CICA California In-Home Supportive Services Consumer Alliance

August 31, 2019

California Department of Social Services
Office of Regulations Development
744 P Street, M.S. 8-4-192
Sacramento, CA 95814
ord@dss.ca.gov

SUBJECT: IHSS Paramedical Ord, #0915-11, Reply Due September 3, 2019

The California In-Home Supportive Service Consumer Alliance (CICA) as a 501(c)(3) non-profit organization representing 34 In-Home Supportive Service (IHSS) Advisory Committees as members. These IHSS Advisory Committees come from throughout the State of California, representing many of the 564,000 IHSS program Consumers and their Providers. Below are comments sharing concerns about the IHSS Paramedical Ord. #0915.11 update.

First, reading the proposed updated form SOC 321a there is concern about how it reads, the second paragraph:

> Before you can receive payment from the IHSS program for providing Paramedical Services for this recipient, you must receive training directed by a LHCP to administer the specific Paramedical Service(s) ordered by the recipient's Physician/Surgeon/Doctor of Osteopathic Medicine (D.O.), Podiatrist, Physician Assistant (PA), Nurse Practitioner (NP), or Dentist. The training may be provided by a LHCP other than the type(s) who ordered the paramedical service, however, only an LHCP who is licensed pursuant to Division 2 of the Business and Professions Code may provide this training. If you have not yet been trained on how to provide the Paramedical Service(s) ordered, you will not receive payment for providing the recipient's authorized Paramedical Service(s).

- Though during the Paramedical Stakeholder call (08/30/2019) it was stated nothing has changed, the wording in this paragraph does not give that impression it is the same.

    - The concern comes from the wording “you must receive training directed by a LHCP to administer the specific…” and “however, only an LHCP who is licensed pursuant to Division 2 of the Business and Professions Code may provide this training.”

      The above wording seems to place more restriction on the Consumer and who can provide the training, “only an LHCP who is licensed…”

      A LHCP would need the Consumer or Provider to make an appointment, which could be 3-weeks or more in the future, but the treatment is needed immediately.

      In the past, this training would often be done by the Consumer who had the ability to guide the Provider through the needs. Or, for those without the ability to train the Provider, it was done at the time of doctor’s ordering the paramedical service, often a parent or spouse who would pass on education n the procedure to other Providers.

      Recognizing it was stated that the LHCP was signing off that the Provider had the training to perform the paramedical service, should wording be placed in SOC 321a that identifies the Family member or individual Provider, or Consumer can provide the training?

      If the LHCP is only signing off who/whom was trained to perform the service, this should be noted as to who can do the training.

Another concern mentioned was the timeliness of the forms being returned to the County Office, mainly the SOC 321 authorizing a specific paramedical service.

- If a provider has been trained and they started performing the service, would they be paid the day the LHCP signed the document, or the first day they performed the service? Or, the date the service was ordered?

  Is there an avenue to clarify this?

The guidance created with time allotted for different paramedical services is in question. It was noted the times given are typical times to be completed for the typical individual, but most individuals being served by the IHSS program are not typical, especially of they are needing paramedical services!

- Times given as guidance are inconsistent with actual times of changing a catheter, digital stimulation for the bowel program, care needs of tracheostomy and ventilator dependent patients, etc.

  The IHSS program is not working with typical individual Public Health Nurses work with visiting homes. There must be consideration to revisiting these estimated times with individuals who perform the paramedical services, not Public Nurses who visit homes and ask questions in a matter of 5 to 10 minutes and move on to other subjects about the client's care.

  It does not take into consideration for those providing the Paramedical Services, married couples who are elderly caring for the other, education level of elderly being cognitive of the service being provided because of their age,

- It was expressed times given by LHCP are also questioned by the Consumer's Social Worker (or County IHSS Staff) when they exceed the guidance tool provided for paramedical services.

  It is agreed, there are inconsistencies and the purpose are to provide program consistency with consistent times to be allowed for each paramedical service, but too often have County Staff questioned the LHCP order and caused either the service to remain at the suggested

time using the paramedical services tool and the provider not getting appropriate pay for time to perform the service.

When County Staff refuses to follow direction of the LHCP the Consumer/Provider either questions the decision and does nothing, or they file an appeal looking for a decision from the Administrative Law Judge (ALJ). This procedure can only be frustrating and costly, both for the Consumer/Provider and State. It also adds to the burden of getting appropriate Providers and keeping them employed without unwanted stress!

It is recognized that County Staff can contact the LHCP for clarification and this is important for keeping program integrity, but the County Staff, not all, but some seem to believe the guidance tool times are set in stone!

Training for filing appeals is greatly needed, both for Consumers and their Providers, as well as County Staff to better understand the use of Form SOC 321.

A couple IHSS program users submitted comments and they are attached and summarized below:

These comments refer to page 3 of 9, in the section regarding Respiratory Care:

1. **INCLUDE A NEW SPECIFIC TASK: "TRACHEAL SUCTIONING / ASSISTED TRACHEAL AIRWAY CLEARANCE"** "Oral / Nasal Suctioning" is allotted 2-3 minutes. This is a valid care task, and the time for the task is valid. However, there is no listing for Tracheal Suctioning / assisted tracheal airway clearance. Tracheal suctioning is an invasive, sterile procedure performed to clear the airway of a tracheostomy dependent patient. Assisted tracheal airway clearance is the process of using normal saline and verbal cues to help the patient cough out their own secretions without the aid of suctioning. Some patients need one of the other types of airway clearance, and some patients alternate between the two. Tracheostomy dependent patients require frequent tracheal

suctioning or assisted tracheal airway clearance in order to maintain a clear airway, or they will be unable to breathe and will die. I would propose 3-5 minutes for tracheal suctioning / assisted airway clearance since tracheal airways are more complex and the procedure is more involved than oral or nasal suctioning. Assisting a patient with clearance of an artificial airway is a sterile procedure that requires more steps and is more complex than oral or nasal suctioning. This task is likely to be performed dozens or even hundreds of time per day for a patient with no ability to maintain his own airway.

2. **CLARIFY SPECIFIC TASK: "TRACHEOSTOMY CHANGE TUBE OR INNER CANNULA"** There is a listing for "Tracheostomy - clean tubes and/or change inner cannula 5-15 minutes" There are two major types of tracheostomy tubes: adult tracheostomy tubes have a disposable inner cannula, and pediatric tubes are a single molded piece that must be entirely removed and replaced. I'm not entirely sure what "clean tubes" means, and it's not really a care task that is generally done for patients with tracheostomies. The care task should reflect the reality of care for tracheostomy dependent patients and should read "Tracheostomy - change tube or inner cannula 5-15 minutes." It's true that caregivers may need to wash and sterilize used tracheostomy tubes for future re-use, but that isn't the sort of thing that happens while the tracheostomy tube is in use and wouldn't be classified as a paramedical service.

3. **CLARIFY SPECIFIC TASK: "APPLY / REMOVE TRACHEOSTOMY HME, PLUG"** There is a listing for "Apply/remove Tracheostomy Heat/Moisture Plug (Nose) or Talk Valve 1-3 minutes" There are three items that can be placed on a tracheostomy tube: A Heat Moisture Exchanger (HME), a cap or plug, or a Speaking Valve. There is no such thing as a Heat Moisture Plug, that's a combination of two entirely different things that serve two different medical purposes. Please clarify the wording to reflect medical products that exist. 1-3 minutes is an appropriate time to apply/remove tracheostomy HMEs or Plugs, and this task is likely to be repeated dozens of times per day.

4. **INCLUDE A NEW SPECIFIC TASK: "APPLY / REMOVE TRACHEOSTOMY SPEAKING VALVE"** Application of a tracheostomy speaking valve requires more time than application of an HME / Plug because the patients work of breathing must be assessed and the tracheostomy cuff must be deflated in order to allow for speaking valve placement. Patients **die** because speaking valves are applied by caregivers without first assessing the patient's breathing, verifying that the tracheostomy cuff is deflated, verifying the ventilator has the appropriate settings, and verifying that the patient is positioned appropriately for the additional work of breathing with a speaking valve. There is a black box warning on tracheostomy speaking valves to prevent patient death that lists the required steps for speaking valve use. An appropriate time for application / removal of a tracheostomy speaking valve is 3-10 minutes. This task is likely to be performed dozens of times per day - patients with compromised breathing frequently need to alternate between use of a speaking valve and recovery breathing with an HME or ventilator.

5. **INAPPROPRIATE TIME FOR SPECIFIC TASK - VENTILATORS APPLY/REMOVE/SETTINGS"** There is a listing for "Ventilators - apply/remove/settings (bedside and/or mobile vent) 1-3 minutes." To be clear: a ventilator is a life support device and patients who use a ventilator require high level care. The comparable listing for "Compressed Air/CPAP/BiPAP - apply/remove/settings" lists 3-10 minutes. Why would a ventilator, a life support device that initiates breathing for a person who can't breathe, take less time to manage than a CPAP or BiPAP? Perhaps this was decided because of the (incorrect) belief that ventilators are only used invasively via tracheostomy and CPAP/BiPAP machines are only used noninvasively with a face mask. Patients can use ventilators either invasively via tracheostomy or non-invasively with a face mask. The process for applying / removing a ventilator involves verifying that the settings are correct, verifying that the circuit is intact and has no disconnects or holes, verifying that the patient's airway is patent, and verifying that the patient is responding appropriately with the machine

in place. This is simply not a 1-3-minute process, even for the most efficient patient and caregiver team.

6. **INCLUDE A NEW SPECIFIC TASK: "RESPOND TO VENTILATOR ALARM"** Ventilators are not a "set it and forget it" machine, they are life support devices. Ventilators frequently and routinely alarm to notify the caregiver that something is wrong and that the patient will die without immediate attention. The caregiver must then respond, locate the source of the problem, and correct it. This may be something as simple as reconnecting the ventilator circuit to the patient or may be complex and require Ambu bag Ventilation the patient while the caregiver does a full replacement of the circuit. 5-10 minutes is an appropriate time for responding to ventilator alarms, and this task is likely to be repeated dozens of times per day.

7. **CLARIFY SPECIFIC TASK "COMPRESSED AIR / CPAP / BIPAP"** There is no such thing as "compressed air" as a breathing treatment. I think this may be referring to the use of compressed air to power a cool mist humidification system, which is sometimes used by patients with tracheostomies who don't use a ventilator to maintain adequate humidification.

The section regarding finger/toenails has left many questions.

"Grooming includes hair combing/brushing; hair trimming when the recipient cannot get to the barber/salon; shampooing, applying conditioner, and drying hair; shaving; fingernail/toenail care; and washing/drying hands. Grooming excludes cutting with scissors and clipping toenails."

- Questions being asked about use of electric trimmers/files, Safety clippers used on babies, etc.

  Is it possible to leave examples of what can be used in the name of protecting the Consumer?

Again, it is important to review the guidance provided as a tool for times allowed for the paramedical services and how these times were identified for the typical person. IHSS users are not typical, especially if they are requiring paramedical services. A stakeholder group of users and providers can be asked to review these times to give more accurate times for the services. Users would provide more accurate information to be used as a tool; this will also eliminate the number of State Hearing requests saving dollars in the future.

Some of the wording changes has caused confusion and they should be elaborated on, such as explain wording for who can provide the training, tools that can be used for nail care, etc. Examples of what can be done and used will assist the population understand nothing has really changed but the wording in some sections of the #0915-11 has caused confusion and there is fear only those in the State will understand them!

Respectfully submitted,

CHARLES BEAN
Executive Director

Sent to Ord@dss.ca.gov

Paramedical comments – Kristine Loomis

Aug 29 at 7:36 PM

Thank you for giving IHSS consumers an opportunity to comment on these revisions. We are the ones that will live with the consequences of what is contained in the new regulations. Since I may not be able to join the call tomorrow, I am submitting my primary concern by email.

I am a consumer that requires paramedical services. I am extremely concerned about the revision which seems to require a doctor to train and sign off on provider training, PRIOR to their authorization to perform these critical services. I can only hope that I am misunderstanding the regulation.

The new requirement is something that will be almost impossible for consumers and if rigorously enforced, may even be life-threatening.

Please do not put us in a position where we are forced to break the rules in order to survive!

In the real world, it can take three weeks or longer to get an appointment with a doctor. Training for paramedical services is often given by physical Therapists, nurses, physician assistants and other healthcare practitioners. To require a doctor is impractical. In many cases the doctor does not even know how to perform a particular service even though they are authorizing it.

In my situation, I need three care providers. Only one of them can accompany me to doctor appointments. Special skills are involved in transferring me and assisting me onto exam tables. So in the real world, that care provider is trained by the healthcare practitioner and then together we train the other care providers. One of my workers does not speak English. Since I cannot translate, it would require, on top of everything else, to have a Spanish-speaking doctor training her. I used a bilingual provider to train her in my home.

I would strongly recommend that the previous regulation, allowing the medical practitioner to sign a form stating a provider was trained in the paramedical service for this consumer, should be all that is required. And

this should be done in conjunction with the assessment process; NOT as a prerequisite for each provider to be authorized.

Some of the services must be done daily, so the timing of authorization for workers is critical.

In closing, I would like to say that my timeline did not allow me to read the complete document carefully, and I apologize if I have misunderstood it's content.

With Care,
Kristine Loomis

Kristie Renee' Sepulveda-Burchit

1. The county can put down SUGGESTED time limits for certain paramedical services.

The county should NOT request the physician justify if they go over suggested amounts. A county nurse should not override a doctor order! (stories from families given numerous times addressing this point)

2. The form should give an explanation that a provider can be trained by other entities or already have training and the physician is simply signing off on a paramedical order.

For the DEPARTMENT
The department should IMMEDIATELY send out an all county letter explaining that if a service is ongoing on a paramedical order that there is no regulation that allows the county to request a new paramedical order annually. All over the state each county is definitely not abiding by this and either annually OR when a new case worker comes on requesting a new paramedical order!!

Jenny McLelland Comments:

Here the public commentary I sent regarding paramedical services.

I usually email back and forth with Elissa Gershon at Disability Rights California, but really, anyone at DRC is competent and great.
Nice to meet you via email.

I'm a mom in Clovis. I'm a parent of an eight year old boy who is tracheostomy and ventilator dependent. I'm active online with the Little Lobbyists, a group of families with medically complex children who drag our kids to political events to fight for health care and disability rights. I'm also running a small and terrible website for Medically Complex Children of California, because I needed an official seeming thing to put on business cards. At some point, I'll make it a more coherent online presence, but for now, it's a guide on how to apply for the HCBA Waiver, because everything about the HCBA Waiver is a big, complicated, secret mess.

https://www.medicallycomplexchildrenofcalifornia.com/about

My pet issues are:

- Medicaid waivers generally and the HCBA Waiver specifically. Initially I just focused on the kids who use the HCBA Waiver for institutional deeming, but then I realized that nobody pays attention to the adults on the HCBA Waiver either. I run a small support group for the HCBA Waiver on FB.

- Coordination of care for medically complex children generally.

- EPSDT nursing for medically complex children, especially the ongoing battle for fair reimbursement rates

- IHSS as it applies to medically complex, technology dependent children.

- really, anything that affects life for medically complex kids.

I won't be able to participate in the call on Friday, the kid has an IEP meeting and those are always a time suck. If you could bring up my concerns, that would be awesome.

Thanks much!

Begin forwarded message:

From: Jenny McLelland
Subject: PUBLIC COMMENT RE: PROPOSED STATE REGULATIONS IMPACTING IHSS PARAMEDICAL SERVICES
Date: August 27, 2019 at 10:24:58 AM PDT
To: ord@dss.ca.gov

I am a parent of a tracheostomy and ventilator dependent child who lives safely at home with our family. I provide care for for my minor child through the IHSS program.

My child is medically complex but has no mental or cognitive impairment, and therefore does not qualify for protective supervision. However, he is tracheostomy dependent all the time and ventilator dependent at night due to serious airway and breathing disabilities.

The proposed changes to the paramedical services allowed time fundamentally misunderstands the reality of caring for a tracheostomy or ventilator dependent person. Since most IHSS workers won't have specific knowledge about the care needs of tracheostomy and ventilator dependent patients, its important for the time for task guidelines to accurately reflect the care needs of the average patient. I understand that every patient will have slightly unique care needs, but the basic time for task framework needs to be revised to reflect actual care tasks that are commonly performed.

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tracheostomy tube: A Heat Moisture Exchanger (HME), a cap or plug, or a Speaking Valve. There is no such thing as a Heat Moisture Plug, that's a combination of two entirely different things that serve two different medical purposes. Please clarify the wording to reflect medical products that actually exist. 1-3 minutes is an appropriate time to apply/remove tracheostomy HMEs or Plugs, and this task is likely to be repeated dozens of times per day.

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Thank you for your time and concern.

Jenny McLelland

Medically Complex Children of California

Working to make sure medically complex, medically fragile, and technology dependent children in California get access to the programs and support they need to thrive.

https://www.medicallycomplexchildrenofcalifornia.com

Joey Riley, Comments

"a) If the recipient has their bowel and bladder care met exclusively by
paramedical services but also requires menstrual care, the recipient shall be designated the appropriate ranking in bowel, bladder and menstrual care based on the recipient's menstrua(l care needs."

This wording is confusing, it reads like bowel and bladder ranking is based on menstrual care needs.

"Grooming includes hair combing/brushing; hair trimming when the recipient cannot get to the barber/salon,"

Most recipients are living on between $600 - $1200 per month, they can not afford to go to the barber/salon. The state assumes that it is not a financial hardship on IHSS recipients and just allows for accessibility hardship.

"Grooming includes hair combing/brushing; hair trimming when the recipient cannot get to the barber/salon; shampooing, applying conditioner, and drying hair; shaving; fingernail/toenail care, except for nail clipping, which is not a service authorized in the IHSS program; when these services are not assessed as "paramedical" services for the recipient; and washing/drying hands. Grooming excludes cutting with scissors and clipping toenails."

Please include that filing of fingernails and toenails, including both manually and with an electric nail filing device (when properly trained) is acceptable.

"...are activities which include the administration of medications, puncturing the skin, or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional acting within the scope of his/her license or certificate pursuant to the Business and Professions Code, Division 2, when the activity has been ordered by an LHCP-PM, as defined in Section 30-701(l)(2)(B)."

Please include that IHSS recipients have the right to train their IHSS/WPCS providers to their own unique paramedical services and can administer training from the need for service, and retro-active pay is available for Providers once the SOC 321 form, signed by the LHCP-PM, is received by the county.

***"(1) The time authorized for paramedical services shall not be based on a specific IHSS provider's skill level or the time it takes for him/her to perform the specific paramedical task but rather on the time it would take an average person IHSS provider who has been trained to do the task pursuant to Section 30-757.193 (a)(1) and (b), and who exercises ordinary care, skill,* and judgment to perform the task for the recipient."**

Is the average IHSS Provider not a female- around 60 yrs of age -with multiple health issues- predominantly of color - living in poverty- many without healthcare- with limited education? Are you timing it for this population or for a 24 year old RN? Because there is a big difference with this demographic.

"***Before providing a paramedical service to a recipient, an IHSS provider shall receive training from a LHCP-PM health care professional licensed pursuant to Division 2 of the Business and Professions Code in each specific paramedical task to be provided to the recipient. An IHSS provider shall not receive payment for providing paramedical services for which he/she has not been trained by a LHCP-PM health care professional licensed pursuant to Division 2 of the Business and Professions Code."***

Please include that IHSS recipients have the right to train their IHSS/WPCS providers to their own unique paramedical services and can administer training from the need for service, and retro-active pay is available for Providers once the SOC 321 form, signed by the LHCP-PM, is received by the county.

"(2) Examples of tasks that cannot be authorized under paramedical services include, but are not limited to, the following: (A) Nail (fingernail/toenail) clipping is not a service authorized in the IHSS program; (B) Active range of motion exercises, as defined in Section 30-701(r)(1)(A); (C) Vital Signs when ordered unrelated to other paramedical services; (D) Blood Pressure Checks, when ordered unrelated to other paramedical services; (E) Applied Behavioral Analysis (ABA) therapy including, sensory, auditory, and visual therapies are not services authorized in the IHSS program; and (F) Monitoring the time in between the initiation and conclusion of the provider performing the paramedical service; including but not limited to the time the g-tube machine is running."

Please state in this paragraph that filing of nails is an authorized task. Please state where (which section code and which category i.e. Rubbing of Skin) the active ROM services can be authorized. Vital signs and blood pressure checks as well as monitoring for skin break down and skin cancers actually should be encouraged as a proactive method towards preventive care. ABA seems like it's a mental health service and mental health services need to be expanded not reduced.

https://www.cdss.ca.gov/Portals/9/Regs/d091511DRAFT_SOC%20321.pdf?ver=2018-11-06-103511-893

https://www.cdss.ca.gov/Portals/9/Regs/d091511DRAFT_SOC%20321A.pdf?ver=2018-11-06-103513-127

There is no "Start Date" (as indicated by Debbi Thomson to recipient Melissa on 8/30/19 Paramedical Stakeholder call) on either the SOC 321 or SOC 321A for the IHSS Provider to be paid back to, for retro-active payments for paramedical services rendered at the time of need.

Also, CDSS went from 2 pages to 8 pages of Paramedical forms to contend with. CDSS should be simplifying forms not increasing work X4. CDSS seems more concerned with liability than with recipient health/safety and continuity of care

"IHSS PROVIDER DECLARATION BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING: I certify that

I have received training directed by a LHCP on the Paramedical Service(s) listed on this form. I accept the responsibility of performing the Paramedical Service(s) to the IHSS recipient named above and I understand that the County and State of California are immune from any related liability. I declare that I have read and understand the requirements as stated in this document. I agree to comply with these requirements. I understand that a copy of this declaration will be provided to this IHSS recipient for his/her records. I THE UNDERSIGNED DECLARE UNDER PENALTY OF PERJURY THAT THE FORGOING STATEMENTS ARE TRUE AND CORRECT. IHSS PROVIDER'S SIGNATURE 4 DATE ."

The Provider may not have had received training from the LHCP but from the recipient, so maybe revise to something like "I certify that I have received training from the IHSS Consumer/recipient. PT, OT, RN under the direction from a LHCP." Why have the Provider declare under penalty of perjury but not the LCHP? Why so mean and hostile to Providers just trying to help?

"It is very important that your provider NOT perform any paramedical service for you until he/she has received proper training by a licensed healthcare professional." https://www.cdss.ca.gov/agedblinddisabled/res/FactSheets/IHSS_Paramedical_Services_Color.pdf

Some SI Consumers need digi-stim bowel, cough assist, suctioning, injections immediately (when they hire a new IHSS/IHO Provider, before they can get the 8 pages of paramedical forms SOC 321 & SOC 321A filled out by the LHCP, so they act as the Employer of their IHSS/IHO Providers and train them as in statute ... IHSS Consumer/recipients have the right to hire, fire, supervise and train their Providers/employees.

Regarding the PARAMEDICAL SERVICE AUTHORIZATION REFERENCE TOOL

Why have a different or lower Standard of Care for paramedical services rendered by an IHSS Provider than at the VA, other hospitals, schools, MSSP, PACE, and other resources rendered by other health care providers? Why not make this an opportunity to include the IHSS Provider

as part of the "Care Team" working in conjunction with the LHCP and other medical providers in a cooperative manner instead of threatening PENALTY of PERJURY like some fraudster (less than 1.3% fraud rate)?

Most EW/SW's do not include Universal Precautions on the NOA's - before and after personal care services such as washing hands for sterile procedures (sometimes multiple times during one paramedical service). Scrubbing hands and nails with a brush and/or pic for 5-7 minutes. Are you going to have the LHCP include sterile hand washing time or possibly instruct with a ACL that the SW's need to include sterile hand washing time with Paramedical Services?