans for post-discharge needs of the patient. A discharge summary may suffice as documentation to close the patient record for one-time visits and short-term or event-focused or diagnoses-focused interventions. A completed discharge summary shall be sent to the primary care physician or other health care professional who will be responsible for providing care and services to the patient after discharge from the home health agency (if any) within five business days after the patient's discharge; and

M) A copy of appropriate patient transfer information. When a patient is transferred to another health facility or health agency for continued health services, the patient transfer records must be sent to the new health facility or health agency within two business days after a planned transfer, if the patient's care will be immediately continued in a health care facility. In the event of an unplanned patient transfer, the transfer information must be sent within two business days from when the home health agency became aware of the unplanned transfer, if the patient is still receiving care in a health care facility.

2) For record keeping, the agency may utilize hard copies or an electronic format. Each agency shall have written policies and procedures for records maintenance and shall retain records for a minimum of five years beyond the last date of service provided. These procedures may include that the agency will use and maintain faxed or electronic copies of records from licensed professionals, rather than original records, provided that the original records are maintained for a period of five years by the professional who originated the records. If the professional is providing services through a contract with the agency, then the contract shall include that the professional shall maintain the original records for a period of five years.

3) Agencies that are subject to the Local Records Act should note that, *except as otherwise provided by law, no public record shall be disposed of by any officer or agency unless the written approval of the appropriate Local Records Commission is first obtained*. (Section 7 of the Local Records Act)

4) Each agency shall have a written policy and procedure for protecting the confidentiality of patient records that explains the use of records, removal of records and release of information.

5) Agencies that maintain client records electronically rather than hard copy may use electronic signatures. The agency shall develop policies and procedures governing these entries and the appropriate authentication and dating of electronic records. Authentication may include signatures, written initials, or computer-secure entry by a unique identifier or primary author who has received and approved the entry. The agency shall enact safeguards to prevent unauthorized access to the records and shall draft a process for reconstruction of the records if the system fails or breaks down.

i) Drugs and Biologicals. The agency shall have written policies governing the supervision and administration of drugs and biologicals that shall include, but not be limited to, the following:

1) All orders for medications to be given shall be dated and signed by the patient's health care professional.

2) Drugs and treatments shall be administered by agency staff only as ordered by the health care professional, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per agency policy developed in consultation with a health care professional, and after an assessment of the patient.

3) All orders for medications shall contain the name of the drug, dosage, frequency, method or site of injection, and permission from the patient's health care professional if the patient, the patient's family, or both are to be taught to give medications.

4) The agency's health care professional or RN shall check all medicines that a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medications, and shall promptly report any problem to the patient's health care professional.

5) All verbal orders for medication or change in medication orders shall be taken by the nurse, written, and signed by the patient's health care professional within 30 days after the verbal order.

6) When any compound, sera, allergenic desensitizing agent, or other potentially hazardous compound drug is administered, the RN shall have an emergency plan and any drugs and devices that may be necessary if an adverse reaction occurs.

j) QAPI. The home health agency shall develop, implement, evaluate and maintain an effective ongoing, agency-wide, data-driven QAPI program. The agency's governing body shall ensure that the program reflects the complexity of its organization and services; involves all home health agency services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes action that addresses the home health agency's performance across the spectrum of care, including the prevention and reduction of medical errors. The home health agency shall maintain documentary evidence of its QAPI program and be able to demonstrate its operations. The program shall:

1) Be capable of showing measurable improvement in indicators when there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care;

2) Measure, analyze and track:

A) quality indicators, including adverse patient events; and

B) other aspects of performance that enable the home health agency to access processes of care, home health agency services, and operations;

3) Use quality indicator data, including measures and data collected to monitor the effectiveness and safety of services and quality of care; and identify opportunities for improvement;

4) Develop improvement activities to focus on high risk, high volume or a problem-prone area; consider incidence, prevalence, and severity of problems in those areas; and lead to an immediate correction of any individual problem that directly or potentially threatens the health and safety of patients;

5) Track adverse patient events, analyze their causes, and implement preventive actions; and

6) Measure actions implemented to improve performance to determine their success and track performance to ensure improvements are sustained.

k) Policy and Administrative Review. As a part of the evaluation process, the policies and administrative practices of the agency shall be reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient

l) Clinical Record Review

Clinical records shall be reviewed continually for each 60-day period that a patient received home health services to determine the adequacy of the plan of treatment and the appropriateness of continuing home health care.

(Source: Amended at 45 Ill. Reg. 11077, effective August 27, 2021)