Alta California
Regional Center

Procedures Manual

Respite for the Medically Fragile
(Applicable to Home Health Agency and Individual Nurse Providers)

Definition

Respite for the Medically Fragile, otherwise known as skilled nursing respite care, is intermittent or regularly scheduled temporary medical care and supervision provided to parents or caretakers to relieve them of the stress of caring for a family member with a care need that requires the skills and expertise of medical personnel, specifically that of a registered nurse or licensed vocational nurse.

Providers of Respite for the Medically Fragile shall be fully licensed and certified by the appropriate certifying or licensing board and service provision shall adhere to the standards as set forth by professional licensure requirements.

"Respite for the medically fragile" refers to respite care that may be provided to a client whose health conditions cannot be classified as chronic or stable; or for whom performance of care during respite cannot be termed routine; or for whom the performance of care during respite by unlicensed persons would pose potential harm.

Respite for the Medically Fragile is designed to do the following:

1. Temporarily assist family members in maintaining a medically intensive client at home while waiting for a generic resource funding process to go through
2. Provide appropriate care and supervision to ensure the client's safety with or without the presence of family members.
3. Relieve family members from the constant demands and responsibilities of caring for medically intensive client
4. Attend to the client's self-help and care needs and other activities of daily living within the home, including inter action, socialization, and continuation of usual daily routines which would ordinarily be performed by caretakers or family members.

"Nursing Care in the home" is synonymous with skilled nursing, shift nursing or private duty nursing terms that mean services provided by a Registered Nurse and Licensed Vocational Nurse, which are more individual and continuous than State Plan intermittent nursing visits. Nursing Care in the home is funded primarily through programs administered by the Department of Health Care Services. These include but are not limited to: Nursing Facility Acute Hospital (NF-A/H) Waiver redefined in January 2007, combining Nursing Facility Waivers Sub-acute (SA), level A and B and Acute Hospital; and Systems of Care – Early Periodic Screening Diagnosis and Treatment (EPSDT).

In rare circumstances and with Best Practices Committee approval, ACRC may fund this type of nursing care in accordance to Welfare and Institutions Code, Section 4659 (d) (1) (A) (B) and (C):

"(d) (1) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not purchase medical or dental services for a client three years of age or older unless the regional center is provided with documentation of a Medi-Cal, private insurance, or a health care service plan denial and the regional center determines that an appeal by the client or family of the denial does not have merit. If, on July 1, 2009, a regional center is purchasing the service as part of a client's IPP, this provision shall take effect on August 1, 2009. Regional centers may pay for medical or dental services during the following periods:
(A) While coverage is being pursued, but before a denial is made.
(B) Pending a final administrative decision on the administrative appeal if the family has provided to the regional center a verification that an administrative appeal is being pursued.
(C) Until the commencement of services by Medi-Cal, private insurance, or a health care service plan "

This temporary funding shall be contingent on the family's agreement to pursue all available generic resources including Home and Community Based Services Waiver (HCBSW) through Department of Health Care Services (NF-AH HCBSW) or ACRC Developmentally Disabled (HCBSW) program.

Additionally, the number of hours allowed for temporary funding of respite for the medically fragile shall be determined in consideration of all other services that the client receives, i.e., In Home Support Services (IHSS) and/or Personal Care Services Program (PCSP- accessed through HCBSW Institutional Deeming Process).

Types of Respite for the Medically Fragile:

- Respite for the medically fragile provided by a Home Health Agency (HHA). The agency provider sends either an LVN or RN into client's home to provide medical related respite service based on client's care needs. The HHA is responsible for ensuring that a Nurse Case Manager is assigned to each case for supervision and monitoring purposes.
- Respite for the medically fragile may be provided by an Individual Nurse Provider (INP) who is an RN independently contracted by the regional center. This type of service requires an assignment of a Nurse Case Manager either by the regional center, client's Nurse Case Manager at Systems of Care for EPSDT or by client's primary care physician.

Authority

- California Welfare and Institution Code (Lanterman Act) § 4646.4 (a) and § 4659 (a) (1) (2) : Utilization and exhaustion of generic funding sources (http://www.dds.ca.gov/Statutes/WICSectionView.cfm?Section=4640-4659.htm)

- California Code of Regulations (CCR) Title 17, §56076: Definition of continuous skilled nursing care; (http://www.dds.ca.gov/Title17/T17SectionView.cfm?Section=56076.htm)

- Welfare and Institution Code (WIC) §4690.2: Definition of Respite (http://www.dds.ca.gov/Statutes/WICSectionView.cfm?Section=4690-4694.htm)

- WIC §4512(b); §4685(c)(1); §4685(c)(3): Authority for respite as one of the Services and Supports for persons with developmental disabilities. (http://www.dds.ca.gov/Statutes/WICSectionView.cfm?Section=4500-4519.7.htm) (http://www.dds.ca.gov/Statutes/WICSectionView.cfm?Section=4685-4689.8.htm)

- Health and Safety Code §1760.2 (a) and §1760.2 (d) and Title 22, Section 51340: Definition and duties of Pediatric Day Health Facilities (http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=01001-02000&file=1760-1761.8)

- Health and Safety Code Section 1743 (a) (b) (c): Legislation that allows private duty nursing agencies to provide appropriate nursing care while upholding the same strong client protections applicable to home health agencies under Title 22 California Code of Regulations (http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=01001-02000&file=1743-1743.37)

- Medi-Cal's Provider Manual: Home and Community Based Services (HCBS)
- California Welfare and Institutions (W & I) Code, Section 14132(t) approval by the US Health and Human Services of the home and community based services through federal financial participation in accordance with Section 1396n of Title 42, United States Code. (http://law.onecle.com/california/welfare/14132.html)

Glossary of Terms:

NF/AH	–	Nursing Facility/Acute Hospital
SA	-	Sub-acute
ACRC	–	Alta California Regional Center
HCBSW	–	Home and Community Based Services Waiver
IHSS	-	In Home Support Services
PCSP	–	Personal Care Services Program
HHA	–	Home Health Agency
INP	–	Individual Nurse Provider

NP	–	Nurse Provider
LVN	–	Licensed Vocational Nurse
RN	–	Registered Nurse
EPSDT	–	Early Periodic Screening Diagnosis and Treatment
MMC	–	Medi-Cal Managed Care
COHS	–	County Organized Health Systems
CCS	–	California Children Services
GMC	-	Geographic Managed Care
POS	–	Purchase of Service
IFSP	–	Individualized Family Service Plan
IPP	–	Individual Program Plan
FSSC	–	Family Services Supports Committee
TAR	–	Treatment Authorization Request
POC	–	Plan of Care
PDHC	-	Pediatric Day Health Center
ADHC	-	Adult Day Health Center

Generic Resources/Natural Resources

Regional Center (RC) funds shall not be used to supplant the budget of any agency which has a legal responsibility to serve all members of the general public and is receiving funds for providing those services. The availability of other public and private resources must be pursued prior to ACRC funding. Medi-Cal has primary responsibility for funding of skilled nursing services for clients qualifying for services through EPSDT program, and the NF-A/H. The MMC system, GMC, and the COHS are other possible generic funding sources available for skilled nursing and shift nursing services. Funding may also be available through Medicare and CCS.

.**Key Considerations for Services**

1. ACRC does not fund long term skilled nursing care or continuous/shift skilled nursing respite care. The responsibility of funding for these types of services lies on primary health insurances, Medicaid State Plan (Medi-Cal), EPSDT (0-21), CCS and NF-AH waiver programs.

2. Requests for long term skilled nursing care or continuous/shift skilled nursing respite care as an exception shall be staffed at the Best Practices Committee for approval.

3. Requests for regular medical respite care shall be staffed at the FSSC.

4. Prior to requesting funding for Respite for the Medically Fragile, the SC shall assist the family in accessing the Medicaid Waiver.

4. Funding is only considered if a client is in the process of accessing generic resource funding programs as qualified by their health/ medical conditions.

These generic resources include but are not limited to: private insurances; Medi-Cal FFS, MMC; GMC and COHS and CCS, NF-AH Waiver and EPSDT program.

5. If there are no generic resources available, and the family is not able to access medical respite anywhere, the SC shall staff the case at the FSSC for a decision to fund or not, or be presented with other possible resources to explore, or both.

6. ACRC's funding of skilled nursing respite hours shall be provided at a three month increment. This should allow ample time for the family and SC to work together towards accessing generic funding sources. POS can be extended for an additional 3 months if necessary.

7. The SC should first attempt to locate non-vendored/generic resources (Home Health Agencies, Independent Nurse Providers, Pediatric Day Health Facilities, etc.) that are directly contracted with Medi-Cal, when facilitating the provision of the service to families.

8. The SC should staff at the FSSC the appropriateness of non-medical respite to meet the needs of the client. Clients with *stable* medical conditions requiring *incidental medical services* (e.g. colostomy, ileostomy, changing bags and cleaning stoma, urinary catheter, emptying and changing of catheter site, gastrostomy tubes, medication administration) may receive *agency respite* if allowed by physician's plan of care and respite worker receives training through respite agency.

   Note: There are currently no available vendored Respite agencies providing this service

8. Siblings and any other members of the household do not qualify for respite services funded by ACRC unless they are also regional center clients and respite services have been designated in the client's IFSP/IPP.

9. For multiple clients in the same family receiving respite care simultaneously from one provider - The service provider will be paid an incremental increase for each client in addition to the first client. The SC will write the authorization based on how many clients are being provided the service at the same time and what the total hours are authorized.

Examples of the multiple client rates for skilled nursing services are as follows:

742	**LICENSED VOCATIONAL NURSE (provided by an HHA)**					
	1st Client	2nd Client	3rd Client	4th Client	5th Client	6th Client

1 client Rate	$	29.410		
2 client Rate	$	18.380	$ 18.380	
3 Client Rate	$	14.707	$ 14.707	$ 14.707

744 REGISTERED NURSE

		1st Client	2nd Client	3rd Client	4th Client	5th Client	6th Client
1 client Rate	$	40.570					
2 Client Rate	$	25.355	$ 25.355				

The SC will write up the authorization based on how many clients are to be provided with the service at the same time with the total hours authorized. For example, if there are two clients being provided service at the same time by an LVN employed by a HHA, each authorization will reflect a rate of $18.38 per hour. For each hour that the nurse provider serves 2 clients, he/she will be reimbursed $36.76 ($18.38 X 2 clients) per hour. Please note, the rates shown above are only examples of rates for agency nurse providers.

When writing the POS, the SC should be mindful to use the correct subcode that lists the correct multiple client rates. If the authorization is set up at the multi-client rate, the expectation is that the clients will be receiving respite care at the same time, and will be reimbursed as such. However, when a client is to receive respite care independent of other clients in the family, a separate purchase authorization is required for that client at the single-client rate.

10. In some situations, families may be utilizing multiple services for multiple clients in the home setting. An example is a family with children receiving both medical and non-medical respite services as described in the IFSP/IPP. In this case scenario, the purchases would need to be written individually and on a per-client basis and must reflect individual service rates.

Amount of Service

ACRC shall fund respite care only in the following situations:

1. Gap funding, defined as ACRC funding to cover the period of time in which it takes for client to access a generic resource program.

2. Hours necessary to maintain a medically intensive client in his or her home, as determined by the client's planning team, above and beyond those hours authorized by and billed to Medi-Cal and other available funding sources.

3. Authorized respite hours shall not exceed 90 hours per quarter. Any exception must be approved by the FSSC and meet the 'extraordinary event' criteria as defined in the "Respite Services Procedures Manual" available in Policytech.

Service Initiation Process

Prior to seeking funding from ACRC for respite care, the SC is required to:

1. Ensure that client's nursing agency is participating in EPSDT or NF-AH or other generic resource that may fund skilled nursing service, if eligible.
    a. Consult with the Federal Programs Manager regarding how to access:
        i. EPSDT – for ages birth through 21 years of age
        ii. NF/AH Waiver- must have full scope Medi-Cal, no age limit provided other eligibility criteria are met
    b. Gap funding may be provided if the client's planning team deems that more immediate skilled nursing services are required to maintain the client's health and safety while accessing generic resources.

2. Ensure that the client's nursing agency is participating in EPSDT or NF-AH or other generic resource and has applied for skilled nursing services through a Treatment Authorization Request (TAR) submitted to Medi-Cal.

    Note: ACRC may provide <u>lag funding</u>, defined as ACRC funding to cover the period of time until a TAR is approved by Medi-Cal. Lag funding is available for a period of 90 days or longer, until the TAR is authorized by Medi-Cal. Since Medi-Cal will provide retroactive payments, it is expected that when a TAR is approved, Medi-Cal will pay the provider for services rendered retroactively. Since ACRC funding was in place for the period of time when there was no Medi-Cal funding, it is the legal obligation of the provider to reimburse ACRC the monies provided as lag funding. As soon as the Medi-Cal authorization is obtained, the SC should cancel ACRC's POS immediately and the provider should bill Medi-Cal from that point forward.

3. Vendored HHA or INP or ACRC Staff RN when needed, shall assess and prescribe the level of care required to safely meet the client's needs. Medical conditions requiring Plan of Care or Health Care Plan include but are not limited to:
    a. Assistance with Self-Administration of medications
    b. Use of any inhalation-assistive device
    c. Colostomy/ileostomy care
    d. Poorly controlled seizures requiring cardio-respiratory assessment and/or intervention
    e. Use of catheter
    f. Staph of other serious, communicable infection
    g. Gastrostomy Care and/or feeding
    h. Serious wound, such as an unhealed, surgically closed incision or wound
    i. Oxygen support

j. Suppositories (except Diastat)
k. Stage 1 or 2 dermal ulcer
l. Stage 3 or 4 dermal ulcer
m. Need for injectable medications, including insulin
n. On-going need for fecal impaction removal, enemas or Diastat suppositories
o. Need for suctioning
p. Tracheotomy care
q. Nasal-gastric and naso-duodenal tube feeding and/or decompression

4. In cases wherein the client cases are outside of the eligibility guidelines, the SC shall staff the case with the Best Practices Committee.

Procedures to access respite for medically fragile for ACRC clients who are deemed eligible to receive respite services by the FSSC:

1. In-Home Respite for the medically fragile:
   a. Home Health Agency (preferred method): HHAs will administer eligibility and billing of skilled nursing services directly with Medi-Cal for clients who have EPSDT and/or the NF/AH Waiver. In such cases, an ACRC POS is not needed for the client to receive skilled nursing services through the HHA.
      - If the client does not qualify for nursing services through generic resources and a Home Health Agency is to be used:
        i. The SC will provide the family with the names of vendored Home Health Agencies that could meet their needs.
        ii. Families may contact each of the agencies to find an agency of choice.
        iii. The planning team shall agree on the agency to be used.
        iv. The planning team shall agree on the number of hours to be used per quarter or per month, based on client's assessed need;
        v. The planning team shall agree on a start date for the service to begin following ACRC POS timelines.

   b. Individual Nurse Provider (INP) RN only: If the client does not qualify for nursing services through generic resources and an RN level care has been identified by planning team:
      i. If the RN or HHA is not currently vendored by ACRC, the SC shall submit Vendorization Form #592 to his/her Supervisor and email it to Vendor Request inbox
      ii. CSS will process vendorization request and obtain all documents required from applicant (nurse or HHA).
      iii. CSS will finalize vendorization and electronically notify the SC that vendorization is completed.
      iv. The SC will submit POS for nursing services.

v. All independent nurse providers must be supervised by an RN (ACRC funded) or the doctor prescribing nursing level care (non-ACRC funded). The SC shall identify a nurse supervisor and if necessary, submit additional POS (2 hours/ month) authorizing case management supervision of an independent nurse provider.

2. Facility-Based Skilled Nursing Services
    a. Pediatric Day Healthcare Facilities (PDHC): PDHC will administer eligibility and billing of skilled nursing services directly with Medi-Cal for clients who have EPSDT. In such cases, an ACRC POS is not needed for the client to receive skilled nursing respite through the PDHC.
        i. If the client does not qualify for nursing respite through generic resources, or the client's planning team has agreed to fund a number of hours above and beyond those authorized by the generic resource, and a PDHC is to be used:
            A. The SC shall provide the family with the names of vendored PDHC's that could meet their needs.
            B. Families may contact each of the agencies to find an agency that would best meet their needs.
            C. The planning team shall agree on the agency to be used.
            D. The planning team shall agree on the number of respite hours to be used per quarter.
            E. The planning team shall agree on a start date for the service to begin following ACRC POS timelines.

    b. Adult Day Health Center (staffing at the Adult Services Committee)

Evaluation of Service Effectiveness

The SC will review and document the effectiveness and value of current skilled nursing services with the client and family or care giver. This review will include:

- A comparison of authorized versus utilized hours and justification for continued services.
- Review of current needs and the availability of resources/services and supports that have become available
- Consideration of the client's current health condition and any documented improvement such that skilled nursing services may no longer be necessary

Technical Support

All services provided by ACRC vendors must comply with approved standards of care and treatment and be within the scope of the approved program design and intended parameters of the service code. Any issues or questions arising related to these standards, or deviations from the intended use of the service shall be referred to the Community Services and Supports Department for a Quality Assurance review and technical assistance.

Termination of Service

Upon termination of the need for skilled nursing services, the SC shall cancel all skilled nursing services POS' when the client exits the program.

Termination of skilled nursing services will occur when:

1. Client becomes eligible for funding via generic resources.
2. Generic resources become available for fulfillment of required skilled nursing hours.
3. Client's health has improved to status wherein skilled nursing services are no longer required (refer to Procedure Manual for Respite Services)

Additional Resources

ACRC Website: descriptions of generic and natural supports, FAQ's, SCs roles and responsibilities

www.medi-cal.ca.gov

Provider Manuals – Inpatient/Outpatient – Home Health Agencies and Home Community Based Services (HOM)
Pediatric Day Health Care (PDHC) – Early Periodic Screening Diagnosis and Treatment (ped)
Health and Safety Code and Title 22 regulations