

NEW YORK STATE  
DEPARTMENT OF SOCIAL SERVICES  
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243



BARBARA B. BLUM  
Commissioner

[An Administrative Directive is a written communication to local Social Services Districts providing directions to be followed in the administration of public assistance and care programs.]

**ADMINISTRATIVE DIRECTIVE**

TRANSMITTAL NO.: 80 ADM-9  
[Services]

TO: Commissioners of Social Services

SUBJECT: Personal Care Services -  
Scope and Procedures

DATE: February 22, 1980

SUGGESTED DISTRIBUTION: Services Staff  
Medical Assistance Staff

CONTACT PERSON: Questions regarding this release should be directed as follows:  
Scope of Service and Procedures for Service Delivery, William Rabbitt, Division of Medical Assistance, 800-342-3715, Ext. 4-9276, or Ann Hallock, Division of Services, 800-342-3715, Ext. 4-9451.  
Questions regarding Nursing Supervision should be directed to Barbara Frankel, Division of Medical Assistance, 800-342-3715, Ext. 4-9256.

I. PURPOSE

The purpose of this administrative directive is to explain the scope of the personal care services program within the Medical Assistance program and to describe in detail the procedures for the delivery of personal care services.

This letter also refers to information presented in other recently released administrative directives regarding the personal care program listed in the Filing References. Local district staff should consult these directives as they review and implement the requirements of this letter. (see page 2)

II. BACKGROUND

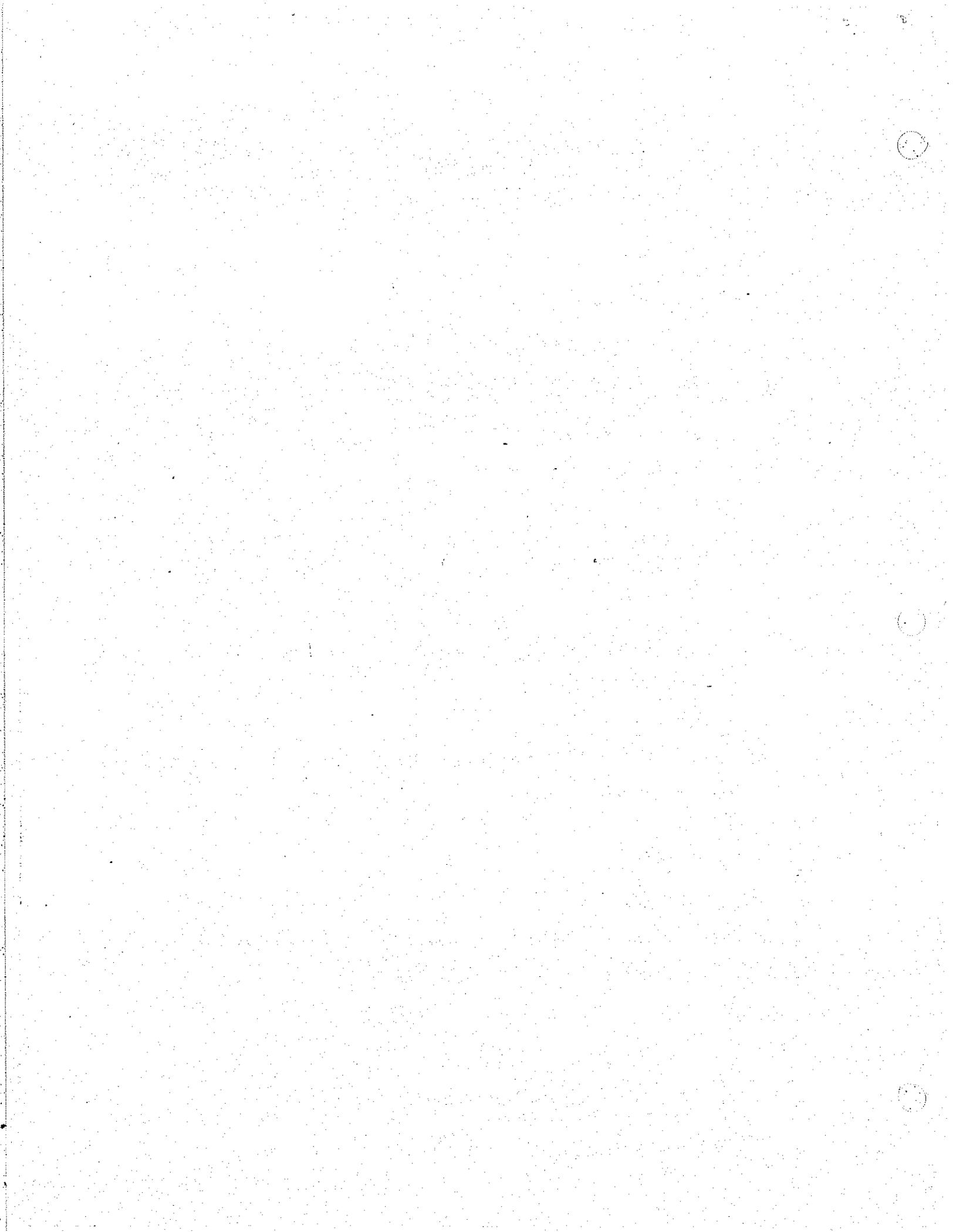
Section 365.a 2 (d) of the Social Services Law provides for the delivery of personal care services. This law is reflected in State Medical Handbook, Item 130, and Department Regulations, Section 505.14. These regulations describe how personal care services (continued on page 3)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Social Services Law and Other Legal References	Bulletin/Chapter Reference	Miscellaneous References
74 ADM-191 77 INF-20 78 ADM-19 79 ADM-34	NONE	505.14	365-a 2.(d)	74 MB-48 Item 130 of State Medical Handbook MB-143b	NONE

1911  
1912  
1913





shall be provided, including obtaining a physician's recommendation, performing nursing and social assessments, providing case management, and supervision by a registered professional nurse. Other letters describe the use of trained providers, explain when the local professional director or a physician designated by the local professional director, should be involved in authorization of the service, describe the required procedures for contracting for the delivery of personal care services and monitoring such contracts and list the health requirements for providers of personal care services.

### III. PROGRAM IMPLICATIONS

#### A. Scope of Personal Care Services

1. Definition: Personal Care Services means assistance with personal hygiene, nutritional support and environmental maintenance necessary for an individual to remain within his/her own home. Specific functions are as follows:

- (1) Assist with care of teeth and mouth
- (2) Assist with grooming - care of hair including shampoo, shaving and the ordinary care of nails.
- (3) Assist with bathing of patient, in bed, in tub and in shower
- (4) Assist patient on and off bedpan, commode and toilet
- (5) Assist patient in moving from bed to chair, wheelchair and in walking
- (6) Assist patient with eating
- (7) Assist patient with dressing
- (8) Prepare and serve meals according to instructions
- (9) Wash dishes and clean kitchen
- (10) Making and changing beds
- (11) Dusting and vacuuming the rooms the patient uses
- (12) Listing needed supplies
- (13) Shopping for patient if no other arrangements possible
- (14) Patient's personal laundry if no family member available or able; this may include necessary ironing and mending
- (15) Other pertinent health care functions according to criteria established by the New York State Health Department when approved by the local professional director or physician designated by the local professional director and when on-the-job instruction and supervision is provided by a certified home health agency.

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As an item of Medical Assistance, the services shall be ordered/prescribed by a physician and supervised by a registered professional nurse.

2. Functions not included: Personal care services does not include any care provided to a person without a medical problem; care provided to children in the absence of the caretaker relative and any instructions provided to achieve adequate household and family management. These services may be provided as homemaker services under Title XX according to the individual county's Comprehensive Annual Social Services Program Plan.
3. Relation to other Home Care Services: Personal care services is related to other home care services by shared functions. The chart in Appendix A shows the differences in program requirements, providers and funding sources between the four major home care services: home health aide, personal care, homemaker and housekeeper/chore services. Each of these services has specific program requirements and the names of the services should not be used interchangeably. All authorization and case recording should properly identify the service being provided. If local districts wish to identify varying levels of personal care services or source of provider, such terms of identification should be used following the words "personal care services". It is extremely important to use the proper name for the service to assure that there is no misunderstanding about the requirements for the service. For example, if the authorization and case record indicated that the client required home health aide services, but the service actually required and delivered was personal care service, it would appear that the district was not delivering the needed service in accordance with all requirements.

The major difference between home health aide and personal care services, provided under the Medical Assistance program, is the increased involvement of a registered professional nurse required for supervision of the home health aide when performing certain health care functions, such as care of dressings and irrigation of catheters, included in home health aide services. Personal care service is related to homemaker service, since both may include certain personal care functions, such as dressing or bathing. The major differences between the two services are the causes or the need for the service. In the instance of personal care service, the need is medical in nature as reflected in the physician's orders for the services and in the nursing assessment of need. On the other hand, homemaker service is provided in response to a social need and involves the professional expertise of the social worker rather than the physician and the nurse. Homemaker services may also respond to other service needs, such as the need for a mother substitute or instruction in home management. Housekeeper/chore services are provided under Title XX and are directed at the environment in which a person lives. This service involves care of the

immediate surroundings in which the client lives and the preparation of food which the client eats. The following requirements for the establishment of the need for personal care services further distinguishes it from other home care services.

## B. Assessment and Authorization Procedures for Delivery of Personal Care Services

The assessment and authorization procedures for the delivery of personal care services have been outlined in a flowchart found in Appendix B of this letter. The determination of financial eligibility for the medical assistance program has not been included in the procedures. It is expected that such eligibility determination will follow established procedures.

In an effort to facilitate program eligibility determinations for all home health care provided under Medical Assistance, whether personal care service, home health aide service or long term home health care, the State Departments of Health and Social Services have agreed that common methods of assessment, physician's orders and case management will be used. This includes a standardized format for recording/documenting the physician's orders and nursing and social assessment.

### 1. Physician's Orders

Receipt of the physician's orders for personal care service is the first step in determining eligibility for personal care services. Under the Medical Assistance program, physician's orders shall be obtained for each initial authorization and all reauthorizations on a form such as is included in Appendix C. If local social service agencies or other home care providers in the area have a comparable form which they wish to use, such forms must be submitted to the New York State Department of Social Services for approval (see Required Action). For MMIS purposes all physician's orders must include primary and secondary diagnoses and respective code numbers.

Information included in the physician's orders must be current in order to accurately determine service needs. In order to assure current information about the patient, all physician's orders for personal care services shall be based on a medical examination, done within 30 days of the date, when the orders are completed. When a change is noted in the patient's condition, new orders shall be requested. One copy of the physician's orders shall be maintained in the case record; another copy shall be forwarded to the certified home health agency with the request for the nursing assessment.

### 2. Nursing Assessment

The assessment of each individual by a registered professional nurse from a certified home health agency is the second step in determining the medical need for personal care services under this title. This nursing assessment shall be recorded on a form approved by the State Departments of Social Services and Health. Local districts and certified home health agencies are encouraged to perform joint assessments whenever possible.

The nursing assessment shall be based upon a visit to the home of the person seeking services and shall include a review and interpretation of the physician's orders, an evaluation of the patient's need for services and the development of specific recommendations for the summary of services requirements. In addition, the registered professional nurse shall develop a plan of care for the patient. This plan of care is an internal working document of the certified home health agency and should include the regimen for the registered professional nurse to use in supervising all health care provided to the patient and in arranging for the delivery of other health services, including nursing visits. Since the plan of care is maintained by the certified home health agency, it should follow the format developed by that agency. If the certified home health agency is not responsible for the supervision of personal care service providers, the plan of care developed by that agency would not have a detailed plan for supervision. In this situation, the nurse in the local social service district or in the vendor agency would have responsibility for development of a detailed plan of supervision, based on the nursing assessment.

The nursing assessment shall include the nurse's recommendations for all services required, including the types of service required, the frequency of service needed, and the duration of the need for service. Equipment needs should also be included. A copy of the completed nursing assessment shall be returned to the local social service district within 15 working days of referral. This assessment should be current. Any change in the patient's condition which would result in type, frequency, or duration of service will require the completion of a new nursing assessment. In the event that a patient is hospitalized, after assessment, a new assessment based on current needs should be completed and used as a basis for service authorization.

The recommendations for scheduling services delivery should be reflective of specific client needs during different times of the day. For example, if the need for service is intermittent within the day, continuous service to cover all period should not be recommended.

Local social services districts are required to have a current DMS-1 or its successor available on each patient receiving personal care. Persons who are being released from a hospital or residential health care facility will already have a completed DMS-1; persons in the community will generally not have such an evaluation. If this evaluation has not been done, previous to the nursing assessment, the registered professional nurse from the certified home health agency conducting the home assessment, shall complete the DMS-1 and forward a copy to the local social service district. It is expected that copies of the nursing assessment and the DMS-1 shall be available prior to the local social service district's authorization of care.

When the assessment and DMS-1 are received, the local district shall use these recommendations as the basis for the development of a summary of service requirements which reflect needs identified in both nursing and social assessments.

In no event shall the local social service district change the recommendations of the certified home health agency without consulting with that agency. When differences can not be resolved, the case shall be referred to the local professional director or a physician designated by the professional director with all appropriate forms for his review. That physicians's decision shall be the final authority.

When it is impossible for a nursing assessment to be completed before authorizing care, care may be authorized by the local social service district, based on the physician's orders and the social assessment for thirty calendar days only. Such interim authorization will be used only in the following situations:

- a) The patient is awaiting discharge from a hospital or residential health facility because such care is no longer appropriate for patient's needs and suitable arrangements for home care have not been made in time to allow completion of the nursing assessment.
- b) If the care is not provided immediately, it will be necessary to place the patient in a hospital or residential health care facility in order to protect the patient's health and safety.
- c) There is a drastic change in the patient's condition and it is necessary to increase services immediately in order to protect the patient's health and safety.

The physician order and the case records should reflect the conditions necessitating the interim authorization. When the nursing assessment is received, the local social service district shall review and incorporate the recommendations into a new summary of service requirements and authorize services accordingly.

### 3. Social Assessment

The social assessment required for personal care services and home health aide services shall be completed on the form approved by the State Departments of Health and Social Services. The local social service district can not delegate this responsibility for social assessments to another agency. The local social service district shall complete the social assessment within 15 working days of referral of the client to the certified home health agency. In the event that there is any change in the patient's condition, a new social assessment shall be done. In the event of emergency cases, it may be necessary for the local districts to complete the social assessments as quickly as possible since it will serve as the basis for the interim 30-day authorization.

All social assessments shall be completed by professional casework staff, who shall also have responsibility for case management (see later section on case management). The social assessment should consider both the expressed and identified needs of the client and the factors impacting on the client's life situation.

One of the most important considerations necessary is an evaluation of the family and community support available to enable the patient to remain at home within the community. The motivation of the patient and his family to maintain the person at home has been found to be one of the most important determinants of the success of a home care plan. Staff from local districts are charged with the responsibility of determining the extent of such motivations and for further maintaining this motivation through case management.

a) Client's Motivation

It must be determined why the client desires in-home care and whether this option is feasible, based upon the case situation. While it must be recognized that clients maintain the right to deny services, once services commence, there must be mutual cooperation between the providers and the client. It is, therefore, advised that clients have input, where possible, in planning for the delivery of personal care services. Reluctance, resistance and mistrust on the part of the client, are often the result of lack of communication and coordination. Personal care services can not serve the needs of the client without the desired amount of cooperation and motivation on the part of the client, as well as effective casework on the part of the case manager.

b) Family Motivation

The role of the family in relation to the client is an essential one. Families should be encouraged to have input and offer emotional support to the client, as well as to provide resources to the case where possible. The moral and/or legal responsibilities of families of clients are not always well defined. Again, as with the client, it is important for the case manager to involve the family in planning needed services. Cases may arise where families of clients would prefer institutional placement for a variety of reasons, but this is not consistent with the desires of the client nor is it recommended by the physician. It can be detrimental if the role of the agency is viewed by the family as threatening. Every effort should be made to bring about good working relationships between the service providers and the family, for the ultimate goal of providing for the needs of the client. The social assessment should also consider other services needed by the patient and family, including services provided under other titles or by other community agencies such as the County Office for the Aging.

#### 4. Development of a Summary of Service Requirements

A summary of service requirements shall outline the total service needs of the patient and shall be completed by the case manager on the assessment forms required by the State Departments of Health and Social Services, based upon the recommendations of the nurse in the nursing assessment and the findings of the social assessment. This summary shall include the following:

- a) Type of services needed
- b) Amount, frequency and duration of need
- c) Name of provider
- d) Unit cost of service
- e) Source of payment

This summary shall be used as the basis for authorizing the services needed. In some cases, questions regarding the appropriate type and frequency of service may arise as a result of differences of opinions among the patient, patient's family, patient's physician, staff from local social service district, staff from the certified home health agency, or other health professionals. In the event that these differences can not be resolved, the local social service district shall refer the case to the local professional director or a physician designated by the local professional director. (See 78 ADM-50, "Role of the Local Professional Director in Home Health Services")

#### 5. Authorization

No personal care services shall be provided without prior authorization of the local social service district. The preparation and signature of the necessary authorizations and arranging for the delivery of all services needed is the responsibility of the person designated by the local commissioner.

At no time shall changes be made in the services authorized without approval of the local social service district. When there is an unexpected change in the patient's condition and service needs, the case should be referred to the local social service district immediately. New physician's orders and assessments shall be obtained and a new authorization developed. In an emergency situation, the local social service district, with the consultation of the certified home health agency, may make interim arrangements for care of the patient, pending a new authorization. Such arrangements without necessary orders, assessments and authorizations, shall be limited to 30 calendar days.

The period covered by the authorization should be dependent upon the needs of the patient and the anticipated duration of the service need at the authorized frequency. In no event, should the period of authorization be greater than six months. Reauthorizations should follow the same procedures, requiring new physician's orders and assessments.

The assessment and authorization process previously outlined shall also apply to home health aide services which shall be provided according to the authorization of the local social service district.

If an emergency situation arises, necessitating home health aide services, and the local social service district is not available to issue an emergency authorization, the certified home health agency may initiate service without the prior authorization of the local district. The certified home health agency shall notify the local district as soon as possible after initiation of services so that the services can be authorized on an interim basis. The local district shall not be responsible for payment for services provided without prior authorization by a certified home health agency if the district is not notified within 4 calendar days of the initiation of service.

6. Written Notification of Services Authorized

Following authorization and prior to the delivery of the service, the local social service district shall prepare a written notification of the services authorized, including a listing of functions of the service needed and the frequency and duration of services. The listing of service functions required should be detailed so there is no question of what activities are appropriately done by the provider. Copies of the notification shall be sent to the following:

- a) Patient and/or family of patient receiving services
- b) Registered professional nurse responsible for supervising care
- c) Agency or individual responsible for providing the service

The letter to the client and the provider should include the name of a contact person from the local department of social services who will be available in case of emergency or complaint and should include information on the client's right to a fair hearing.

7. Provision of Service

The case manager shall arrange for the necessary services according to the authorization. Instructions for selecting and contracting with providers of personal care services are outlined in the Administrative Directive, "Contracting for Personal Care Services and Contracting for Nursing Assessment and for Nursing Supervision of Personal Care Services by Social Services Districts," 79 ADM-34.

Since personal care services involve assistance with basic human functioning, the establishment of a mutually agreeable relationship between patient and provider is extremely important. In some situations, the provider and patient may not be congenial. Every effort should be made to assure a good relationship between patient and provider, where both are able to communicate freely.

The local social service district shall provide the provider agency with all information necessary for provision of services. As services are provided, two supporting functions, nursing supervision and case management, should continue to assure that services meet the needs of the client.

A future administrative directive will further address the assessment procedures for delivery of personal care services when the patient is hospitalized and awaiting discharge.

### C. Program of Supervision

Under State Regulations, all persons providing personal care services, including persons providing environmental support, shall be subject to a program of supervision. A program of supervision shall consist of two parts, administrative supervision and nursing supervision.

#### 1. Administrative Supervision

Administrative supervision assures that the quantity and kind of services authorized by the local social service district are actually being provided. Administrative supervision should assure that the services are provided in compliance with the terms of the contractual agreement between the local district and the provider. This supervision is essentially a managerial supervision. It entails checking time cards, and personnel records for required documentation; reviewing the amounts and kinds of services authorized by the local district with the provider; arranging for coverage service in the event of provider illness; and telephoning the client to assure that the authorized service is being provided. It requires knowledge of the state personal care services regulations, the local districts personal care service program and personnel policies. Although some districts may prefer to have a nurse assume the responsibilities as well as nursing supervision described below, this supervision does not require the services of a registered professional nurse.

The local district has two options for providing this type of supervision. It may assume this responsibility itself or it may transfer it by means of a contractual agreement to a voluntary homemaker-home health agency, a certified home health agency, or a proprietary agency already providing personal care services.

#### 2. Nursing Supervision

Ongoing professional nursing supervision is an essential component of personal care services under the Medical Assistance program. The objective of the nursing supervision of personal care service providers is to assure that the client receives both appropriate and quality health care services. To achieve this objective, nursing supervision shall be done in the home of the patient, and involve the patient and his family (when available) and the provider. All personal care services shall be supervised by a registered professional nurse. As an integral part of their personal care services program, each local social service district shall develop a program of nursing supervision.

Each district has two basic options for providing nursing supervision. The local district may contract with a Certified Home Health Agency or it may provide the service by a nurse on its own staff.

a) Nursing Supervision by Contract from a Certified Home Health Agency

When the local social service district elects to contract with a certified home health agency for nursing supervision, the contract between the two agencies shall comply with requirements for such contracts, as outlined by the New York State Department of Social Services as stated in the Administrative Directive on Contracting for Personal Care Services.

Since all nurses employed by a certified home health agency (Article 36 facilities) already meet the minimum qualifications listed in personal care services regulations, the local district utilizing this option is not required to check the qualifications of these nurses.

b) Nursing Supervision by a Local District Staff

If the supervision is provided by an employee of the local social service district, it is the local district's responsibility to assure that the person meets the following minimum qualifications:

- 1) A limited permit to practice or a license and current registration to practice as a registered professional nurse in New York State. A nurse employed as a nurse supervisor shall be licensed and currently registered in this state or hold a limited permit to practice as a registered nurse in this state pending the issuance of a license. Both the local district and the nurse may be subject to prosecution in accordance with the provision of Title VIII of the Education Law if a nurse during any period of his/her employment does not have a current New York State license or limited permit.
- 2) At least two years satisfactory experience as a registered professional nurse. A nurse shall have been employed for at least two years as a registered professional nurse. Employment in other capacities is not acceptable, however, a combination of education and experience, described in (3) below may be acceptable. In addition, the nurse shall have references from all relevant previous employers indicating satisfactory performance.

- 3) A combination of education and experience which is equivalent to the experience requirements described in b) above with at least one year experience. The applicant may substitute a Baccalaureate Degree in nursing from a school registered by the New York State Education Department for one year of experience required above. However, this applicant must have at least one years satisfactory experience as a registered professional nurse. (See appendix for more specific guidelines for the selection of a nurse supervisor).

In staffing this position, the local district may opt to develop its own civil service title. Larger counties may wish to create a specialist title to hire an employee whose functions are primarily personal care services. Smaller counties may want to develop a civil service title which encompasses several different programs or the local district may assign this function to a current employee. For assistance in the development of such titles, local districts may contact John Hodgson, Office of Personnel, Supervisor of Employee Development, 800-342-3715, Ext. 4-9637.

In addition to the two basic options described above, the local district may request an exception to use a nurse supervisor from a voluntary or proprietary agency (a home care agency that is not certified under Article 36) who is under contractual arrangement to provide personal care services to local departments. In general, this request should explain why a local district desires to provide nursing supervision utilizing this option rather than the two basic options described above. It should describe the local district's plan for providing this supervision through the vendor agencies including identification of the agency (ies) providing the service and supervision, the qualifications required for the nurse, if they exceed the minimum described above for the nurse in the local districts, how these qualifications will be monitored, and the anticipated staffing ratio for nurse supervisor to personal care services aides.

It is important to note that the local district's plan must demonstrate that the nurse supervisor meets the minimum qualifications described above and that the nurse is an employee of the agency. (See Appendix E for job guidelines).

Since a thorough understanding of the program is crucial to the nurse's successful functioning, the local district should assure that the agency orients the nurse to the personal care services program. This orientation should include an explanation of the roles and functions of the various individuals involved in the program (nurse supervisor, nurse from certified home health agency, Department of Social Services Case Manager, personal care service provider, etc.) and an explanation of the requirements of personal care service programs under Title XIX, including requirements for nursing assessment, physician's orders, nursing supervision, training requirements for personal care service providers.

To assist the vendor agency in providing satisfactory nursing supervision, the local district should provide the agency with the following items:

- 1) Guidelines for nurse supervisor (See Appendix E)
  - 2) Section 505.14 of the Regulations of the New York State Department of Social Services Personal Care Service
  - 3) This Administrative Directive
  - 4) 78 ADM-19, "Training for Personal Care Providers"
  - 5) A copy of the Home Health Assessment Abstract for each client
- c) Requirements for Nursing Supervision

1) Frequency

The registered professional nurse responsible for the supervision of personal care services shall make supervisory visits as often as needed to assure both quality and appropriate services. However, the minimum frequency of these visits is dependent upon the amount recommended by the nurse from the certified home health agency and approved by the local social service district. This would be indicated on the summary of service requirements (See Appendix D). For the majority of patients, the certified home health agency nurse is required, by regulation, to recommend that these visits be made at least every 90 days. This means that the supervisory visit must be made at least 90 days from the date of the last nursing visit. Nursing visit in this case may mean the nursing assessment performed by the nurse from the certified home health agency or the initial required orientation visit performed by the nurse supervisor. (As explained below, 2) Functions, an orientation visit is required for all newly assigned aides). Exceptions to this 90 day minimum will be made only by the certified home health agency nurse and local social service districts when they have determined that the patient is a self-directing person whose medical condition is stable with little or no change or deterioration expected during the period of authorization. In these instances, the supervisory visits and assessment visits can be combined and performed every six months.

It is important to note that the frequency of these nursing supervisory visits should always be consistent with what is listed in the summary of service requirements. If the supervisory nurse determines that these visits should occur more frequently, she/he should notify the case manager in order that a revised summary of service requirements may be authorized. (last part of the Home Health Assessment Abstract. Appendix D).

2) Functions

a) Orientation of Personal Care Services Aide

Within the first week of the aides assignment to a case, the nurse shall make an orientation visit to assure that the person providing the personal care services understands and is capable of delivering the specific services authorized by local social services departments on the summary of service requirements. An exception to the initial orientation will be made only when the patient is a self-directing person, who is capable of directing the services.

During this initial visit to the client's home the nurse should do the following:

- (1) Introduce the provider to the client and the client's service needs.
- (2) Become acquainted with the patient and provider, evaluating the feasibility of development of a congenial relationship.
- (3) Review the written notification of service functions with the patient and/or his family and the provider to assure that there is complete understanding of the services which must be provided.
- (4) Discuss the health goals established in the plan of care, including activities necessary for reaching these goals.
- (5) Review all activities required with the provider and patient and/or family where necessary for delivery of care to the client.

b) Evaluation of the Personal Care Providers

The nurse should continually evaluate the provider's skills and performance by reviewing the patient's condition and the home environment and talking with the patient and family members. If the nurse determines the client's health and safety is in jeopardy, the nurse is responsible for notifying the case manager immediately so that appropriate changes can be made.

c) On-the-Job Training

Based on continuing evaluations of the provider's performance and the patient's individual needs, the nurse supervisor shall identify any significant gaps in the provider's ability to

function competently and safely and shall provide necessary on-the-job instruction. (See 78 ADM-19, "Training for Personal Care Service Provider"). The purpose of this instruction is not to provide comprehensive training, but to correct any such gaps. If it is not possible (i.e., nurse lacks appropriate expertise), he/she should arrange for appropriate instruction through available resources.

d) Evaluation of the Patient

Assessing the patients health care needs on each supervisory visit, the nurse should continue to review the appropriateness of the original amount and type of services assigned to the client. Whenever the nurse determines that these services are no longer appropriate for patients, she/he shall contact the case manager in order that new physician's orders and assessments can be obtained and less or additional services authorized.

e) Maintenance of Records and Forwarding of Reports

The nurse supervisor shall maintain records of all supervisory visits made and any action taken during the visit. Copies of this information should be forwarded to the case manager for inclusion in the patient's case record.

f) Involvement in Training

In addition, the nurse supervisor may also be involved in the development and implementation of a plan for training of personal care providers as outlined in Administrative Directive 78 ADM-19, "Training for Personal Care Service Providers".

D. Requirements for Case Management

Local district staff are responsible for responding to a request for personal care services by providing information and/or referral for appropriate services, or by arranging for or providing services directly to the applicant; in addition, local district staff are responsible for providing or arranging for services to meet other identified needs. Case management is the mechanism by which all these services are provided in an effective coordinated basis to an individual client and/or her/his family. Concerned with the person's total situation in determining needs and coordinating the delivery of services, the role of the case manager should be viewed as a pivotal one, with the case manager functioning as a team leader. He or she provides linkages between the client, the client's family, the nurse supervisor, the personal care provider (whether or not the provider's services are direct or purchased), and the local social service district.

Case management requirements are applicable to both personal care services and home health aide services. Case management shall be the responsibility of the professional staff of the local district social service agency, and cannot, under any circumstances, be delegated to another agency. Depending upon the practices of the local district, the case management staff could be located in either the Services or Medical Assistance Division. This case management role is different from the role assumed by Social Service workers in arranging other medical services provided under the Medical Assistance program such as care provided in Skilled Nursing or Health Related Facilities. The safety and well-being of the patient receiving personal care is dependent upon the ability of the case manager to coordinate services in response to needs. If the case manager, is located in the Medical Assistance section of the local social service district, the district should assure adequate linkages to other service programs.

Case management begins when the case is made known to the agency, and is on-going through reauthorization to the time when the services are no longer required. Referrals may come from any sources, both within and outside the agency. Examples of sources of outside referrals would include physicians, family and/or friends of the applicant, hospital discharge planners, nursing homes, other human service agencies, etc.

It is the responsibility of the local district to determine the Medicaid and program eligibility requirements for each applicant. The case manager is responsible for seeing that all eligibility determinations are carried out in a timely manner; whether or not this is a specific function of the case manager would be determined by local prevailing practices. In cases where this is a function of another staff person, the case manager should make himself/herself available to offer assistance, such as helping the client to gather all necessary documentation, filling out applications, and where applicable, making in-home visits to execute the application.

It is the responsibility of the case manager to assure that the following are obtained and/or developed and maintained:

1. Physician's orders (see page 5 ).
2. Nursing assessment prepared by a registered professional nurse of a certified home health agency (see page 5 ).
3. Social assessment (see page 7 ).
4. Recommendations or determinations of the local medical director, when necessary (see page 9 ).
5. Summary of service requirements (see page 9 ).
6. Authorizations (see page 9 ).
7. Written notification of services authorized (see page 10).

8. **Case Records:** The case manager shall be responsible for maintaining accurate and complete documentation for each case assigned to him/her, including copies of the above and copies of reports from the registered professional nurse supervising personal care services. She/he should encourage the individual providing personal care services to keep some form of mini-log that can reflect the attitudes of the provider and the client and the progress as well as the obstacles involved in attaining the services goals.
9. **Nursing Supervision** (see page 11).
10. **Monitoring:** Monitoring of personal care services by the case manager should include various methods of assuring that the services are being provided in accordance with all authorizations. Each local district will be required to have a plan for monitoring the entire personal care program. The monitoring of individual cases by the case manager is one part of that plan to assure that the individual client's needs are met. (see future administrative directive on monitoring). The case manager may request and review periodic reports from the providers of services, whether these services are provided directly or by purchase. The nature and severity of the case problems should determine the frequency in which these reports are required. The case manager should also receive and review periodic reports from the nurse supervisor. The case manager should also make periodic home visits to monitor the progress, problems, and changes pertinent to each particular case. Again, the frequency of such visits should be determined by the specifics of the case and indicated in the summary of service requirements. It is, however, recommended that where possible, visits should be made monthly. This is not to say that in specific cases, involving highly severe and complex problems, visits should not be made more frequently.
11. **Reassessment:** The case manager, in conjunction with the nurse from the certified home health agency, shall reassess the case every six months in accordance with the previously outlined procedure. This shall include obtaining the required documentation:
  - a) Updated physician's orders
  - b) New nursing assessment
  - c) New social assessment
  - d) Recommendation of medical director, if applicable
  - e) The summary of service requirements

The case manager shall then arrange for the continuation of services, the provision of alternative services, or the termination of services, if services are no longer needed. If it is determined that services are to be termination, or reduced, written notification of such decision and the client's right to a fair hearing must be sent to the client, with copies to the provider, the nurse supervisor and a copy maintained in the case record.

E. Medicare Maximization

Before providing personal care services, local social service districts shall make maximum use of home health services provided under Medicare, whenever program eligibility conditions under that title can be met. Requirements for the provision of home health care under Medicare Parts A and B are as follows:

Part A (Hospital Insurance)

Medicare's hospital insurance can pay for home health visits if six conditions are met. These conditions are:

1. Patient was in a participating hospital for at least three consecutive days. (Patient may be eligible for home health services following release from a skilled nursing facility providing the patient had been in a participating hospital for three consecutive days prior to placement in the SNF).
2. the home health care is for further treatment of a condition which was treated in a hospital or skilled nursing facility;
3. the care needed includes part time skilled nursing care, physical therapy, or speech therapy;
4. patient confined to home;
5. a doctor determines patient needs, home health care and sets up a home health plan within 14 days after discharge from a hospital or participating skilled nursing facility; and
6. the home health agency providing services is participating in Medicare.

Hospital insurance (Part A) coverage is limited to 100 visits during the 12 month period following discharge from a hospital or skilled nursing facility.

Part B (Medical Insurance)

Medicare's medical insurance can help pay for up to 100 home health visits in a calendar year. The patient is not required to have a three day stay in the hospital for medical insurance to pay for home health care, but medical insurance can pay for the visits only if the following four conditions are met. These conditions are:

1. Patient needs part time skilled nursing care or physical or speech therapy;
2. a doctor determined the need for services and sets up a plan for home health care;
3. patient is confined to home; and
4. the home health agency providing services is participating in Medicare.

Such services can be provided only by a certified home health agency. Whenever a local social service district receives a request for personal care services, such client should be referred to the certified home health agency for assessment. That agency shall consider the provision of home health services under Medicare, Title XVIII when the clients meets appropriate standards. As long as the patient continues to meet the Medicare criteria, that resource should be used.

Home care and discharge planning will be the subject of a future administrative directive and will further address use of home health services under Medicare, Title XVIII.

F. Payment

1. Payment for personal care services shall be based upon the authorization for service and submission of documentation of the time actually spent in provision of the services. Each local district should have a monitoring plan which will evaluate the validity of the documentation. (A future administrative directive will outline monitoring requirements).
2. Federal Regulations prohibit payment of relatives for provision of personal care services. This means that a patient's spouse, parent, son, son-in-law, daughter, or daughter-in-law, may not be paid to provide personal care services to that patient. However, other relatives may be paid under one of the following conditions:
  - a) The relative is not residing in the patient's home
  - b) The relative is residing in the patient's home because the care of the patient necessitates his/her presence.
3. Payment to the providers of personal care service should be made in accordance with contractual arrangements (see administrative directive on contracting - 79 ADM-34) with each provider.

When providers of personal care services are employed by the local social service district, payment shall be based on the local district's salary schedule and benefit package.

4. Payment for all assessments performed by the certified home health agency shall be at the rate established by the State Commissioner of Health and approved by the State Director of the Budget, for a nursing visit by that agency.

5. Payment for nurse supervisory services shall be made as follows:

- a) When the supervision is provided by contractual arrangements with a certified home health agency, payment for all visits shall be at the rate established by the State Commissioner of Health and approved by the State Director of the Budget for a nursing visit by that agency.
- b) When the supervision is provided directly by a registered professional nurse employed by the local social service district, payment shall be based on the local district's salary schedule and benefit package. Such costs are eligible for reimbursement as skilled professional medical personnel under this title (Federal - 75%, State - 12 $\frac{1}{2}$ %, Local - 12 $\frac{1}{2}$ %).
- c) When the supervision is provided by contractual arrangement with a private home care agency, the local district may determine the method of payment.
  - (1) Payment may be viewed as part of the home care agency's administrative costs and thus included as part of the agency's rate for personal care services.
  - (2) Payment may be made on a fee for service rate basis as determined by the local district.

6. Procedures for claiming personal care services will be described in a future administrative directive.

#### IV. REQUIRED ACTION

##### A. Physician's Orders

Local social service districts shall take immediate steps to implement requirements for the procedures for delivering personal care services. The forms for the physician's orders should be implemented with new cases beginning immediately. It is anticipated that the required form will be used with all new authorizations and with reauthorizations as they are processed. If the local social service districts wish to submit their own form for physician's orders, such forms must be submitted for approval to the New York State Department of Social Services within 90 days of the release of this directive.

B. Nursing and Social Assessments

Local social service districts should also begin utilization of nursing and social assessments upon receipt of this letter. The local social services district has two options: First, they can utilize the form found in Appendix D of this letter, or second, they may develop in conjunction with the certified home health agency, forms for nursing and social assessments which must be submitted to the New York State Department of Social Services for review and approval. The State Department will forward a copy to the Department of Health for approval. If using the form in Appendix D, copies of that form may be obtained according to instructions found in Section V. The assessment forms should be utilized with all new authorizations and with all new reauthorizations. The assessment forms must be used in all cases within six months of the release of this letter. In order to receive maximum benefit from the assessment process, it is recommended that the local social service district discuss the requirements of this letter with all certified home health agencies with whom they contract. Procedures for the handling of all assessments should be developed. In addition, requirements for supervision and case management should also be discussed. The delivery of personal care services, according to criteria developed jointly by the Departments of Social Services and Health, require that the local departments of social services and certified home health agencies cooperate in carrying out their respective functions to assure that the client receives appropriate services according to assessed needs.

C. Plan for Delivering Personal Care Services

The majority of the services under the Medical Assistance program are uniformly delivered across the State and specific plans have not been requested. However, in the personal care program, local social service districts have numerous options which can be used to provide a service which will meet all State requirements. Therefore, the State Department of Social Services is requiring that each local social service district complete the pre-printed plan contained in Appendix F of this letter and forward it to the State Department of Social Services.

This form can be used in several different ways:

1. Self-Evaluation Tool

If the local social service district completes this plan, staff will be able to determine that district's compliance with minimal requirements for the personal care program. This will provide districts with a method of determining where weaknesses exist within the program and will also offer some guidelines for possible change.

2. Request for Exceptions

The plan includes the necessary requests for the exceptions to use proprietary agencies or individual providers. Completion of all parts of the plan will provide the State Department of Social Services with all information necessary for evaluating the need for such exceptions.

3. Monitoring Tool

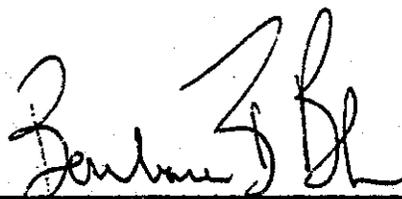
The State Department of Social Services will monitor personal care programs based upon the plan submitted by each social service district. When these plans are received, they will be reviewed by both the Divisions of Medical Assistance and Services. Communication will be sent to each local social service district regarding strengths and weaknesses of the proposed plan as well as approval or disapproval of requests for exceptions.

Staff in the State Department of Social Services will monitor the personal care program in each local social service district to determine that the district's operation conforms with the plan submitted to the State. In addition, the State will maintain records of the granting of exceptions and will in the future, require that a similar plan be submitted on an annual basis.

The completed plan shall be forwarded to Mrs. Ann B. Hallock, Director, In-Home Services, within 30 days of the release of this letter.

V. ADDITIONAL INFORMATION

Copies of the assessment form and the plan for delivery of personal care services are available from the New York State Department of Social Services, Forms and Publications Unit, 800 N. Pearl Street, Albany, New York 12243.



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Barbara B. Elum  
Commissioner

