APPENDIX A-

MECHANICAL VENTILATOR DEPENDENT WAIVER
SCOPE OF SERVICES
FOR
IN-HOME RESPITE

A. Objective

The objective of In-home Respite Services is to provide temporary care in the home for mechanical ventilator dependent participants who live at home and are cared for by their families or other informal support systems. This service will provide temporary relief for the primary caregivers and maintain the participant at home. This service is necessary to avoid institutionalization.

B. Description of Services to be Provided

1. The unit of service will be a twenty-four hour period.

2. The number of units and services provided to each participant will be dependent upon the individual participant's needs as established or approved by the Case Manager and set forth in the participant's Service Plan. In-home respite services may be provided for a period not to exceed fourteen (14) days per State fiscal year (July 1-June 30) in accordance with the provider contracting period.

3. In-home respite services will provide skilled medical services as ordered by the physician and will be performed by a Registered Nurse, or Licensed Practical Nurse, who will perform their duties in compliance with the Nurse Practice Act and S. C. Code of Laws, Regulations, Chapter 91, State Board of Nursing.

4. In-home respite services will include, but are not limited to, any household care, meal preparation and personal care services as needed by the participant during the in-home respite period. All other waiver services will be discontinued during the in-home respite period.

5. Agencies must utilize the automated systems mandated by CLTC to document and bill for the provision of services.

6. Providers must accept or decline referrals from CLTC or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

7. The provider must verify the participant’s Medicaid eligibility when it accepts a referral and monthly thereafter to ensure continued eligibility. Providers should refer to the CLTC Services Provider Manual for instructions on how to verify Medicaid eligibility.

8. Providers may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Staffing

1. A licensed practical nurse or registered nurse who meets the following requirements:

   a. Currently licensed by the state of South Carolina.

   b. At least one year experience in public health, hospital, or long term care nursing.

   c. Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing for PPD Tuberculin test requirements.
   http://www.scdhec.gov/health/licen/hladcinfo.htm

   Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201, phone (803) 898-0558.

2. Minimum training for registered nurses:

   a. The provider assures CLTC that the nurse has adequate experience and expertise to perform the skilled services ordered by the physician including the care required by individuals requiring mechanical ventilator assistance.

   b. The provider will provide a minimum of six (6) hours relevant in-service training per year (based on date of employment) for each nurse.

D. Conduct of Service

1. The name of a designated person(s) and telephone number(s) will be furnished to CLTC in order to provide CLTC seven (7) day twenty-four (24) hour accessibility.

2. An individual participant record must be maintained. The record must include the following:

i. CLTC authorization
ii. Skilled nursing orders signed and dated by the physician
iii. Plan of Care
iv. Documentation of daily care and services provided

3. The provider will be responsible for procuring the skilled nursing orders from the physician.

4. In-home Respite Services must begin on the date negotiated by the case manager and the provider.

5. The provider must send a plan of care to the case manager which includes goals, after completion of the first in-home respite nursing visit. If applicable, recommendations to change the service schedule from that on the initial Service Provision Form may be sent to the Case Manager at that time.

6. The In-home Respite Service must not be provided prior to the authorized start date as stated on the Service Provision Form.

7. The provider will notify the Case Manager within two (2) working days of the following participant changes:

   a. Participant's condition has changed and the Service Plan no longer meets the participant's needs or the participant no longer needs In-home Respite Services.

   b. Participant dies or moves out of the Service area.

   c. Participant no longer wishes to receive the In-home Respite Service.

   d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

8. A record keeping system will be maintained which establishes an eligible participant profile in support of units of In-home Respite Services. A daily log will reflect the services provided by the nurse and the time expended for this service.

9. The provider must develop and maintain a state approved Policy and Procedure Manual which describes how it will perform its activities in accordance with the terms of the contract.

10. The case manager will authorize In-home Respite Services by designating the amount, frequency, and duration of service for participants in accordance with the participant's Service Plan. This documentation will be maintained in the participant's file.

11. The case manager will obtain the initial physician's order for In-home Respite Services. A copy will be sent to the provider to be placed in the participant's file.

12. The provider will be responsible for procuring the direct care physician's orders.

13. The case manager will review the participant's Service Plan within three (3) days of receipt of the provider's request to modify the plan.

14. The case manager or CLTC will notify the provider immediately if a participant becomes medically ineligible for CLTC services.

E. Administrative Requirements

1. The provider must inform CLTC of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document shall include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will ensure that its office is staffed by qualified personnel during the hours of 10:00 am to 4:00 pm. Outside of these hours, the provider agency must be available by telephone during normal business hours, 8:30 am to 5:00 pm, Monday through Friday. The provider must also have a number for emergencies outside of normal business hours. Participant and

personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

6. The provider must develop and maintain a policy and procedure manual which describes how it will perform its activities in accordance with the terms of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

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