

**Department of Health Care Policy & Financing**  
**PAT Listening Log**

<b>Comment Number</b>	<b>Date Received</b>	<b>Comment</b>	<b>Department's Response</b>
1	28-Aug-13	Can you post to the web a copy of the language that defines "skilled" and "unskilled"?	Posted on the Home Health webpage 9/4.
2	28-Aug-13	How should time for G-tube feeding be calculated?	Time allotted should represent all related tasks per day, including set-up and flushing, etc. and should not include the time to administer the feeding.
3	28-Aug-13	Regarding ADL - age appropriate. Ages + Stages still applies, correct?	Yes
4	28-Aug-13	The September 4th deadline provided in the August 28th meeting is for providing feedback and/or asking questions in reference to the meeting content, rather than the deadline for the testing proposed, correct?	Yes
5	28-Aug-13	How will this intersect with disability?	To identify differentiation for disability, ask yourself: Specifically, what do you do for this child above and beyond what you would do for a typical child of the same age?
6	28-Aug-13	Will the formula or "algorithm" used to score the PAT be made public?	Yes
7	29-Aug-13	DORA licensure question - If we decide to use CNAs with med authority will CDPHE recognize that?	Per Colorado Department of Public Health and Environment they "we would defer to DORA regulation, rule and requirements and hold the agency to that."
8	30-Aug-13	PAR extensions question	PARs coming due during October will be extended for an additional month

10	28-Aug-13	PAT presentation slide #34: Link should be provided to Colorado Benefit Standard for Unskilled Labor and/or the actual language reference (if less than a paragraph) should be provided in presentation.	The skilled and unskilled section of the Home Health Benefit Coverage Standard has been included on the HH webpage of the HCPF website. Training of the revised PAT will include more detailed information regarding what makes ADLs skilled/unskilled
11	28-Aug-13	Are “unskilled” and “skilled” labor consistently defined the same way throughout Medicaid rule?	The skilled and unskilled labor is consistent with CDPHE's licensure and regulations standards for Class A and Class B agencies. There is some variation between waiver services and skilled HH that is unavoidable due to the CMS conditions of participation, the nurse aide practice act and the Home Care regulations issued by CDPHE.
12	28-Aug-13	Will the Home Health agency let parent CNAs (of randomly chosen children for the PAT test) know that their child has been chosen randomly to take part in testing the tool? The future validity of the test will be compromised if CNAs are not included.	The Department will obtain a random sample of clients from claims data based on the agencies that have agreed to participate with the pilot review of the tool. As always, the Department encourages agencies to include the client and their family in the assessment and care planning activities. The Home Health agency will have the opportunity to involve their CNAs when filling out the revised PAT.
13	29-Aug-13	I am wondering on the revised PAT if there will still be questions about the most recent hospitalization, number of hospitalizations in the past year, the risk for hospitalization and the overall prognosis of the patient? These were not mentioned yesterday at the meeting and I am just following up. Thank you for your time.	No. The PAT Revision Workgroup made the decision to remove these questions due to the inequality and institutional biases of the questions. The idea will be that, should a client have a recent hospitalization, or a worsening diagnosis, that leads to increased care of that client, then a new PAT should be filled out and submitted.

14	30-Aug-13	Whether or not the tool is understandable and missing major areas will hopefully be identified by stakeholder feedback, but also during the testing phase. If identified, it should be transparent and then training and implementation should be delayed. I have only a few questions/comments for consideration.	Any revisions that take place, regardless of how the changes were identified, will be presented in their entirety during the next stakeholder meeting and during training sessions.
15	30-Aug-13	1) Are parents being notified of their child's random selection?	Home Health Agencies will be permitted to involve the randomly selected families as they deem necessary in completing the pilot tool.
16	30-Aug-13	2) Will the 10 or so HHA be public knowledge? As you probably can surmise the best in the field are the ones who attend meetings, not the ones who have notorious difficulty. I know HCPF knows which those are. I wish an awesome new tool could fix the intrinsic disconnect between families and the HHA not present at meetings.	Yes, the list of Home Health agencies that participated in the PAT testing will be reported.
17	30-Aug-13	3) Is 150 families the minimum number or could the standard of error be achieved with fewer? I assume the testing will air on the side of greater sample size.	Yes, the Department has already requested a random sample size that will hopefully allow room for error or incomplete forms.
18	30-Aug-13	4) Will the same sample size (150 or greater) and cases be given to APS for comparison purposes? If not, cross referencing will be difficult. I wish an awesome new tool could fix the intrinsic disconnect between APS and the community physician.	Yes, APS will be given the same client list and information received from the Home Health agencies.
19	30-Aug-13	5) There were 75 dismissed appeals during all of this PAT change due to improper notices from HCPF. I hope the 150 randomly selected children have a large percentage of those 75 as well as the other couple hundred who received impactful reductions.	The Department will be obtaining a random sample of clients for the PAR pilot. Based on the method, not other criteria will be used to identify clients (such as appeal status, decrease or increase in services, etc.).

20	30-Aug-13	6) Even though specific diagnosis related questions were not incorporated (i.e. Autism/Down syndrome), it seems as though the complexity of care and modifiers were built in to minimize discriminating language and keep it level of care=level of care. I get that, but it also mentions in bathing, if a child can be verbally 'cued' to bathe there are no points given. Wouldn't a modifier trump this? I know children who would require above and beyond (definition provided without dissent by Christy Blakely, current MSB member) assistance even after being verbal cued.	The PAT questions should all be answered based on the definitions of skilled vs. unskilled care; verbally cuing during bathing is unskilled. The intent of the Modifier language is to capture areas that impact the skilled care provided by the CNA.
21	30-Aug-13	7) Will this tool be unveiled after testing with a 'step-down' process for those being cut 30% or more?	Yes, the same step-down process will be implemented.
22	03-Sep-13	1) There are errors on the FAQ--some are typos such as referring to the wrong question number for additional documentation (they say 13 but mean 12). There are other places that contain errors and lack of clarity. Someone needs to proofread. I would suggest doing testing also.	Yes, as mentioned during the Home Health stakeholder meeting, the revised PAT was a draft. Every effort will be made to diligently proofread prior to implementation.
23	03-Sep-13	2) They need to be clear about how to ask for continuing benefits, that clients can do so and must receive them as a matter of law pending resolution, that client may be asked to repay if client loses, etc. Agencies need to know this also as there has been lots of miscommunication about this issue. Appeals chart does not ID where the Department makes continuing benefits happen.	

24	03-Sep-13	3) Training uses patient and client and child interchangeably. I would advise using child, but otherwise use client, patient is a derogatory word and not appropriate for long term service recipients even when the service is medical in nature. The fact that this would be used at all is yet more evidence that staff desperately needs disability cultural competence training because anyone with basic training would know this. Disability 101 material going back to the 80's always starts with material that says "we are not patients"	The draft PAT will be reviewed and corrected in effort to provide consistent language and formatting prior to publishing a final draft of the tool. Any reference to "patient" will be changed to "client."
25	03-Sep-13	4) Using the term age appropriate is not really good either --perhaps use the SSA language about comparison to typical peers	A definition of what constitutes "age appropriate" has been added.
26	03-Sep-13	5) The amount that the client is able to "help" or participate or the amount of effort expended by client is not a good judge of how much time to allocate, often it is more work for the helper if the client is participating in the care but we want to encourage as much participation as possible.	It was the goal of the PAT Revision Workgroup to not only capture the time it takes to provide skilled care (by use of the Modifiers) but make an attempt not to penalize caregivers who encourage client participation.
27	03-Sep-13	6) They ask how many competent adults in the home, ask how many work outside of home. What about adults who work inside the home (home based business, telecommute, etc.)? They still might not be able to do 100% attention when home if employment requires work. What about a physically disabled parent who cannot do physical care like bathing? That is not incompetence. Finally, even if there are more adults, just because there are more adults does not mean people are available to care for the kid. Someone might have a boarder to help with rent, this does not mean that the extra adult is available to do care.	These questions have all been removed from the revised PAT.

28	03-Sep-13	7) Vision and hearing should also address auditory and visual processing---it does this a little in following questions (I think that is what it is trying to do) but not clearly.	The Modifiers surrounding Sensory Status addresses visual and auditory status as well as how the client understands what they see or hear and their ability to expresses their thoughts, feelings, and needs.
29	03-Sep-13	8) Strength should be looked at holistically, for a kid who is combative strength is an issue but also issue for kid with something like Duchennes who will tire towards end of day and will need more help.	When filling out the revised PAT, the instruction will be given to score based on a client's lowest (or weakest) ability for an average day.
30	03-Sep-13	9) Where is there consideration for kids who have high weight due to medications? Kids with MD are often put on steroids at age 7 and 8 to keep them walking, this causes serious obesity by the time they are 15 and they also lose mobility at that age. Often they will require 2 person transfer or a lot more DME. Same thing with kids with DD some of whom get put on antipsychotics at young ages (bad idea in my opinion but it happens)	The client's weight is captured in the Modifier section.
31	03-Sep-13	10) Should assume that all kids with aug com devices need assist with set up	We will rely on the Health Care professional filling out the PAT to know each client's ability regarding any devices they may use.
32	03-Sep-13	11) Should be clear that pain management is not comfort and convenience	Assessing a client's pain has been added to the tool under the modifier's section because pain can impact the client's ability to receive and participate in care. Because of this, it is a necessary part of the PAT.

33	03-Sep-13	12) Is one week for testing realistic?	There will be several weeks of actual testing, however, there may be some sections of the testing that only take one week. For example, it may only take the Home Health agencies one week to complete their portion of the testing. If the Department decides that we will not have enough total time allotted for testing, that issue will be addressed when it is identified.
34	03-Sep-13	<p>I have two observations about the new tool.</p> <p>1. Bathing – Water Temperature Management - Although this skill, or lack thereof may be considered elsewhere in the tool (I can't discern this if it is), the ability of the client to adjust the temperature of the water for bathing to avoid scalding is as important as any other bathing skill. There are three ways I know to manage this concern, and there may be more:</p> <ul style="list-style-type: none"> <li>a. A competent person manages the water temperature throughout the bathing process</li> <li>b. A scald-guard is installed (very expensive – and they tend to break, unfortunately)</li> <li>c. A client is taught water-temperature management as a learned skill</li> </ul>	Any concerns regarding the client's ability to safely navigate their environment (during skilled care activities) should be captured in the Modifier section under the Levels of Cooperation section.

35	03-Sep-13	<p>2. Refusal to eat – it is not uncommon for children with disabilities and serious health concerns, at one point at least, to be a failure to thrive concern because, for individualized reasons, they refuse to eat, even if they can eat independently. Often, a parent must consult with a feeding specialist, which is probably best done at home. Having experienced this concern personally for many years, and undergoing numerous feeding consults outside the home which rendered no results, I know for some families, it would be critically important to have an in-home option of a skilled provider investigating ways to assist a failure to thrive concern child who refuses to eat, or will only eat such limited nutritional foods, that they cannot sustain life – even if they can feed themselves without choking.</p>	<p>Under the Colorado Home Health Benefit Standards, the definition of skilled care regarding meal preparation and feedings are well defined. If a failure to thrive child receives physician orders that require the assistance of either an RN or Certified Nurse Aid, those activities should be captured in the PAT.</p>
36	03-Sep-13	<p>[Continued from above] it is likely that these domains are not in the nurse or CNA acts – but perhaps they should be considered to be included – which would require a change in a different area of statute.</p> <p>Which brings up another point. We can count on things changing. Do you feel the PAT has that flexibility if the acts do change to accommodate new areas of medicine or practice? I think flexibility is key so that it doesn't require statutes to make changes.</p>	<p>Yes. Since the PAT is a utilization management tool, and these tools do not reside in regulation. This allows the Department to update and revise the tool as needed, with stakeholder input, when changes are brought on by DORA, CDPHE or amendments to the Department's regulations.</p>

37	03-Sep-13	<p>I have a child that has Down Syndrome and is also Autistic. Why is the new tool still not taking in consideration that round the clock care is definitely needed to keep our children safe? My child does not understand safety due to her mental disability. Also I have to have her sleep with me due to her sleep apnea and making sure her O2 is placed properly. She doesn't breath well at night which requires round the clock care as well.</p> <p>Other then that the tool works for others who don't need round the clock care but still is missing the fact that keeping people safe and alive so they too can live a somewhat normal life, never stops.</p>	<p>It was the goal of the PAT Revision Workgroup to capture time allotted for client safety measures during the completion of skilled tasks; the PAT only applies to tasks that can be reimbursed under the Medicaid Home Health Benefit that are performed by either the Certified Nurse Aide or the RN.</p>
38	03-Sep-13	<p>My son is in the adult side now but I did review the PAT. In the Bowel Care protocol, there was not an scenario for his care when he was a child. Urology at Children's put in a cecostomy button. The amount of water that goes in is 350 ml. It was described as giving him a daily enema. There is no digital stim or meds used. The amount puts it over the limit for the over-the-counter enemas. I was paid as his CNA to perform this duty. Something to consider if you are trying to cover all the bases with the PAT.</p>	<p>Since no tool can capture every possible scenario, any skilled care that falls outside the standard PAT questions should be reiterated under "box 6" in the CareWebQI web based utilization management program for review by the COPAR Program along with the supporting documentation from the client's physician.</p>

39	03-Sep-13	<p>Hello, I do feel this new approach and re-advised PAT is much better although I do have some confusion. My child doesn't have any special devices she has autism, bipolar, sensory integration, auditory processing disorder, learning disabilities and has been tested by children's hospital and is at a 9yr old level socially and a 5/6 yr old level in almost all other areas ... She is in O.T along with Speech and Language . She needs help in MULTIPLE areas !! I am a bit frustrated with the showering as I have to help my daughter with all things in all areas when it comes to bathing and due to her not having any type of wheelchair etc. She gets no points for that and I just don't understand that is a lot of work and not only is it a lot of work during the process I am trying to ALWAYS teach her to do it on her own such as scrubbing the shampoo in hair, putting soap on washcloth and washing as all these things are difficult due to sensory along with her O.T. !! I just feel this should be something that should be looked at as it is very hard as my child is 15 and it isn't an easy thing to do ... Thank You Jennifer Hopton</p>	<p>The goal of the PAT is to capture all the skilled care tasks that can be reimbursed under the Medicaid Home Health Benefit that are performed by either the Certified Nurse Aide or the RN. The PAT cannot take into account all the time required for tasks that are not defined as skilled care.</p>
40	04-Sep-13	<p>Under Nursing Care, the tool needs to include behavioral care which is part of nursing skills - Skinner's behavioral approach. This is in the scope of a R.N.</p>	

41	18-Dec-13	Definitions of Assistance: for minimal is it thought of as 0-25% for a given task? My thinking is about the clinical difficulty in determining difference between 18 and 20% or 20 and 25%.	The idea behind the Definitions of Assistance is to give the providers a guideline in determining how much assistance is required. In an effort to make this task easier, we grouped minimal to moderate (25-50%) and maximum to total (50-100%) in the task section. We also added the language monthly, weekly, and daily as way to help differentiate the Modifiers. If a client needs less than 25% assistance then this would be considered personal care.
42	18-Dec-13	Modifier B: Airway Status and Seizures: "or" doesn't make a ton of sense to me because anything but a stable airway would have an effect and any seizure even absence have an impact on ability to function as one without seizures	The idea behind all the Modifiers is to capture how often each directly affects care. For example, while one client may have daily seizures they may not be severe in nature and/or they truly do not affect giving skilled care. On the other hand, another client may have daily debilitating seizures; it is these clients the Revision Team was attempting to capture.
43	18-Dec-13	Modifier B: Vision: do high prescription glasses fall under moderate since without it would cause further safety issues?	If a client's vision affects daily skilled care, he or she should would receive points regardless if the client has glasses. If the client wears glasses which correct his or her vision, then that client should not need extra time factored in for skilled care.
44	18-Dec-13	Modifier B: Weight: 50lb intervals seem like a lot	The Revision team wanted the focus to be on the heavier clients since this was a stakeholder concern. If a client's weight affects a client's skilled care needs and the providers do not feel that issue is captured adequately in the scoring, that information should be entered into box 8. A Peer to Peer or Reconsideration can also be performed if needed.

45	18-Dec-13	Feedings should be skilled when over-stuffing has been documented. That increases the choking risk exponentially. This should make it a skilled task because many kids are skilled enough to shove food right into their throats.	Skilled Care definitions are taken directly from the Benefit Standard and additions and/or deletions cannot be made.
46	18-Dec-13	For eating or oral feedings a score of 3 must equal 0-50% for minimal to moderate assistance, right?	For a client to receive minimal to moderate assistance with feeding they must require 25% to 50% assistance to complete the task and the task must meet skilled standards as defined by the Benefit Coverage Standard. If they do meet this criteria, the agency should score them as needing minimal to moderate assistance which has 3 points assigned to it.
47	18-Dec-13	In Mouth Care of personal hygiene, if the task begins non-medical and client bleeds as a result of basic oral hygiene does it then become skilled?	Bleeding in association with mouth care is not uncommon due to common illnesses such as gingivitis, in this event, bleeding would be controlled and minimal and would not necessitate skilled care.
48	18-Dec-13	If a client is cut in some way just before the non-medical shaving task, how is it handled if CNA hasn't been deemed competent since it is a skilled task, client must wait for new PAR? I would guess it certainly wouldn't be acute home health unless a major injury.	A CNA is permitted, under their practice act, to provide simple skin care which includes the application of Band-Aids, which would be applied during the normal course of the visit.
49	18-Dec-13	In Nail Care, non-medical task, please remain consistent with language, such as, "non-medical provider" versus "unskilled provider." THIS HAPPENS THROUGHOUT DOCUMENT	This was an error on our part and all language should be updated. All "unskilled" and "non-medical" have been changed to personal care.
50	18-Dec-13	Also in Nail Care, it should specify that cuticles cannot be pushed back with fingers for reasons of cleanliness and potential scraping.	Skilled Care definitions are taken directly from the Benefit Standard and additions and/or deletions cannot be made.

51	18-Dec-13	In Skin Care, is a triple antibiotic or Neosporin considered non-medical? Either can be preventative and not just therapeutic.	The Skin Care questions are broken down into two questions. The first refers to a physician prescribed overt-the-counter medication/ointment. The second skin question has to do with “routine” or simple skin care which may also involve over the counter non-medicated products.
52	18-Dec-13	For ROM, I agree with our previous discussion about a score of 4 being equal to a program consisting of less than 1 hour per day and a score of 6 being equal to a program consisting of more than 1 hour per day secondary to the high variability for disabilities such as, CP; Catatonia; Huntington’s.	The Department agrees.
53	18-Dec-13	In Toileting Bowel Program, since the flu, food and even medications (new or old) can cause a change, should there be an area for scoring of 2 pts?	The PAT is meant to capture a client’s average or “typical” skilled care needs. The PAT is not designed to give additional hours for short-term illnesses such as the flu, however, if the client has a change in status that requires increased skilled care needs, a new PAT should be completed.
54	18-Dec-13	In Catheter Care, if a child with spina bifida is in training of catheterization, would that qualify for 1pt given the difficulty of task?	Catheterizations are not within the scope of the CNA practice act.
55	18-Dec-13	In Menses, if a client requires minimal to moderate assistance how can that be a score of 0? Perhaps it goes to 1 and maximum goes to 2. In Urinary Hygiene, since a catheter and age-appropriate in the same sentence is an oxymoron, an option to change is 0-nonmed; 1-presence of catheter; 2-minimum to moderate; 3-maximum.	Menses alone is not a skilled task, this question asks as a modifier to the skilled care need of urinary hygiene, therefore the client’s need for maximum to total assistance with menses care adds to the difficulty of the task.

56	18-Dec-13	In Transfer/Positioning, possible scoring change to prevent bed sores could be 0-nonmed; 1-present need, but low freq; 2-minimum to moderate; 3-present need with high freq; 4-maximum.	Risk for bed sores is assessed in the skin modifiers, this coupled with the skilled task of positioning should capture the need for re-positioning to prevent bedsores. Also for consistency, we have attempted to keep the categories of assistance as similar as possible.
57	18-Dec-13	In Section III, is medication by g-tube included in scoring?	CNAs may not administer any medications regardless of route unless they have obtained their CNA-MED Certification. All medications, regardless of how administered, should be captured in the Medication section.
58	18-Dec-13	In Elimination Status, #6 I think letter e should be a score of 4 and not 3?	Because Bowel Hygiene is a more difficult task than Urinary Hygiene, it was given slightly less points.
59	18-Dec-13	In Feedings, why wouldn't CNA delegation be equal to a score of 1?	We are not sure that we are entirely clear on your question. However, a client would score points on any skilled feeding that is performed by the CNA (even for delegated G-tube feedings).