1250-D RESPITE CARE

REVISION DATES: 11/01/17, 03/15/15, 10/01/14, 07/01/12, 10/01/11, 07/01/11, 07/01/10, 10/01/07, 03/01/06, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

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Description

AHCCCS covers respite care as a short term service for ALTCS members residing in their own home. Services are provided as an interval of rest and/or relief to a family member or other persons caring for the ALTCS member.

Amount, Duration and Scope

The services may be provided by a respite provider coming to the member's residence, as well as by admitting the member to a licensed institutional facility or an approved Home and Community Based (HCB) alternative residential setting for the respite period.

When respite care is provided for a period of less than 12 hours regardless of the date during which the respite began, the respite care is authorized according to the number of units provided. The unit of service for respite care less than 12 hours is 15 minutes. When respite care is provided for 12 – 24 continuous hours regardless of the date during which the respite began, the respite care is authorized at a per diem rate. The combined total of short-term and/or continuous respite care cannot exceed 600 hours per benefit year. The benefit year is defined as a one year time period of October 1st through September 30th. The 600 hours are inclusive of behavioral health respite care.

Respite care may only be delivered as specified and authorized by the member's case manager in the member's service plan. Respite services include, but are not limited to:

1. Supervision of the member for the period of time authorized by the case manager

2. Provision of services during the respite period which are within the respite provider's scope of practice, are authorized by the member's case manager and are included in the member's service plan, and

3. Providing activities and services to meet the social, emotional, and physical needs of the member during the respite period.

If respite care is provided by one of the facilities listed below, that facility must be licensed by the Arizona Department of Health Services and Medicare certified when applicable.

1. Nursing care institutions,

2. Adult day health care providers,

3. Approved HCB alternative residential facilities included in Policy 1230 of this Chapter, and

4. Home Health Agencies (HHA).

A person who assists an elderly person or an individual with a disability with activities necessary to allow them to reside in their own home (including respite services) must be employed by a provider agency in order to provide respite services to ALTCS Members. The provider agency establishes terms of employment.

No later than 10/01/2018, provider agencies must develop policies and procedures for, and begin conducting background checks of Direct Care Workers (DCWs) that comply with the following standards:

a. At the time of hire and every three years thereafter conduct a nationwide criminal background check that accounts for criminal convictions in Arizona

b. At the time of hire and every year thereafter, conduct a search of the Arizona Adult Protective Services registry.

c. Prohibit a DCW from providing services to ALTCS members if the background check results contains:
   i. Convictions for any of the offenses listed in A.R.S. §41-1758.03(B) or (C), or
   ii. Any substantiated report of abuse, neglect or exploitation of vulnerable adults listed on the Adult Protective Services registry pursuant to A.R.S. §46-459.

d. Upon hire and annually thereafter, obtain a notarized attestation from the DCW that he/she is not:
   i. Subject to registration as a sex offender in Arizona or any other jurisdiction

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ii. Awaiting trial on or has been convicted of committing or attempting, soliciting, facilitating or conspiring to commit any criminal offense listed in A.R.S. §41-1758.03(B) or (C), or any similar offense in another state or jurisdiction.

e. Require DCWs to report immediately to the agency if a law enforcement entity has charged the DCW with any crime listed in A.R.S. § 1758.03(B)or (C).

f. Require DCWs to report immediately to the agency if Adult Protective Services has alleged that the DCW abused, neglected or exploited a vulnerable adult.

g. Agencies may choose to allow exceptions to the background requirements for DCWs providing services to family members only. If the agency allows a DCW to provide services under this exception, the agency shall:
   i. Notify the ALTCS member in writing that the DCW does not meet the background check standards and therefore otherwise would not normally be allowed to provide services, and
   ii. Obtain consent from the ALTCS member to allow the DCW to provide services despite the findings of the background check.

h. Agencies are prohibited from allowing exceptions to the Adult Protective Services for DCWs providing services to family members only.

Effective 10/01/2018 provider agencies required to comply with Fingerprint Clearance Card requirements outlined in A.R.S. Title 41, Chapter 12, Article 3.1, may use a DCW's Fingerprint Clearance Card as evidence of complying with the criminal background check required by this Policy; however, the agency must still comply with the obligation to check the Arizona Adult Protective Services Registry. DCWs are prohibited from providing services to ALTCS members if the DCW is precluded from receiving a Fingerprint Clearance Card or has a substantiated report of abuse, neglect or exploitation of vulnerable adults listed on the Adult Protective Services registry pursuant to A.R.S. §46-459.

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At a minimum, individuals who provide respite care must hold a current certification in cardiopulmonary resuscitation and first aid, have appropriate skills and training to meet the needs of each member assigned to them and submit three letters of reference. All references, skills and training must be verified and documented in the employee's personnel file when working for an agency.

If respite care is provided in an institutional setting or an HCB approved alternative residential setting, other ALTCS services may be provided, as allowed in the specific setting and if included in the member's individualized care plan. Examples are as follows:

1. If the member resides in his/her own home and is authorized to receive home health skilled nursing services but is receiving respite care from a Nursing Facility (NF), the facility may provide nursing services but the services will be included in their per diem.

2. If the member also requires home health therapy services, the NF may provide the services, but because they are not part of the NF per diem, the services should be billed/reported in addition to the per diem day. Refer to Policy 1210 of this Chapter for additional information regarding institutional services and Policy 1240 of this Chapter for information related to HCBS.

If respite care is provided in the member's own home, all HCB services included in the member's service plan may be provided in conjunction with respite care. Examples are as follows:

1. If the member is receiving personal care services, he/she may continue to receive this service in conjunction with the respite care. However, if the service is included in the scope of practice of the respite care provider, it is included as a part of the unit rate for respite care and is not billed separately.

2. If the member requires home health skilled nursing services, the services may be provided in conjunction with respite care, but are billed/reported separately by the HHA.

When respite care is determined necessary for members with skilled nursing needs living in their own home, or an HCB approved alternative residential setting, it must be provided at the member's level of medical need. Respite care may be provided by private duty skilled nursing services, if available and determined to be medically necessary and cost effective.

If skilled nursing personnel are unavailable to provide respite care to members with respiratory care needs (such as ventilator dependent members), services may be provided by a respiratory therapist when both of the following conditions are met:

1. The member's primary care provider must approve/order the care by the respiratory therapist, and

2. The member's care requirements must fall within the scope of practice for the licensed respiratory therapist as defined in A.R.S. §32-3501 and

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orientation to the care needs unique to the member must be provided by the usual caregiver or the member.

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