Family Profile: Private Duty Nursing

OAC 5160-12-02 Private duty nursing services: provision requirements, coverage and service specification

Here are the needs: My 22-year-old child gets nutrition through a total parenteral nutrition (TPN) line. A TPN feeding is usually for ten hours per day. Also, a clinical evaluation is needed twice per day. These clinical evaluations take 30 minutes to do. All of these services are provided one after the other, for 11 hours each day. My child's doctor has ordered registered nurse supports in my home. My child was recently enrolled on an IO waiver and does not get state plan services through a Medicaid managed care plan.*

Services: Private Duty Nursing (PDN), Registered Nurse (RN)

How the service helps meet the need: PDN is used when a nursing visit is between 4-12 hours in length, per nurse, on the same date, or during a 24-hour period. The situation above outlines a total visit of 11 hours which could be covered by two nurses so long as each visit is at least four hours.

Why PDN is appropriate: The needs of the person are within the criteria to get PDN because the visit is longer than 4 hours and less than 12 hours. Because the person is older than 21 years old, the person must meet these criteria for PDN to be appropriate:

- The adult is age 21 or older;
- The adult needs, as ordered by the doctor, constant nursing including getting on-going maintenance care;
- The adult has a similar level of care as shown by enrollment on an HCBS waiver.
- Note: If the feeding had been ordered as a 20 hour/day feeding…it would still qualify as a PDN visit – but the individual nursing shift must be less than or equal to 12 hours in duration, except in an unforeseen event where it could be extended to 16 hours.

What the SSA would need to do: Because the person is an adult with a DODD waiver, the provider giving PDN services must submit the request to the county board who will then give the request to DODD. The county board will also do a Nursing Task Inventory to help decide a person's need for nursing services and hours. Any documentation needed by DODD will be provided by the provider of PDN services. DODD does not contact the provider directly but gives the approval to the county board, who is responsible for making sure PDN is written into the ISP and that the provider is told it is approved. The SSA must make sure PDN is written correctly in the ISP.

Note: The scenario above does not describe a situation in which the EPSDT or "HealthChek" benefit applies because the person is over the age of 21. If the scenario above was for a person under the age of 21, they may qualify for additional PDN services if the criteria in OAC 5160-12-02 paragraph I is met:

> (I) A child may qualify for additional PDN services if:
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> (1) The individual is under age twenty-one and requires services for treatment in accordance with Chapter 5160-14 of the Administrative Code for the healthchek program, and
>
> (2) Requires, as ordered by the treating physician, continuous nursing services, including the provision of on-going maintenance care. Services cannot be for habilitative care as defined in paragraph (D)(1) of this rule, and
>
> (3) Has a comparable level of care as evidenced by either:
>
> (a) Enrollment on a HCBS waiver; or
>
> (b) For a child not enrolled on a HCBS waiver, a comparable institutional level of care, including a nursing facility-based level of care pursuant to rule 5160-3- 08 of the Administrative Code, or an ICF-IID level of care pursuant to 5123:2-8-01 of the Administrative Code, as evaluated initially and annually by ODM or its designee. In no instance do these criteria constitute the determination of a level of care for waiver eligibility purposes, or admission into a Medicaid covered long-term care institution.

Family Profile: Home Health Nursing

OAC 5160-12-01. Home health services: provision requirements, coverage and service specification

Here are the needs: My 10-year-old child requires tube feedings that occur through their nose (nasogastric). Feedings typically last 2 hours and occur two times daily. My child is on the waiting list for a DODD waiver, but is on Medicaid with a managed care plan and does receive case management through my county board of DD. My child's doctor has ordered 28 hours per week of registered nurse supports in the home.

Services: Home Health Nursing

How the service helps meet the need: Home health services (including home health nursing) are only used when a service is needed on a part-time or intermittent basis.

- No more than a combined total of 8 hours per day of home health services (nursing, aide, and skilled therapies) with exceptions.
- No more than a combined total of 14 hours per week of home health services in (nursing, aide, and skilled therapies) with exceptions.

Why Home Health is appropriate: The child's need is for 2 hours per day, 2 times daily. This equals a total service need of 28 hours per week. This would usually not qualify for intermittent home health nursing. However, because: the child is 10 years old, requires more than 14 hours total per week as ordered by a doctor, and has a similar level of care needed for enrollment on a waiver program, home health nursing can be authorized for the needed 28 hours per week.

What the SSA would need to do: In this case, the SSA needs to make sure the Home Health service is documented correctly on an ISP. This will need to be coordinated with the Managed Care Plan using the approved County Board Communication Protocol. The doctor should make the request directly to the Managed Care plan using ODM form 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services." The SSA can help support the family by encouraging the family to reach out to their Managed Care plan with any questions or concerns they may have.

***Note: The scenario above discusses the process needed to obtain home health services for a 10-year-old child. The child's age indicates that this individual is covered under the EPSDT benefit. No other process is necessary to receive EPSDT benefit services (like extended home health) for a qualifying individual under the age of 21.**

Family Profile: Behavioral Health Needs

Here are the needs: My 17-year old child is non-verbal and has a diagnosis of Autism. He is a high functioning young adult who sometimes has difficulty managing his behaviors and will sometimes act out through aggression towards others and self-harming tactics. He recently has had difficulty managing his behaviors and was in the hospital due to trauma he got from his self-injurious behaviors. At this time, he does not qualify for waiver services and has been placed on the waitlist with a "current need." He is currently enrolled on one of Medicaid's managed care plans and does receive some services through the Medicaid state plan.

Services: Many supports are available to meet this child's needs, and a combination of supports may be needed to help address his behaviors and diagnoses. The above scenario is for a child who is enrolled with a managed care plan. Through a managed care plan, a child may receive Applied Behavior Analysis (ABA) therapy Community psychiatric supportive treatment (CPST) is defined in OAC 5122-29-17 and is available for both children and adults, regardless of managed care enrollment. CPST is delivered by community-based teams with the intent to provide specific, measurable, and individualized services to each person served. Some activities covered under CPST include ongoing assessment of needs, assistance in achieving personal independence in managing basic needs, symptom monitoring, coordination and/or assistance in crisis management and stabilization, and mental health interventions.

Also, the child may be a good candidate for stabilization in an Intermediate Care Facility Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD) if chosen by the family and the child's care team. Placement at an ICF/IID does require a child disenroll from a managed care plan if enrolled at the time of admission. Respite, as defined in OAC 5160-26-03, is available through the child's mental health benefit under State Plan Medicaid, and through a Managed Care Plan, if eligibility criteria are met.

Now available for families in Ohio is what is called Multi-System Youth (MSY) funding. MSY funding is to help prevent a family from giving up custody of their child. If a child is currently in the custody and placement of Children Services, MSY funding is not utilized for the cost of the placement but rather the transition back to the community and/or non-custody settings (reunification). MSY funding is available to children regardless of their Medicaid enrollment status and is available for a child up to the age of 21. In the past, funded services have included respite care, in-home parenting, parent education, safety and adaptive equipment, home modifications, medical equipment, and residential treatment. This is to just name a few, we have also been able to fund therapy dogs, fences, door alarms, etc. With each funded case, the program has prevented a child from being relinquished or supported a child who had been relinquished as they reunited with their family. For more information on MSY funding and available technical assistance, please see https://www.fcf.ohio.gov/MSY-TA-Funding-Requests.

Services may be available to support a youth's needs through telehealth. Telehealth was greatly expanded as a result of the COVID-19 pandemic. Services like Occupational Therapy, Physical Therapy, and behavioral health services may now be provided through telehealth. For more information on expanded telehealth delivery as a result of the

COVID-19 pandemic, please see https://medicaid.ohio.gov/COVID/ODM-Emergency-Telehealth.

How the services help meet the need: The services highlighted above are just some resources available for children whose needs cross different delivery systems. As every child is unique, there is not a certain set of services that will meet the needs of each child. Instead, different services, across all delivery systems, should be explored including but not limited to DODD waiver funding. Each of the above services highlights different aspects of services that are available through Medicaid and other funding that together help meet the unique needs of children.

What an SSA would need to do: For assistance with a child whose needs are met in multiple systems, the first step is always to understand if a child is Medicaid eligible, and if so, if that child is currently enrolled on a Medicaid managed care plan. SSA's can reach out to any of their resources at the Department of Developmental Disabilities for assistance in determining Medicaid eligibility/Managed Care enrollment. The unique needs of the child should be discussed as a team including the individual's parent or guardian. State resources are available if assistance is needed to help determine what services and supports are available to meet a child's needs.