



Effective July 1, 2017

**UNIFORM APPLICATION PROCEDURES AND STANDARDS:
LONG TERM CARE SERVICE PROVIDERS**

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SECTION I.

INTRODUCTORY MATERIAL

A. PCA's MISSION STATEMENT

PCA's mission is to improve the quality of life for older and disabled Philadelphians, assisting these individuals in achieving maximum levels of health, independence, and productivity. Special consideration is given to assuring services for those with the greatest social, economic and health needs. Based on the principle that older persons have the ability and the right to plan and manage their own lives, PCA seeks ongoing input from the elderly. PCA recognizes the dignity of all older people and respects their racial, religious, sexual, and cultural differences.

PCA's mission is carried out through five major functions: planning, advocacy, program development, service coordination and provision, and administration of public and private funds to purchase services. It works with organizations representing and serving older Philadelphians to develop a comprehensive, coordinated, and accessible system of services responsive to the needs of the aging population within community and institutional environments.

PCA is the Area Agency on Aging for Philadelphia, as designated by the Commonwealth of Pennsylvania in response to the 1973 amendments to the Older Americans Act of 1965. It operates under the authority of the Pennsylvania Department of Aging.

B. LETTER FROM PCA'S PRESIDENT

As a proud member of Philadelphia's health care and human services communities, the Philadelphia Corporation for Aging (PCA) faces the challenge of seeking workable solutions to basic human problems within a rapidly changing environment. We are grateful for the expertise of the hundreds of agencies with whom we partner to serve Philadelphia's large and diverse elderly population a group whose proportional size is unmatched by other major American cities.

During its many years of developing, funding, and implementing services and programs that represent Philadelphia solutions to Philadelphia problems, PCA and its partners have produced a versatile and unique "network of care", now touching the lives of an estimated 100,000 people each year. For many, our aging network offers a caring, helping hand providing guidance, reassurance, and reinforcement. For some, we fill a definite gap in family support -- allowing them to resume normal family life despite setbacks caused by functional ability or health. For others, who are without family or informal support, we are a lifeline assuming essential day-to-day care giving responsibilities.

As PCA coordinates a local "network of care", it is a member of a national network that touches seniors across the nation. We are one of 629 Area Agencies on Aging which derive authority from the Older Americans Act of 1965. This Act sets forth a unified set of goals and directions that broadly guide our nation's formal support of the aging. Its wisdom proven by the test of time, the Act remains relevant, versatile, and adaptable in practical application. The 2005 White House Conference on Aging -- attended by 1,200 delegates representing every state -- issued a resounding endorsement for the Older Americans Acts, its reauthorization and funding. For those working within the aging network, and for the countless individuals touched by its network, this is a true statement of success.

PCA is proud to be linked to the Older Americans Act network and national counterparts through common purpose and direction. We acknowledge and embrace our responsibility to provide proactive leadership, as we tackle demographic challenges, which have yet to confront most cities and states.

Our activities are guided by four central mandates set forth in the Older Americans Act: Facilitating Independent Living, Empowering Older People Through Community Involvement, Advocating to Protect Rights, and Targeting and Responding to Priority Needs. These practical themes formulate the core of PCA's mission and guide its progress each year. Thanks to our dedicated funding from the Pennsylvania Lottery and the collaborations we have established with other agencies, we have reached beyond baseline requirements of the Older Americans Act in developing programs for Philadelphia's aging community and non-elderly in need of long-term care services.

We are proud that PCA's programs serve as models for other Area Agencies on Aging who derive benefit from our developmental work as they strive to fortify their own networks.

Sincerely,

Holly Lange

C. PROVIDING QUALITY CARE

PCA is charged with the responsibility for building and improving long-term care towards a goal of providing a life-long "continuum of care." This goal is being accomplished through PCA's visible leadership role as a coordinator of long-term care, provider of information and referral services, and vocal advocate of public policy that benefits the frail elderly and adults with disabilities.

Together with its staff and community partners, PCA strives to remain accessible and responsive to the needs of individuals in their communities. Central to these efforts is an emphasis on diversity -- designing a flexible array of programs that respond to individual and cultural preferences and needs.

PCA's perspective is that of an agency committed to consumer choice and to considering individuals' diversity and personal preferences along with their medical needs.

Faced with financial constraints, which is the hallmark of this era of health care cost containment, PCA advocates full use of technological advances, along with thoughtful care decisions. It is hoped that the influence of PCA's home and community-based care philosophy will lead to innovative and improved models of long-term care.

But foremost on the agenda, as it has been since 1973, is cultivating the practical expertise and common compassion that are needed to make quality of life a fact of life for older women and men across the country.

Chronically ill and disabled adults often need help to live safely and comfortably at home. Some can afford to pay for services from the burgeoning home-care industry, but most rely on informal support systems for daily assistance. Since Medicare and Medicaid provide limited care in the home, PCA fills the service gap for them.

Since the mid-1980s, PCA has dedicated an increasing percentage of its resources to funding long-term care services and each year, thousands of Philadelphians (elderly and non-elderly) receive home-based support services through PCA.

D. **PCA'S LONG TERM CARE (LTC) PROGRAM**

Since the inception of PCA's Long Term Care Program (LTC) in 1976, the agency has maintained a commitment to assuring quality consumer services. In support of its mission "to improve the quality of life for older and disabled Philadelphians and to assist them in achieving optimum levels of good health, independence and productivity", PCA continues to make quality of life a fact of life through its integrated LTC program.

Through the use of centralized oversight, common procedures, and consumer choice, PCA is able to provide an integrated and seamless service response. This integrated approach reduces administrative overhead, increases program efficiency, and enhances communication with service providers.

1. **PCA'S LTC DEPARTMENTS**

The Long Term Care (LTC) Program consists of four primary Departments:

The **Long Term Care Assessment (LTCA)** Department is responsible for determining, through performing an assessment, an applicant's level and locus of care, and makes a referral to the appropriate Long Term Care program.

The **Long Term Care OPTIONS (LTCO)** Department is responsible for developing and arranging a care plan, authorizing services, and providing ongoing care management for those consumers determined appropriate for home and community based services.

The **Community Living Options** Department is responsible for two programs. The Domiciliary Care (Dom Care) Program provides eligible consumers residential and supportive services in a homelike setting. The Nursing Home Transition Program assists persons residing in nursing homes who are capable of living independently to move back into the community.

The **Caregiver Support Program (CSP)** provides assistance to eligible unpaid primary caregivers in order to reduce stress and burden. Services offered include benefits counseling, caregiver education and training, reimbursement of some care giving expenses, and home modifications.

2. **LONG TERM CARE SERVICES**

PCA's LTC Program includes a wide range of services so that older and disabled adults may live in the most independent setting as possible.

To receive services, individuals must be 60 years of age or older and, when clinically eligible for nursing home care (NFCE), they must be in need of assistance with multiple activities of daily living. A consumer's care needs are met through care plans developed jointly with a PCA Service Coordinator. Consumers choose the providers they wish to use for services from a list provided by the Service Coordinator. Over 15,000 individuals receive services at any one time. The range of services offered includes:

Adult Day Care
Personal Care
Home Support
Personal Assistance
Financial Management

Major Cleaning and Extermination
TeleCare Services
Emergency Response Systems
In-home or Institutional Overnight Shelter
Medical Equipment and Supplies

Participant Directed Goods and Services
Community Transition
Counseling
Nursing
Physical, Occupational, and Speech Therapy

Home Delivered Meals
Transportation
Environmental Modifications

SECTION II.

GENERAL INFORMATION FOR APPLICANTS

INTERESTED IN BECOMING AN OPTIONS SERVICE PROVIDER

GENERAL INFORMATION

This application packet provides interested service providers with information to prepare and submit applications for consideration by the Philadelphia Corporation for Aging's (PCA) Business Administration Department, to provide services to homebound elderly residents of Philadelphia participating in PCA's Long Term Care Program.

A. Response to Applications

Applications may be submitted to PCA at any time, however, the required information must be submitted in the order and format detailed in the forms packet.

PLEASE NOTE: New OPTIONS Provider agreements will be issued annually, effective as of January 1. Application packages must be submitted by December 1 of each year.

If any of the required information and forms are missing or are incomplete, the applicant will be given 30 days to provide the additional material. Additional time may be granted in special circumstances. If an application cannot be processed in a reasonable period of time, as determined by PCA, the provider may resubmit all material at a later date.

PCA reserves the right to verify any information that appears inconsistent, unclear, or erroneous. Any applicant that willfully provides false information, as verified by PCA, shall be immediately disqualified from consideration for a period of up to one year. However, PCA reserves the right to waive minor errors or irregularities. PCA reserves the right to request best and final price quotes from applicants and acceptance of a final price quote rests solely with PCA.

NOTE: Because of PCA's on-site monitoring and audit requirements, PCA will only consider applicants that have a local office (i.e., an office located within a reasonable distance of Philadelphia), so as to facilitate access to all required provider records. While it is recognized that certain services can be delivered through electronic and/or mail service, PCA must still be able to access provider records and documentation related to both the due diligence process for provider certification, as well as the delivery of authorized service.

B. Unit Prices

Reimbursement for services provided will be based on **unit prices**. The unit prices stated on the Price Certification Forms shall apply to the LTC program as indicated.

NOTE: It is requested that providers offer the same unit price(s) to PCA consumers who wish to purchase additional service on their own.

C. Areas of Service

All applicants must have the capacity to deliver service to one or more of PCA defined geographic areas of Philadelphia. Applicants should select only those areas they are confident they can comfortably serve.

D. Agreement Period

Subject to the availability of funds, PCA intends, through this process, to contract with providers to provide service during 3-year agreement periods.

E. Quantity of Service

PCA does not guarantee any minimum or maximum volume of service for the fiscal year. PCA assures providers that all providers will appear on the lists from which consumers select providers.

The dollar amount of any PCA contract does not represent intent, either expressed or implied, to purchase service at any level, and shall not be construed as a guarantee of payment beyond service specifically ordered through an official PCA Service Order form and delivered by the provider.

F. Third Party Payor Reimbursable Service

The LTC Program is mandated by the Pennsylvania Department of Aging to pursue reimbursement through other sources, such as Medical Assistance and Medicare and other third party payors. Any provider offering a service covered by Medicare or Medical Assistance must be enrolled to provide that service before certification or contracting through this application process. Any consumer who is eligible and meets the requirements for Medical Assistance or Medicare must receive service paid for by the third party source. For such a consumer, service will be ordered and paid for by PCA only if it cannot be provided by Medical Assistance or Medicare or other third party payor. PCA expects each applicant to be knowledgeable about third party reimbursement; therefore, PCA will not retroactively reimburse a provider if the claim is rejected by Medical Assistance, Medicare, or other third party payor. A large number of PCA consumers meet the requirements for billing to Medical Assistance and Medicare.

Concerning Medicare billable services, PCA requires that services be billed directly to Medicare and not to PCA or the consumer.

The applicant must be knowledgeable about the billing requirements for Medicare and Medical Assistance in Pennsylvania, and must process all required forms, including having the forms completed by the consumer's physician. **NOTE: The provider must inform the PCA Service Coordinator every time a service can be billed to Medical Assistance or Medicare.** PCA will provide the necessary insurance information and the name and telephone number of the consumer's physician at the time the service is ordered. The Service Coordinator will assist the provider in contacting the physician and in facilitating the completion of forms only in exceptional situations (e.g., when the provider's repeated attempts to contact the physician have been unsuccessful).

G. Service Delivery

The provider must have the capacity to start service **within 3 business days** after receiving the service order, or within the times frames defined in the individual Service Standards and/or Service Specific Operational Procedures. There may be instances where a PCA Service Coordinator requests next day delivery in order to meet a consumer's urgent needs.

PCA requires that providers obtain consumer full signatures for all services provided to PCA consumers. No request for payment shall be made without a signed receipt for each unit of service. Any service billed based on unsigned or forged verification forms will be deducted from the provider's next payment. **NOTE: Falsification of invoices will result in the immediate termination of the provider's contract.**

PCA requires that providers deliver service on the days and at the time(s) requested. If PCA's request cannot be met or an exception occurs once service has started, the consumer and the consumer's Service Coordinator must be notified. Any alternate plan must be approved by the consumer and the PCA Service Coordinator.

H. Quality Improvement and Consumer Satisfaction

PCA recommends that providers periodically review and analyze their services focusing on quality improvement and the identification of problems. It is also recommended that providers periodically survey consumers to gauge their satisfaction.

I. Financial Stability

Providers making application to PCA must be financially solvent and able to demonstrate an ability to meet daily operational and payroll expenses. Should a provider enter into bankruptcy proceedings, the PCA Contract Manager must be notified immediately.

J. Annual Financial Statements

All providers are required to submit a copy of their annual financial statements to their PCA Contract Manager. These annual financial reports will be due no later than ninety (90) days after the end of the provider's fiscal year.

K. Transition to a New Provider

In the event that a consumer selects a new service provider or the current provider terminates services, the current provider must participate in any plan to transition services. Participation shall include providing a copy of the consumer's record including a service summary, and attending an orientation meeting with the new provider and any additional meetings needed to successfully transfer the consumer.

L. Personnel Policies

The provider is required to submit a copy of their personnel policies as part of their application. The policies must cover hiring practices, employee benefits, supervision procedures, and employee training as it relates to the services covered by the application.

M. Providers are prohibited from making the following arrangements with other providers:

1. The referral of consumers directly or indirectly to other practitioners or providers for financial consideration or the solicitation of consumers from other providers.
2. The offering of, or paying of, or the acceptance of, remuneration to, or from, other providers for the referral of consumers for services or supplies.

N. Insurance

Providers must provide evidence that they meet PCA's insurance requirements in order to participate in the Long Term Care Program.

It is strongly advised that before completing an application, providers verify with their insurance carriers that they are able to meet PCA's insurance requirements.

The insurance requirements are provided below.

PCA's INSURANCE REQUIREMENTS

Provider shall, at its sole cost and expense, procure and maintain in full force and effect, throughout the term of the Agreement, the following insurance from companies licensed or approved to do business in the Commonwealth of Pennsylvania, or through a qualified self-insurance program approved or registered by or with the Commonwealth and acceptable to PCA, in the forms and on the terms and conditions specified herein. All insurance companies must maintain a Best's Insurance Guide rating of at least "A-" and a financial size of at least Class VII for companies licensed in the Commonwealth or Class X for companies approved but unlicensed in the Commonwealth. Except as specifically provided herein, all such insurance shall be written on an occurrence basis.

1. General liability insurance (including coverage for physical abuse and sexual molestation with sublimits of at least \$500,000 per occurrence and 2,000,000 per annual aggregate) with no self-insured retention, and with no endorsements excluding or limiting coverage, including, but not limited to, contractual liability coverage, naming PCA and the Commonwealth of Pennsylvania and their directors, officers, employees and agents as additional insureds, with an endorsement stating that the coverage afforded the additional insureds shall be primary and non-contributory to any other coverage available. Such coverage shall have limits of coverage, on a stand-alone basis or in combination with excess or umbrella coverage, of not less than \$1,000,000 combined bodily injury and property damage per occurrence and \$3,000,000 per annual aggregate.
2. Automobile liability insurance written on the current Insurance Services Office's commercial auto form or its equivalent, with no self-insured retention, naming PCA and the Commonwealth of Pennsylvania and their directors, officers, employees and agents as additional insureds, with an endorsement stating that the coverage afforded the additional insureds shall be primary and non-contributory to any other coverage available, and with limits of coverage, on a stand-alone basis or in combination with excess or umbrella coverage, of not less than \$1,000,000 per occurrence combined single limit for bodily injury and property damage, covering owned, non-owned and hired vehicles;
3. Workers compensation insurance (with statutory limits of coverage and no deductible) and employers liability insurance (with limits of coverage of not less than \$100,000 per accident, \$100,000 per employee by disease and \$500,000 policy limit by disease and no deductible) endorsed for all states in which work is to be performed under the Agreement (including, without limitation, Pennsylvania).
4. Professional liability insurance naming PCA and the Commonwealth of Pennsylvania and their directors, officers, employees and agents as additional insureds (except with respect to Health Care Providers under the Medical Care Availability and Reduction of Error (MCARE) Act), with an endorsement stating that the coverage afforded the additional insureds shall be primary and non-contributory to any other coverage available, and with no endorsements excluding or limiting coverage, as follows:
 - a. "Participating Health Care Providers" under the MCARE Act must have statutory limits and must participate in the MCARE Fund;
 - b. "Non-participating Health Care Providers" under the MCARE Act and other providers of professional services (including, but not limited to, social and legal

services providers and those health care providers who are not “Health Care Providers” under the MCARE Act) must have limits of coverage of not less than \$1,000,000 per occurrence and \$2,000,000 per annual aggregate and no self-insured retention.

- c. Professional liability insurance may be written on a claims-made basis, provided, however, that the policy permits Provider to purchase extended reporting period coverage (“Tail Coverage”) upon termination of the policy.
 - (1.) In the event that insurance is written on a claims-made basis, Provider hereby agrees to maintain, following termination of such coverage or of the Agreement (whichever is earlier), professional liability insurance, covering claims arising out of occurrences during the term of the Agreement, whether by (i) purchasing additional policies of insurance with no exclusion for prior occurrences and the option of purchasing appropriate Tail Coverage, or (ii) purchasing the appropriate Tail Coverage. Tail Coverage for medical professional liability coverage shall be of unlimited duration. All other Tail Coverage shall be maintained for a period of not less than the greater of six years or as required by law, following termination of the Agreement or of such claims-made coverage (whichever is earlier). In no event shall any such Tail Coverage provide limits of coverage lower than the limits of coverage required herein for professional liability.
 - (2.) In the event that Provider elects to maintain insurance written on a claims-made basis, these undertakings (and the provision of certificates or policies of insurance evidencing compliance with same, as further specified below) shall survive termination of the Agreement.
5. All-risk or special form property damage insurance, naming PCA and the Commonwealth of Pennsylvania as additional insureds and loss payees, insuring as they may appear the interests of Provider, PCA and the Commonwealth of Pennsylvania in all personal property, fixtures and improvements to real estate funded or supplied by PCA, whether titled to Provider or to PCA. Such coverage shall be written for the full replacement value of the property in question without penalty or deduction for coinsurance or deductible greater than \$500.00, and shall be amended as necessary to reflect changes in inventory.

If Provider has contracted with PCA for any prior period(s) and has in force general liability or, if applicable, excess insurance, written on a claims-made basis, covering claims arising in connection with its performance under contract with PCA during such period(s), Provider shall maintain said insurance during and for a period of not less than the greater of six years or as required by law, following the term of the Agreement (whether by (i) purchasing additional policies of insurance with no exclusion for prior occurrences and the option of purchasing Tail Coverage, or (ii) purchasing the appropriate Tail Coverage); provided, however, that all other terms and conditions contained in this Exhibit “C” are otherwise met. In the event that Provider elects to maintain insurance written on a claims-made basis, as provided in this paragraph, this undertaking (and the provision of certificates or policies of insurance evidencing compliance with same, as further specified below) shall survive termination of the Agreement.

Provider shall provide PCA with certificates of insurance evidencing compliance with the requirements of this Exhibit "C" prior to performance under the Agreement in substantially the form attached hereto as Appendix 1 to this Exhibit "C". All certificates shall evidence the agreement on the part of the insurer to provide PCA with prior written notice of any non-renewal, cancellation or modification of coverage, or of any impairment greater than \$100,000 of the aggregate insurance available as a result of loss (except in connection with physical abuse and sexual molestation coverage for which insurer shall report any impairment of the aggregate insurance available) no later than the time period for a notice of cancellation as set forth in the policy. Any language on the certificate which states that the insurer will "endeavor to" mail such notice and any language stating "but failure to do so shall impose no obligation or liability of any kind upon the insurer affording coverage, its agents or representatives, or the issuer of this certificate" shall be deleted. PCA shall have the right, in its sole discretion, to pay any premium necessary to maintain in force the coverages required hereunder, and to recover the amount of such payment, whether by set-off against amounts due to Provider under the Agreement, or otherwise. PCA shall have the right to require Provider to submit certified copies of policies of insurance required hereunder upon reasonable notice.

The insurance requirements set forth, and shall not be construed, to limit or reduce (or be limited or reduced by) any other insurance obligation of Provider under the Agreement; nor to limit Provider's liability under the Agreement to the limits of coverage required or procured.

SECTION III.

**GENERAL OPERATIONAL PROCEDURES
FOR ALL LONG TERM CARE SERVICE PROVIDERS**

GENERAL OPERATIONAL PROCEDURES

This section sets forth the operational procedures that LTC service provider must follow.

A. INTAKE

The LTC Assessor or LTCO Service Coordinator develops a care plan in conjunction with the consumer and/or caregiver. In cases where a need for specialized services exists, the Assessor or Service Coordinator contacts the provider selected by the consumer to make the initial referral.

The provider agency will be given information necessary to authorize service by way of a Service Order from the Assessor or Service Coordinator. The type of service and time frame in which the service is to be provided will be specified. If the provider is not able to meet the request, the Assessor or Service Coordinator will refer the consumer to another agency of his/her choice.

The Commonwealth of Pennsylvania mandates that all other third party payers be billed before PCA funds are invoiced.

B. IDENTIFICATION OF FIELD STAFF

All staff persons in contact with LTC consumers are required to wear attire appropriate to the industry and function being carried out. All field staff shall be given provider issued photo identification cards.

C. COMMUNICATION

Communication by phone, voice mail, fax, and e-mail, as well as face-to-face meetings, when necessary, between the LTC staff and the provider, and between providers, are at the core of responsive service to consumers. The points in time when communication is necessary between the provider and PCA, fall into seven primary categories:

1. If required, or if concerns arise, following initiation of service;
2. When a change in the consumer's functioning is observed;
3. When collaboration between service providers is necessary;
4. When there are changes in the plan of treatment;
5. When there are consumer complaints;
6. When emergencies occur; and
7. At the time of discharge or suspension of service.

D. EMERGENCIES

1. **CONSUMER** - All providers shall develop and follow written policies and procedures regarding the handling of medical emergencies that consumers may experience during service provision. The written policies and procedures will be reviewed as part of regular monitoring.
2. **PCA STAFF** - Providers shall notify designated staff immediately in the event an emergency occurs while providing service, and shall submit an incident report (see Item F below) to PCA.

3. WEATHER EMERGENCIES/DISASTERS - Providers shall have written policies and procedures describing the actions to be taken to ensure continued service to LTC consumers in the event of a weather emergency or a disaster. The policies and procedures must especially note the actions to be taken to ensure continued service to those consumers identified by the provider and/or LTC staff as most at risk. The written policies and procedures will be reviewed as part of regular monitoring.

E. ON CALL PROCEDURES

1. The provider shall provide PCA consumers with written procedures for how to contact a staff person to discuss problems or concerns that require attention during non-business hours (weekdays after 5:00 PM and week-ends).
2. If the provider agrees to accept referrals for service to start within 24 to 72 hours, staff shall be available after normal business hours and on the weekends to receive referrals. In addition, the provider shall have the capacity to commit over the telephone when called to start service. It is anticipated that this need for extended-hours of coverage will apply primarily to home health and personal care service providers. Providers of other types of services who may utilize answering machines or answering services, are expected to respond to such referrals on the next business day.
3. The On Call Procedures will be reviewed as part of regular monitoring.

F. INCIDENT REPORTING

1. PCA requires that administrators and employees of home health care agencies and facilities report incidents to individuals receiving services from that agency or organization. Home health agency is defined to include any home health care organization or agency licensed by the PA Department of Health, and any public or private agency or organization which provides care to an individual in the individual's place of residence.

Note: Older Adult Daily Living Centers have specific reporting obligations, as delineated by their licensing authority.

In the course of the provision of home and community-based services, an incident related to the following is considered reportable: death; injury; hospitalization; provider and staff misconduct; abuse – physical abuse, psychological abuse, sexual abuse; verbal abuse; exploitation; neglect; service interruption; and medication errors.

Without in any way limiting providers' duties and responsibilities as promulgated by OLTL and or any licensing authority, providers shall report **incidents** – as noted above, including: threats to the consumer, an unsafe environment, alleged theft, and damage to the consumer's property:

- a. All incidents must also be reported immediately to the Service Coordinator (or the Service Coordinator Supervisor) and be followed by submission of a written Incident Report within 24 hours to the LTC Service Coordinator and the Contract Manager in the Business Administration Department.

- b. A representative of the provider shall visit the consumer to discuss the incident, prepare a written statement that describes the incident from the consumer's perspective, ask the consumer to sign the statement, and submit the statement along with the Incident Report. The consumer should be encouraged to file a police report if appropriate.
- c. Irrespective of the willingness of a consumer to sign a statement and/or file a police report, the provider must resolve the situation consistent with industry standards and consistent with consumer preferences. The provider shall advise the PCA Service Coordinator and Contract Manager of the results of these efforts.

G. SERVICE ORDERS

1. All service orders will be sent by Philadelphia Corporation for Aging personnel only.

LTC Care Management staff (Assessors, Service Coordinators, Supervisors, Nurse Consultants, or PCA administrative staff) are the only staff authorized to place service orders. The provider must receive the service order before service delivery can begin.
2. If the service order is unclear or erroneous, the PCA Service Coordinator or Service Coordinator Supervisor must be contacted immediately to discuss the concern. A corrected service order must be received before initiating or continuing service. The PCA Service Coordinator or Service Coordinator Supervisor will make any needed corrections in the care plan and forward a new service order, as indicated.
3. Please see the Service Order Procedures in Section IV, noting especially PCA's requirements for website accessing of referrals by providers.

H. LEGAL RESIDENCY STATUS

Without in any way limiting a provider's duties under any other term or condition of any agreement between the provider and PCA, the provider shall comply with the Immigration Reform and Control Act of 1986, 29 U.S.C. Section 1802 et seq.

I. CONSUMER SIGNATURES

1. The provider shall obtain the consumer's full signature, or the signature of an authorized representative, on a standardized form or time-slip, each time a service is delivered to a PCA consumer. Use of an authorized representative is permissible when the consumer is unable to sign due to either physical and/or cognitive limitations. The consumer's PCA Service Coordinator must confirm the approval and designation of an authorized representative. Providers must maintain proof of that designation in their consumer records.
2. The consumer or the consumer's authorized representative must be given a copy of the signed time-slip or comparable form as a confirmation of delivery of service. It is recommended that providers utilize multi-part forms to facilitate this acknowledgement of the receipt of service on the given day.
3. For those services authorized and ordered in time increments (e.g. hour), the service verification form or time-slip must clearly identify the consumer served, the worker

providing service, the time service started and ended, **including whether A.M. or P.M.**, for each date of service, and must be signed by the consumer and the worker for each day and/or instance of service in a given day (e.g. split shift of personal care service, etc.).

When service is delivered at an adult day service center, the verification of attendance by a single consumer signature must indicate the arrival and departure time. In those instances where a consumer is unable to sign on a given day because of an acute health condition or episode, the signature of a designated center representative will be acceptable, but the event must be documented in the consumer's record.

For those services where the unit of service is defined as either a visit, an installation, the delivery of an item(s), a one way ride, or a repair, the service verification form or time-slip must identify the consumer served, and the date of service, and must be signed by the provider of the service (e.g. nurse, counselor, driver, etc.) and the consumer, or the consumer's authorized representative.

The Service Specific Operational Procedures for each service need to be referenced for further guidance related to service delivery or time-slip requirements.

4. For those services that are to be delivered on a recurrent basis within the consumer's care plan (e.g. personal care, adult day service, etc.) the provider must obtain a sample of the consumer's signature at the time service is initiated, for verification purposes, using a staff member other than the person providing the service. If the consumer cannot sign, the signature of a person authorized to sign is to be obtained. The authorized person must sign their own name each time and indicate they are signing for the consumer

Exceptions to obtaining the sample signature include services that are provided on a one-time basis and/or entail a monthly rental cost for equipment. In such instances, the signature of the consumer or the consumer's authorized representative at the point of service or the time of installation will suffice.

5. The signed service verifications or time slips are to be cross-checked with the sample signature and be kept in the consumer's files or with the billing documents at the provider's office. The documentation shall be made available, as needed, for PCA's reviews.

No payment claim is to be submitted to PCA without a signed receipt for each individual item or service. Any questionable or missing signatures during a review by PCA or other authorized agent will result in a deduction of the amount billed from the next invoicing period, for the consumer(s). The mailing of copies of signed time slips to PCA is NOT required, unless specified by PCA. Documentation verifying service provision, as invoiced and reimbursed, must be made available for purposes of PCA reviews.

6. **NOTE: Personal Care service providers are required to use a scheduling system for each field worker visiting PCA consumers. That schedule shall identify the worker's name, each consumer to be visited, the date, starting and ending time, travel time between visits, and break time. Each worker's schedule, combined with the daily time slips, must back-up that worker's payroll records and the hours billed to PCA.**
7. Just as careful scheduling of times of service is important to assure the most responsive and efficient level of service to our consumers, PCA expects that the scheduling of visits for

workers be done with an eye to a reasonable visit pattern, including the overall work-load, breaks, and travel time. PCA's monitoring, in consumers' homes and in the provider's office, includes an evaluation of worker visit patterns and the number of hours per week scheduled, with an eye to: allowing travel time, no overlapping schedules (including staff working for more than one provider), realistic working hours, and rate of pay. Rescheduling of service shall occur only with consideration of the consumer's needs, the plan of care, and with LTC Care Management approval.

8. Provider shall not (i) seek a payment guarantee from a consumer prior to the start of services authorized by PCA; (ii) bill a consumer for services rendered based upon a PCA referral or Service Order; and (iii) include language in its written forms for consumers' signature that obligates consumer to guaranty payment for PCA authorized services or implies that consumer will be billed for services performed under Provider's agreement with PCA.
9. **Telephony Service - A provider's use of electronic / telephony systems in place of the consumer signature process, described throughout this section, is possible only with PCA's prior written approval. Acceptable telephony systems must have the following:**
 - a. Have the capability to schedule and modify worker hours and services.
 - b. Allow a start time window (allow call-in within 5-15 of scheduled time).
 - c. Allow an end time window (allow call-out within 5-15 minutes of scheduled time).
 - d. Provide real time notice of delayed service visits and missed visits.
 - e. Use participant telephone number.
 - f. Not be the phone of a paid staff worker.
 - g. Use a toll-free number for calling in.
 - h. Generate bills using data recorded from the telephony system and must be based on actual time(s) of service(s); **rounding-up time of service is not permitted.**
 - i. The system must be secure and HIPAA compliant.
 - j. Providers must have protocols for making edits to electronic time sheets that includes making contact with the participant and the worker.
 - k. Providers must have protocols for use of paper time-sheets in instances where a participants declines use of the telephony system and/or as a back-up option when the system is not operational or accessible.

J. INVOICING

1. Invoices to PCA are to be submitted **on a monthly basis**, based on prices agreed upon through the provider application process and the presence of consumer signatures on time slips. Invoices are to be submitted via the web-based Automated Billing System (ABS) procedures.

Questions regarding billing are to be directed to the provider's PCA Contract Manager.

2. All services must be billed for the month that they are delivered to a LTC consumer. PCA does not allow any back billing for an individual consumer once an invoice has been submitted for a month.

Service Coordinators must be notified of any service that is not delivered in the month it was ordered, so that corrections can be made to care plans.

3. **Travel time** – providers may not invoice for staff travel time to and from a consumer's home.

K. MONITORING OF SERVICES

1. Each consumer is given the opportunity to evaluate the quality of the services they receive through consumer satisfaction surveys, to select their service provider(s), and to approve the staff serving him or her.
2. Service Coordinators and administrative staff document their experiences regarding the level and quality of communication with providers, as well as the quality of the services being provided to the consumers, based on telephone, in the office, and in the home contacts.
3. PCA's Business Administration Department reviews the provider's records in order to: verify services are delivered according to the consumer's ISP/care plan, mitigate financial fraud and abuse through a review of provider payments for authorized services and support for those services, and review for contract compliance.

Findings from these reviews are shared with providers so that they may develop and implement appropriate corrective actions. Failure of providers to implement corrective actions can lead to contract termination and/or referral of the findings to the designated licensing authority.

L. CONFLICT OF INTEREST POLICY

1. It is PCA's expectation that providers will develop and maintain a Conflict of Interest Policy as part of their operating procedures. The policy must be in effect as a condition of certification, and will be reviewed during PCA's monitoring. The policy shall include language addressing conflict of interest in the recruitment of staff and consumers, the provision of services, the marketing of services, and consumer confidentiality. Specifically, in order to minimize risk to the provider, PCA, and consumers, the policy shall include references to:
 - a. Recruiting staff in a proper and professional manner;
 - b. Respecting the right of all consumers to make a free choice in the selection of providers, without encouragement to change providers through the offering of financial or other enticements, pressure, or threats. This applies to consumers receiving services from another provider and when an employee leaves the provider's employment;
 - c. Receiving prior written approval from PCA before using PCA's proprietary material and marketing services in a way that respects the right of all consumers to make a free choice in their selection of providers, without encouragement to change providers through the offering of financial or other enticements, pressure, or threats;
 - d. Protecting consumer confidentiality, including not revealing that a PCA consumer is known to the provider or revealing any information about any PCA consumer, assuring that employees during and after employment will never reveal the names of consumers served by the provider or any other information about the consumers.

Providers are encouraged to have employees sign a form, as a condition of employment, assuring that no consumer information will ever be revealed.

- e. Not engaging in any activity or conduct that conflicts with, or appears to conflict with, the interests of PCA or its consumers.

M. FALSE CLAIMS ACT POLICY

Philadelphia Corporation for Aging **False Claims Act Policy**

(Preventing and Detecting Fraud, Waste and Abuse in Federal Health Care Programs)

Introduction: Philadelphia Corporation for Aging (“PCA”) is subject to federal and state laws and regulations relating to Medicare and Medicaid programs benefiting PCA consumers. This policy addresses certain provisions in those laws that are intended to benefit PCA’s consumers by preventing and detecting fraud, waste and abuse in those programs.

Specifically, Section 6032 of the Deficit Reduction Act of 2005 (“DRA”), entitled “Employee Education About False Claims Recovery,” mandates the amendment of Medicaid State Plans to require certain entities, including PCA, to implement written policies that describe: (1) the prevention and detection of fraud, waste and abuse; (2) false claims laws; and (3) whistleblower protection. Accordingly, without in any way limiting any other policy, procedure or other requirement, including any requirement dealing with related matters, the following shall apply:

Policy: The purpose of this policy is to comply with requirements set forth in Section 6032 of the DRA regarding federal and state false claims laws. Entities covered under this provision of the DRA must ensure that all employees, including management, and their contractors and agents who furnish health care services or authorize health care services under those programs on behalf of the entity, are educated regarding federal and state false claims laws and the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, including Medicaid and Medicare.

Because PCA arranges for health care services and provides social services funded by federal health care programs, it is important to assure that PCA’s directors, employees, and contractors and agents who furnish or authorize the furnishing of Medicare or Medicaid health care items or services on behalf of PCA (“PCA Workforce”) understand and comply with the compliance requirements for such programs.

False Claims Laws: False claims laws are intended to combat fraud and abuse against the government, including fraud and abuse in federal health care programs. The laws allow the government, and in some cases, private individuals, to bring civil actions against healthcare providers to recover damages and penalties when providers submit fraudulent or false claims to the government. There are many different types of false claims. Examples include:

- overcharging the government program
- charging for services that were never performed
- providing less than what was promised
- providing unnecessary services
- misrepresenting the services provided
- billing for services provided by an unlicensed or unqualified provider

Federal Laws: There are both federal laws and Pennsylvania laws that address false claims and protections for individuals who report fraud and waste to the government (commonly referred to as “whistleblowers”). The Federal False Claims Act prohibits any person or entity from knowingly submitting or causing the submission of a false or fraudulent claim for payment to the federal government. For purposes of the Act, the term “knowingly” means having actual knowledge or acting in reckless disregard or deliberate ignorance of the truth or falsity of the information. Violators of the Act may be liable for up to three times the amount of the fraud, plus a civil penalty of not less than \$10,957 and not more than \$21,916 for each claim. The Federal False Claims Act authorizes private individuals to bring false claims actions on behalf of the government, for which the individual may receive between 15 and 30 percent of any recovery depending in part upon whether the government intervenes in the action. The Act applies to federally funded programs, including Medicare and Medicaid.

The Federal False Claims Act also prohibits an employer from retaliating against an employee for attempting to uncover or report fraud on the federal government. Any employee who is discharged, demoted, suspended, threatened, harassed or in any other way discriminated against in his or her employment as a result of the employee’s lawful acts in furtherance of a false claims suit may bring an action against the employer in federal district court. An employee who is retaliated against as set forth in the Act is entitled to reinstatement at the same level, two times the amount of back pay plus interest, and compensation for any special damages sustained as a result of the discrimination, such as litigation costs and reasonable attorneys’ fees.

The Program Fraud Civil Remedies Act of 1986 (“PFCRA”) is another federal law that provides administrative remedies for the knowing submission of false claims and false statements. For purposes of the PFCRA, a false claim or false statement includes a claim or written statement submitted to the federal government which asserts a material fact that is false, omits a material fact, or is for services that were not provided. Penalties for a violation of the PFCRA include a civil penalty of up to \$10,957 per claim, plus an assessment of up to twice the amount of each false claim.

Pennsylvania Laws: The Commonwealth of Pennsylvania has not yet enacted a false claims statute like the Federal False Claims Act. However, it does have anti-fraud laws that impose criminal and civil penalties for false claims and false statements. The law applicable to Medicaid providers prohibits the submission of false or fraudulent claims to Pennsylvania’s medical assistance programs as well as the payment of kickbacks in connection with services paid in whole or in part by a medical assistance program. A violation of the law is a criminal felony offense that carries with it penalties of imprisonment of up to 7 years, fines, and mandatory exclusion from Pennsylvania’s medical assistance programs for five years. Beyond criminal penalties, the law authorizes the Pennsylvania Department of Human Services (formerly known as the Pennsylvania Department of Public Welfare) to institute a civil action against a provider for two times the amount of excess benefits or payments paid plus interest.

Pennsylvania has another anti-fraud law that prohibits beneficiaries of medical assistance programs from making false claims or false statements in connection with an application for medical assistance benefits or payments. Depending upon the nature of the violation, criminal penalties range from felony to misdemeanor offenses. In addition, the Department of Human Services may institute a civil action against a beneficiary.

Pennsylvania also has a Whistleblower Law that prohibits an employer from discharging, threatening or otherwise discriminating or retaliating against an employee of a public body because the employee in good faith reports or is about to report wrongdoing or waste to the employer or appropriate authority. While the Law applies only to employees of a “public body,” Pennsylvania courts have interpreted the phrase “public body” to refer to entities that receive money from the Commonwealth. This includes Medicaid providers.

How to Report Concerns Regarding Fraud, Abuse and False Claims: PCA is committed to conducting its business in a lawful and ethical manner. The PCA Workforce must comply with all applicable laws, regulations, policies, procedures and other requirements. PCA requires all PCA Workforce members to identify and report immediately any issues regarding fraud, waste, abuse and false claims, including any suspected issues or concerns involving PCA, to PCA's Manager of Auditing Services or Vice President of Business and Finance. Any questions about this policy should be directed to PCA's Compliance Officer, the Vice President of Business and Finance.

Reports may be made on an anonymous basis. Any reported matters that suggest substantial violations of applicable laws, regulations, policies, procedures and other requirements shall be documented and investigated promptly.

References: Deficit Reduction Act of 2005, §§ 6031 and 6032
Federal False Claims Act, 31 U.S.C. §§ 3729-3733
Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812
Pennsylvania Whistleblower Law, 43 P.S. §§ 1422-23
Pennsylvania Public Welfare Fraud and Abuse Control Laws, 62 P.S. § 1407, § 1408

Original policy effective January 1, 2007 and revised May 16, 2007, February 1, 2009, January 15, 2015, July 15, 2015 and May 26, 2017.

N. SERVICE ORDER AUTHORIZATION PROCEDURE

1. No service is to be initiated, changed, or terminated prior to care plan expiration, or included on an invoice without receipt of a service order. Providing service without a service order is not allowed and will not be reimbursed.
2. Upon development and approval of the PCA care plan, a service order will be issued to the provider. If the provider identifies an error on the service order, or has a question, they are to call the LTC staff person **immediately** to clarify any concerns.
3. Only the lesser of the amount of service ordered or the service amount that is delivered will be paid. The amount invoiced for each consumer is not to exceed the authorized amount in the care plan. Any amounts invoiced by the provider that exceed PCA authorized amounts will not be paid and reported back to the provider as discrepancies.
4. With the implementation of web-based service orders, it is absolutely essential that providers log into the PCA site and download service orders daily.
5. If a provider is expecting a service order to start service and the service order is not received in sufficient time to initiate service, the provider must contact the Service Coordinator (or his/her direct Supervisor, if unavailable) to verify the current status of the request.
6. Service orders are labeled (**I**) Initial, for all new consumers and those care plans that are renewed twelve month care plans; (**M**) Modified, for changes to a service during the twelve-month care plan period; or (**T**) Terminated, to terminate specific services. Services put on hold are reflected on a Modified service order, (refer to attached codes). All service types, which are re-ordered, will show as Duplicates.
7. It is important that particular attention be paid to the dates on the service order and the

monthly totals. If a provider is not able to start a service as specified, the provider must notify the Service Coordinator (or his/her direct Supervisor) to assure the service is still needed and remains appropriate and to assure it is re-entered for the next month. All rescheduled service or additional months or units must be authorized through a service order.

8. If the days of the week that service is provided differ from those indicated on the service order, the total amount of service projected for the month in PCA's system may be less. If this happens, the excess service during the month delivered by the provider will not be paid and the full amount reflected on the provider invoice will not be reimbursed. Each service order specifies the total units and/or cost for each month. It is each provider's responsibility to assure the service being billed is equal to, or less than that specified on the service order. It is important that providers notify the Service Coordinator of all delivery patterns, especially if there is a change, so that PCA and provider records are identical.
9. Please note that although the LTC Program may authorize provision of service by a service order, payment remains contingent upon fulfilling any related reporting requirements, as delineated by PCA for consumers.
10. Care plans typically are ordered for a one year period. It is suggested each provider set controls to track all consumer care plans to assure service orders are received prior to expiration of the previous care plans. If a new service order is not received in a timely manner (received before the next period begins), the provider must contact the Service Coordinator or his/her direct Supervisor and obtain a copy before continuing service. Providers must not continue to provide service without an updated service order.
11. The reason codes that follow are used to explain the basis for revising care plans.

REASON CODES

CODE	TERMINATIONS
01	Consumer deceased.
04	Nursing Home placement.
05	Closure - (moved out of area, withdrew, situation resolved, etc.).
15	Internal transfer. Service/case transferred to another PCA Department.
19	Consumer is clinically ineligible.
29	Consumer is financially ineligible.
CODE	HOLDS / EXCEPTIONS
16	Temporary hold - (Hospitalized, vacation, etc.)

30	Provider no show. Worker did not show up or call to cancel visit.
36	Temporary hold - skilled care/ Medicare. Consumer receiving third party reimbursed services.
66	Temporary hold - Housing service not performed yet.

SECTION IV.

SERVICE STANDARDS &

SERVICE SPECIFIC OPERATIONAL PROCEDURES

A. ADULT DAY SERVICE: STANDARDS

Any Adult Day Service funded by an Area Agency on Aging (AAA) must take place in an Adult Day Services Center that is licensed by the PA Department of Aging (PDA) and governed by “6 PA Code Chapter 11: - Older Adult Daily Living Centers”.

Licensed Adult Day Service operators are responsible for reporting unusual incidents to the Department of Aging, Division of Licensing as defined in “6 PA Code Chapter 11, Section 11.3 – Definitions” and to submit the reports within the timeframes outlined in “6 PA Code Chapter 11, Section 11.16 - Reporting of Unusual Incidents”.

Adult Day Service may be requested by Domiciliary Care Home (DCH) and Personal Care Home (PCH) residents. The same provisions that apply to any person age 60 or older requesting this service will apply. The PCH or DCH residents must meet the admission criteria for Adult Day service. This does not supersede the current DCH and PCH regulations but works in conjunction with those regulations.

All Adult Day Service provided must be consistent with the care plan authorized by the AAA.

1. Service Reporting

Persons providing Adult Day Service must comply with all reporting requirements as specified by the AAA.

2. Scheduling

Days and times schedules for Adult Day Service must be consistent with the Care Plan provided by the AAA.

3. Confidentiality

All agencies that provide Adult Day Service must comply with all federal, state, and local laws relating to research on human subjects and consumer confidentiality.

Agencies must provide all Service Coordinators with consent forms and approval from all appropriate review boards for those consumers who wish to be part of a research study.

A. 1. ADULT DAY SERVICE - SERVICE SPECIFIC OPERATIONAL PROCEDURES

These operational procedures set forth requirements and “best practices” for facilities providing Adult Day Service to Philadelphia Corporation for Aging (PCA) consumers. The operational procedures are in addition to the Adult Day Service Standards, as well as those as delineated by the Pennsylvania Department of Aging license standards pursuant to Pennsylvania code, “Title 6, Aging, Chapter 11”, as amended.

1. License

All providers must have demonstrated experience in the delivery of adult day service to consumers and be in operation with all the necessary components, prior to being placed on a consumer selection list. All adult day care providers must have, as a minimum, a “Provisional” license from the PDA.

2. General Requirements

a. Administrative Structure and Organization

- (1.) The adult day care center shall have clearly delineated lines of authority and supervisory structure.
- (2.) The adult day care center shall have a full-time administrator/program director with the authority and responsibility to direct and manage the operations of the center.
- (3.) The legal entity operating the adult day care center will furnish proof of ownership by person, society, corporation, governing authority, or partnership legally responsible for the administration and operation of a center. Such proof shall include:
 - Indication of legal business structure and type of control. If the legal entity is a corporation, it shall submit a copy of the articles of incorporation. If a partnership, a copy of the partnership agreement. Copies of a fictitious name approval and a charter approval, if applicable.
 - Listing of all directors, board members, and shareholders; preferably documented via a “certificate of incumbency” signed by the secretary of the corporation;
 - Copy of an IRS tax identification number, e.g. IRS notification letter or tax label.

b. Staffing

- (1.) The adult day care center staff will have experience working with older adults with functional and/or cognitive impairments and meet the specific education, experience, and skill requirements for the following positions, as applicable, as defined by the PDA License requirements:

- Program Director/Administrator;
 - Social Worker;
 - Registered Nurse or Licensed Practical Nurse;
 - Activities Coordinator;
 - Program Aides.
- (2.) The program staff-client ratio shall be a minimum of 1 (one) to 7 (seven) at all times. Use of volunteers to supplement staff is encouraged however they cannot be used to fulfill minimum staffing requirements.
- (3.) Staff persons may simultaneously perform the duties and responsibilities of more than one position. In such instances, the staff person shall meet the licensure requirement for each of the positions held, and at least the minimum education or equivalent experience requirements for each of the positions held.
- c. **Nutrition** – Adult Day Service centers may prepare food onsite or arrange for service from outside sources. In all instances, all meals served shall be based on the following:
- (1.) Each meal shall conform to the requirements of the Nutrition Services Incentive Program (NISP), Title III of the Older Americans Act. Specifically, each meal shall provide at least one-third of the current Dietary Reference Intakes (DRIs) using the reference female, 71 years of age or older (representative of the majority of the participants in Pennsylvania’s meal programs) as established by the Institute of Medicine. Each meal must also adhere to The Dietary Guidelines for American, most recent edition.
- (2.) Each meal shall conform to the Philadelphia Corporation for Aging (PCA) Congregate Meal Program Standards, which include the submission and approval of two, six month, 20-day menu cycles or 28 day cycle if weekend meals are included.
- (3.) All onsite and offsite meal preparation and serving areas must be inspected and approved to assure compliance with local Health Department food handling and serving regulations.
- d. **Unit of Service Defined**
- (1.) A full day of adult day service is defined as a consumer participating at a center for duration of over 4 hours. A half-day of service is defined as consisting of consumer participation of 4 hours or less.
- (2.) Authorization for full day or half day of service is a function of a consumer and/or caregiver needs as reflected in the plan of care and confirmed by a service order.
- e. **Referral Process**

- (1.) The PCA Service Coordinator will make the referral for adult day care service.
- (2.) The adult day care provider will conduct their assessment of the consumer. Additional discussions and/or request for clarification can occur, as needed.
- (4.) If the consumer is determined appropriate for the program – by the center, the Service Coordinator will authorize service, as per the approved individual service plan (ISP), through the issuing of a Service Order.

f. **Service Authorization and Days of Service Policy**

Adult Day Service cannot be provided without prior written authorization by the Service Coordinator, in accordance to the PCA Service Authorization Procedures

Providers may accept consumer and/or caregiver initiated rescheduling of day of service within the same week. Approval by the Service Coordinator is not required in such instance nor is a new Service Order. **However, it is imperative that the provider remind the consumer that adjustments in other scheduled services may also be required, e.g. personal care.** When CCT-Shared Ride is involved, any rescheduling of days of service will require the provider to make the requisite arrangements with the CCT-Shared Ride Coordinator.

On occasions where the length of an authorized unit of service is inadvertently affected by factors such as transportation problems through the CCT-Shared Ride vendor, inclement weather, and/or illness the adult day care provider will be paid for delivered service at the authorized unit of service level. However, the Service Coordinator needs to be notified of such instances or changes in the consumer's circumstance so that, if needed, the consumer care plan can be adjusted.

In addition, when making such schedule changes, consideration must be given to days at the beginning or end of the month, as the change may affect the total days billed for that period. When rescheduling within the same week results in an increase of total authorized units within a month, it is imperative for the provider to contact the Service Coordinator immediately so as to obtain a revised Service Order, confirming the change in authorization totals for both adult day care and meals.

g. **Reporting Requirements**

- (1.) Adult Day Care providers are required to send a copy of the formal plan of care for each consumer to the PCA Service Coordinator within thirty (30) days from the start of service.
- (2.) Adult Day Care staff must communicate with the Service Coordinator to keep him/her informed of any changes in the status of the consumer's health and overall wellbeing, attendance, and incidents. Adult Day Care providers are required to forward written progress reports to the Service Coordinator when requested.

(3.) The adult day care will comply with all reporting requirements specified by PCA, including the reporting of Shared Ride transportation service.

- h. **The provider shall obtain the consumer's signature on a standardized form (attendance log, etc.) for each day the service is delivered to a PCA consumer. Confirmation of attendance can be made by an authorized representative in those documented instances where the consumer cannot sign due to physical and/or cognitive limitations. If or when requested, consumers and/or caregivers must be given a copy of the signed form as a confirmation of delivery of service. Providers can utilize multi-part forms to facilitate this acknowledgement of the receipt of service on a given day.**

3. Communicable Diseases

- a. Adult day care providers are expected to follow procedures recommended in the Center of Disease Control (CDC) Guidelines and OSHA Regulations when caring for consumers with communicable diseases. Adult day care centers are responsible to provide appropriate in-services regarding these universal precautions.
- b. The adult day care shall notify the PCA Service Coordinator upon determining or learning from another source, that a consumer has a communicable disease.
- c. The provider must follow CDC and OSHA Guidelines regarding the disposal of contaminated needles.
- d. All consumer-contact employees shall have a **Mantoux Interacutaneous PPD Test** according to CDC recommendations and, if the results are positive, it will be followed by appropriate physician directed treatment.

In order to continue employment, the employee must be free of active TB. Verification by a physician that the employee is free of TB must be in the personnel file and updated every 2 years, minimum. Chest X-rays are required based on physician's advice.

- e. All employees must be offered and/or received the **Hepatitis B Vaccine** designated by OSHA Regulations.

B. COUNSELING: STANDARDS – (Please Note: Not accepting new Providers)

Counseling services must be provided by a licensed/certified professional. Counseling services may include but not be limited to:

- a) individual counseling
- b) marital/couple counseling
- c) family counseling
- d) group counseling
- e) nutrition counseling

1. DEFINITION

A broad array of health and mental health related counseling services may include the following:

- problem solving and coping skills,
- nutrition education, counseling and/or diet instruction,
- music therapy,
- alcoholism,
- drug dependency,
- individual/marital/family stress,
- family problems including situations of abuse or neglect,
- detection and treatment of depression and other mental health conditions.

2. EDUCATIONAL QUALIFICATIONS

All in-home counselors will have the appropriate credentials as deemed valid by experts in their specialized areas. Examples include:

- Master's Degree or Ph.D. in Counseling; Social Work; Clinical Psychology; Educational Psychology or Music Therapy;
- Nursing Master's Degree in Psychiatric Adult Mental Health;
- Registration with the American Dietetic Association;
- License as required by that profession/discipline, i.e. PA license for MSW, etc.

3. SERVICE ACTIVITIES

- Individual counseling
- Marital/couple counseling
- Family counseling

- Group counseling

4. UNIT OF SERVICE SPECIFICATION

- a. Visits will consist of approximately one hour spent with the consumer.
- b. The consumer assessment should include the counselor's problem identification, goal setting, timeframe, treatment techniques and recommendation.
- c. Every assessment and every visit will be documented by the counselor in a clinical progress note.

5. SERVICE AUTHORIZATION

- a. Service Coordinators will assess the need for mental health assessment and/or intervention and refer the consumer/caregiver to the counselor/agency as part of the consumer's comprehensive care plan.
- b. The counselor will discuss the case with the Service Coordinator and make an appointment to assess the consumer's situation.
- c. After the assessment, the counselor will write up the assessment, and propose a preliminary plan for treatment, should it seem appropriate, to the Service Coordinator.
- d. Together they will project units of service.
- e. The counselor will keep a case record on each consumer served, containing pertinent clinical information.
- f. The counselor will keep a monthly log, listing consumers' names and dates of actual visits, and recording supervisory conferences, as they are completed. Individual time slips must be signed by the consumer or family member/caregiver and the counselor to document each unit of service billed.

6. SERVICE REPORTING

Persons providing counseling services must comply with all reporting requirements as specified by the AAA.

7. SCHEDULING

Days and times scheduled for counseling must be consistent with the care plan provided by the AAA.

8. CONFIDENTIALITY

All agencies who provide counseling services must comply with all federal, state and local laws relating to research on human subjects and consumer confidentiality.

Agencies must provide all Service Coordinators with consent forms and approval from all appropriate review boards for those consumers who wish to be part of a research study.

B.1. COUNSELING - SERVICE SPECIFIC OPERATIONAL PROCEDURES

These Operational Procedures are in addition to the Counseling Standards. They delineate further expectations and “best practices” for providers delivering service to Philadelphia Corporation for Aging (PCA) consumers.

1. Definition and Operating Principles

- a. The primary objective of in-the-home mental health counseling service is the provision of short term, goal oriented counseling for consumers and/or their caregivers in order to restore, remediate or rehabilitate in order to improve functioning and independence.
- b. In addition to the array counseling services identified in the Counseling Standards, counseling includes:
 - Telephone supportive therapy;
- c. When applicable, service providers must be Medicare certified and have a provider number for counseling service.
- d. PCA shall be the payer of last resort. Providers shall bill counseling service to third party payers – (Medicare, MA fee schedule, managed care), when eligible and indicated.

2. Staffing

- a. Providers will utilize staff that has the appropriate credentials as deemed valid by experts in the industry. Exceptions to staffing requirements may only be made with prior written approval by PCA.
- b. Supervisors must have a Master’s Degree, minimum, and a reasonable length of clearly delineated experience in therapeutic counseling and supervision of clinicians.
- c. Providers shall make available the services of a psychiatrist, when needed, for the purpose of consultation and clinical support to counselors and supervisors.

3. Service Authorization and Reporting

- a. No service may be provided without prior written authorization by the Service Coordinator, in accordance to the PCA Service Authorization Procedures.
- b. An initial assessment shall be completed within ten (10) working days of the receipt of a service order. The initial assessment evaluation results will be forwarded to the referring Service Coordinator within ten (10) working days of the evaluation visit. The initial evaluation shall include:
 - Diagnosis;
 - Therapeutic goals;
 - Plan of treatment.

- c. Clinical progress notes that will contain sufficient clinical content regarding the treatment process and visit must be maintained in individual consumer records. A clinical progress report that includes goals and progress towards achieving those goals will be forwarded to the Service Coordinator on a monthly basis.

- d. The provider shall obtain the consumer's signature (or that of other authorized representative) on a time slip or other standardized form each time a service is delivered to a PCA consumer. Consumers must be given a copy of the signed form as a confirmation of delivery of service. It is recommended that providers utilize multi-part forms so that the consumer can receive their copy as an acknowledgement of the receipt of service on the given day.

C. PROFESSIONAL EVALUATION - SERVICE SPECIFIC OPERATIONAL PROCEDURES

1. General Information

These Operational Procedures delineate further contractual requirements for providers of Medical, Psychiatric, Psychological and OBRA Psychological consultations and evaluations. The following services may be ordered by representatives of PCA's LTC Program: LTCO (Long Term Care Options), LTCA (Long Term Care Access) or OAPS (Older Adult Protective Services) Departments:

- Medical Physician Services

Provide medical consultations, case reviews and training to PCA programs; participate at court hearings or appeals, and provide home visits when requested. Refer to **2. below**, Medical Physician Services, for a detailed description of services required.

- Psychiatric Physician Services

Provide psychiatric evaluations, case reviews and training to PCA programs; participate in court proceedings and appeals; and perform home visits. Refer to **3. Below**, Psychiatric Physician Services, for a detailed description of services required.

- Psychological Evaluation

Provide psychological evaluations, case reviews and training to PCA programs; participate in court proceedings and appeals; and perform home visits. Refer to **4. Below**, Psychological Evaluations, for a detailed description of services required.

- OBRA Psychological Evaluations

Provide specialized consultative, training and evaluation services relating to Mental Retardation or a Related Condition as required under OBRA at the request of PCA's LTCA Department. Refer to **5. Below**, Responsibilities of the OBRA Qualified Mental Retardation Provider, for a detailed description of services required.

a. **INTAKE**

- (1.) When the need for professional consultation or evaluation is identified, the Service Coordinator, assessor, investigator or supervisor ("PCA Representative") will contact the provider, selected by the consumer when appropriate, to make the initial referral and to arrange for a home visit (if required) or other service, which shall be performed by the provider within five (5) working days, or within 24 hours in the event of an emergency.
- (2.) Upon confirmation of a date for the evaluation, the Service Coordinator will forward a Service Order to the provider authorizing service.
- (3.) To the extent that the above is at variance with the specific requirements of

the Attachment directly applicable to the services ordered, the requirements of that Attachment shall control.

b. SERVICE DELIVERY

- (1.) Upon receipt of the service order, the provider will confirm the scheduled date of evaluation with the PCA Representative. If indicated after initial consultation with the provider, a joint visit may be made with the PCA Representative and any other providers involved in the consumer's plan of care.
- (2.) Provider staff needs to communicate with the PCA Representative to keep PCA informed of any changes in the consumer's health status.
- (3.) Provider staff shall communicate with the PCA Representative as follows:
 - (a.) Within 24 hours of the initial contact with consumer, consumer records or other provider involved in the consumer's plan of care, the results of the visit, review or contact shall be provided by phone to the PCA Representative. The provider will advise the PCA Representative of any diagnosis and recommended plan of care. **No additional visits are to be made without a further service order.**
 - (b.) When there is a professional conflict regarding the delivery of care between the provider and other professionals.
 - (c.) When the consumer is hospitalized or experiences a health emergency.

c. REPORTING REQUIREMENTS

- (1.) A written report of the evaluation findings will be forwarded to the PCA Representative by the fifth (5th) working day following the visit or other consultative activity. Evaluation findings for emergency request will be submitted to the PCA Representative within 24 hours after the visit or other consultative activity.
- (2.) A telephone report of the evaluation will be provided to the PCA Representative within 24 hours of the assessment visit.
- (3.) To the extent that the above is at variance with the specific requirements of the Attachment directly applicable to the services ordered, the requirements of that Attachment shall control.

d. STAFF QUALIFICATIONS

- (1.) Providers will assign staff that has the following qualifications:
 - (a.) Medical Physicians - must be board certified in internal medicine (and preferably with added qualification in geriatric internal medicine) or

family practice; have current Pennsylvania license; have experience in aging and community-based care; and have experience in working with social workers, nurses, and other health and social service professionals.

- (b.) Psychiatric Physicians - must be board certified or board eligible in psychiatry (and preferably with added qualification in geriatric psychiatry); have current Pennsylvania license; and have admitting privileges at a local hospital.
 - (c.) Psychologists - must have a Ph.D. level degree and be Pennsylvania licensed clinical psychologists.
- (2.) Providers shall submit for review and approval any exceptions to the above staff requirements, in writing, addressed to the Contract Manager in PCA's Business Administration Department.
 - (3.) Providers shall notify their Contract Manager in the Business Administration Department if there is any change in their roster of professionals assigned to perform work under their Agreement.
 - (4.) To the extent that the above is at variance with the specific requirements of the Attachment directly applicable to the services ordered, the requirements of that Attachment shall control.

e. COMMUNICABLE DISEASES

- (1.) When performing services under their Agreement, providers shall comply with all applicable law and adhere to all generally recognized professional standards relating to communicable diseases, including but not limited to Center for Disease Control (CDC) guidelines and OSHA regulations. Provider shall provide its staff with appropriate training and supervision in these areas, including in the use of universal precautions. (A training tape is available from CDC upon request; the CDC toll-free number is 1-800-232-4636).

Providers shall also provide to their staffs appropriate protective articles including, but not limited to, aprons, gloves, masks, and gowns as needed.
- (2.) Providers shall develop written policies regarding communicable diseases consistent with CDC guidelines, OSHA requirements and generally recognized professional standards, and shall submit copies of these to their PCA Contract Manager.
- (3.) Providers shall notify their PCA Service Coordinator upon determining that a consumer has a communicable disease.
- (4.) Providers shall adhere to applicable law, including but not limited to CDC and OSHA guidelines and generally recognized professional standards, regarding the disposal of medical waste.

- (5.) To the extent that the above is at variance with the specific requirements of the Attachment directly applicable to the services ordered, the requirements of that Attachment shall control.

2. Medical Physician Services

a. Scope of Services:

- (1.) The use of Physician evaluations or consultations are intended to:
 - (a.) Evaluate at-risk consumers who do not currently have a primary physician or those whose primary physicians are not responsive to the consumers' needs;
 - (b.) Complete MA51 for those consumers who do not have an identified primary physician;
 - (c.) Provide consultation in those difficult or borderline level of care and/or locus of care decisions;
 - (d.) Provide evaluations and/or consultations in those instances where there is anticipation of a formal appeal of level and/or locus of care decisions.
- (2.) The consumer population will include adults age 18 and over. However, the majority of consumers will be over the age of 65.
- (3.) Upon request, the physician consultant will make home visits.

b. Provider Responsibilities:

- (1.) Review completed assessments and/or care plans of consumers selected by PCA with Service Coordinators, Service Coordinator Supervisors, and Nurse Consultants.
- (2.) Consult with consumer's physician and/or other health and social service professionals regarding consumer's recommended LOC and/or community based home health care needs. If necessary, visit consumers at their home for final recommendations.
- (3.) Recommend a LOC determination when there is a disagreement among PCA supervisors regarding the most appropriate LOC.
- (4.) Review care plans of community based consumers from a quality assurance perspective and make such recommendations, as the consultant deems appropriate.
- (5.) Provide documentation of case review and recommendation within the case file of consumers selected for consultation.
- (6.) Participate when requested by PCA in supervisory or team conferences regarding selected consumers for Long-Term Care programs.
- (7.) Provide training requested by PCA through in-service training sessions.
- (8.) Attend staff meetings as requested by PCA to review program implementations, procedures and policies.
- (9.) Participate as requested by PCA in fair hearings or appeals processes or as witness in court proceedings.

- (10.) Provide medical information for consumers who do not have a physician relative to the MA-51 form.
- (11.) Provide home visits for Older Adults Protective Services consumers.
- (12.) Coordinate with PCA and hospital or geriatric practice on use of students and residents.
- (13.) Be available up to six (6) hours per week, fifty (50) weeks per year, to provide the above services.
- (14.) Be available for emergencies on 24 hours' notice.

If these services are unavailable during vacation periods, backup telephone consultation, at a minimum, and other services mutually agreeable to the parties shall be provided by a member of the provider's internal medicine medical staff.

3. Psychiatric Physician Services

a. Scope of Service

The primary objective of a Psychiatric Evaluation is the physical, functional, and mental health assessment of homebound elderly consumers who are referred by either the LTCO, OAPS, or LTCA Departments. The psychiatric evaluation is used in assisting PCA in the development of a consumer's plan of care and/or the need for protective service or other (including emergency) intervention. On occasion, the psychiatrist may also be needed to give testimony in legal proceedings regarding a consumer's mental status.

Evaluations are to be provided by a Board certified or Board eligible psychiatrist licensed to practice in the state of Pennsylvania. Certain aspects of evaluations may also be conducted by gero-psychiatric nurses under the supervision of a licensed psychiatrist.

- (1.) Psychiatric Evaluation - the psychiatrist or psychiatric nurse shall perform an assessment of mental status, history, and need for treatment of referred consumers. In emergency situations, the psychiatrist shall focus on evaluating the consumer's ability to receive and evaluate information effectively and communicate decisions essential to the health and safety and the management of finances. Unless otherwise specified, evaluations will be conducted in the person's home. Consumer evaluations shall be coordinated with the referring PCA Representative, within 5 working days from the date of the referral. Emergency evaluation requests shall be conducted within 24 hours. If appropriate, the psychiatrist shall develop a recommended treatment plan, which may include medication, outpatient psychiatric services, supportive services, or in-patient psychiatric treatment. When hospitalization is needed, the psychiatrist shall facilitate admission to the appropriate licensed hospital. All medical treatment and/or hospital admissions shall be coordinated with the consumer's physician.
- (2.) Participation in Legal Proceedings - As needed, the psychiatrist shall participate in legal proceedings that may include:
 - (a.) Petition for a 302 involuntary commitment for psychiatric evaluation;
 - (b.) Testifying at hearings for a 303 or 304 commitment;
 - (c.) Testifying in court as to consumer competency in guardianship hearings;
 - (d.) Providing testimony as to consumer mental capacity in court petitions for emergency orders under the Older Adults Protective Services Act. Such testimony may be made orally or in writing at PCA's direction.
- (3.) Documentation of evaluations is to be reported as follows:
 - (a.) If requested, a verbal/telephone report of the evaluation shall be provided to PCA within 24 hours of the assessment visit.
 - (b.) A written report of the evaluation findings shall be forwarded to PCA by the 5th working day following the assessment visit.

- (c.) Evaluation findings for emergency requests shall be submitted to PCA within 24 hours after the assessment visit.

4. Psychological Evaluations

a. Scope of Service

The primary objective of a Psychological Evaluation is the functional and mental health assessment of homebound elderly consumers who are referred by the LTCO, OAPS, or LTCA Departments. The psychological evaluation is used in assisting PCA in the development of a consumer's plan of care and/or the need for protective service or other (including emergency) intervention. On occasion, the psychologist may also be needed to give testimony in legal proceedings regarding a consumer's mental status.

Evaluations are to be provided by a Ph.D. level psychologist licensed to practice in the state of Pennsylvania.

(1.) Psychological Evaluation - the psychologist shall perform an assessment of mental status, history, and functional capacity of referred consumers. In emergency situations, the psychologist shall focus on evaluating the consumer's ability to receive and evaluate information effectively and communicate decisions essential to the health and safety and the management of finances. Unless otherwise specified, evaluations will be conducted in the person's home. Consumer evaluations shall be coordinated with the referring PCA Representative, within 5 working days from the date of the referral. Emergency evaluation requests shall be conducted within 24 hours.

(2.) Participation in Legal Proceedings - As needed, the psychologist shall participate in legal proceedings that may include:

- (a.) Petition for a 302 involuntary commitment for psychiatric evaluation;
- (b.) Testifying at hearings for a 303 or 304 commitment;
- (c.) Testifying in court as to consumer competency in guardianship hearings;
- (d.) Providing testimony as to consumer mental capacity in court petitions for emergency orders under the Older Adults Protective Services Act. Such testimony shall be given orally or in writing at PCA's direction.

(3.) Documentation of evaluations is to be reported as follows:

- (a.) If requested, a verbal/telephone report of the evaluation shall be provided to PCA within 24 hours of the assessment visit.
- (b.) A written report of the evaluation findings shall be forwarded to PCA by the 5th working day following the assessment visit.
- (c.) Evaluation findings for emergency requests shall be submitted to PCA within 24 hours after the assessment visit.

5. Responsibilities of the OBRA qualified Mental Retardation Provider

- a. Provider shall make available the services of a licensed, Ph.D. level, clinical psychologist with special training and experience in the evaluation of mental retardation for the purpose of assessing an applicant's need for active treatment as required under OBRA. These services must be available at least two (2) hours per week, Monday through Friday, between 8:30 am and 5:00 pm. Services shall include record review, telephone consultation in fifteen (15) minute minimum blocks of time, in-home evaluation, and other related activities appropriate and necessary to the individual case. Travel time is allowable at the hourly rate. Home visits are required when the individual applicant has not been evaluated previously by a qualified professional for the purpose of determining mental retardation or a related condition and measuring IQ.
- b. The psychologist shall:
 - (1.) Identify the applicant's intellectual functioning measurement;
 - (2.) Validate that the applicant has "mental retardation or a related condition"; and
 - (3.) Assess whether the applicant needs active treatment in order to function.
- c. The psychologist may be required to provide one or more in-service training sessions to LTCA staff in the area of Mental Retardation or Other Related Conditions. In-service training sessions shall be one (1) to two (2) hours. A maximum of two (2) hours of preparation time is allowable at the hourly rate for each in-service training session.
- d. The psychologist shall provide information to the Department of Public Welfare that identifies the extent to which an applicant compares with each of the following characteristics, commonly associated with the need for active treatment:
 - (1.) Inability to take care of most personal care needs;
 - (2.) Inability to understand simple commands;
 - (3.) Inability to communicate basic needs and wants;
 - (4.) Inability to be employed at a productive wage level without systematic long term supervision or support;
 - (5.) Inability to learn new skills without aggressive and consistent training;
 - (6.) Inability to apply skills without aggressive and consistent training;
 - (7.) Without direct supervision, inability to demonstrate behavior appropriate to the time, situation or place;
 - (8.) Demonstration of severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety;
 - (9.) Inability or extreme difficulty in making decisions requiring informed consent; and
 - (10.) Presence of other skill deficits or specialized training needs which necessitates the availability of trained Mental Retardation personnel, 24 hours per day, to teach the person to learn functional skills.

D. HOME HEALTH CARE: STANDARDS

As Medicare certified providers, agencies providing Home Health services must meet the requirements for training and supervision as established in regulation by the Centers for Medicaid and Medicare Services (CMS), Code Of Federal Regulations “42CFR484” Subpart C - Furnishing of Services, and “42CFR484.4” Personnel qualifications, “42CFR484.3” Conditions of Participation. Agencies providing Home Health services must also meet the requirements for training and supervision as established by the PA Department of Health in “28 PA Code Chapter 601 Home Health Care Agencies”.

All home health services provided must be consistent with the care plan authorized by the AAA.

The provider must have documentation to support services delivered including date, time, and what actual services were delivered.

Home health services include home health aide, nursing care, occupational therapy, physical therapy, and speech therapy provided to an individual to enable them to remain in the community. These professionals may be required to work as a team in their approach to the consumer’s care. Duration and scope of the services are limited only by the care plan.

1. SPECIAL ELIGIBILITY CRITERIA

- a. Eligibility for Home Health Care service is established on the basis of a comprehensive needs assessment conducted by the AAA Care Management Unit.
- b. The need for Home Health Care service must be confirmed by the Service Coordinator.
 - (1) The Service Coordinator will review the Care Management Assessment and other pertinent medical information, including information obtained by contracting health care providers who have cared for the consumer, to assure the appropriateness of the service.
- c. Home Health Care service must be ordered by a primary physician.
 - (1) The order must reflect the consumer’s medical condition and/or disability.
 - (2) The order must include the specific nursing and/or therapeutic service required.
 - (3) The order must be obtained by the Home Health service provider prior to service authorization.
 - (4) The order for continuation of service must be obtained every sixty days.
- d. The registered nurse and therapist, if therapy service is being rendered, must evaluate the consumer to determine the consumer’s potential for rehabilitation and to enable the therapist to develop or modify a plan of care for him/her prior to service and every 60 days. This plan and recommendation for service must be submitted to the Care Management Unit prior to service authorization.

If skilled care is not required, the services of the home health aide will be provided only as long as the need for supportive service continues. This necessitates that the registered nurse

or therapist performs a sixty-day evaluation to monitor the consumer's improvement or regression. With each evaluation, instructions must be written for the home health aide including any changes in how supportive activities are to be rendered.

2. ACTIVITIES FOR HOME HEALTH AIDE

- a. Home Health Aide services are provided by a supervised aide who may be a trained home health aide or a license practical nurse. In addition to personal care, home health activities include:
- (1.) Performing simple measurements and tests to monitor the consumer's medical condition including vital signs, simple urine checks for sugar and albumin and measuring intake and output.
 - (2.) Assisting with ambulation when the consumer also uses an ambulation aide.
 - (3.) Assisting with other medical equipment use.
 - (4.) Assisting with exercises taught by a nurse or physical therapist.
 - (5.) Changing and/or reinforcing simple dressings on stable surface wounds.
 - (6.) Low level care of decubitus ulcers (as directed by a registered nurse).
 - (7.) Caring for well-healed normal functioning colostomy.
 - (8.) Assisting with changing of a colostomy bag (as directed by a registered nurse).
 - (9.) Monitoring of dietary habits and preparing special diet meals.
 - (10.) Assisting in retraining the consumer in self-help skills.
 - (11.) Reporting changes in the consumer's condition and needs to the registered nurse supervisor.

3. STANDARDS FOR HOME HEALTH AIDE

- a. Appropriately trained (see training standard).
- b. Supervised by a licensed practitioner.

4. TRAINING STANDARDS FOR HOME HEALTH AIDE

Basic training of a minimum of 60 hours must be completed during the first 3 months of employment. This may be waived if the Home Health Aide worker provides documentation of completion of related training and/or is able to demonstrate competency in all skilled areas required in the basic training. In-service training shall be ongoing and home health aide workers must have demonstrated competency in procedures and activities they are asked to perform.

5. SUPERVISION STANDARDS

- a. Home Health Aide services must be supervised by a registered nurse and are provided under physician's orders. Home Health aides are supervised by the subcontract agency's registered nurse and/or the therapist if they are assisting with therapeutic activities.
- b. The supervision must occur in the consumer's residence every two weeks with the supervisor reassessing the consumer's situation, monitoring and assessing the home health aide job performance. It is not required that the home health aide be present every two weeks during the supervisory visit in the consumer's home, but it is encouraged that he/she is present during these visits as often as possible.

It is required, however, that included in the supervisory notes there be documented communication between the registered nurse supervisor and the home health aide at least every two weeks, regarding the consumer's condition, response to service and satisfaction, the home health aide's job performance, re-evaluation of the care plan meeting consumer's needs, etc., and any other pertinent information regarding the consumer's condition, aide job performance or care plan implications.

6. RECORDS AND DOCUMENTATION

- a. The Home Health Care provider must maintain a standardized record keeping system. The system must ensure uniformity and consistency in documentation of the service provision, the consumer's response to the service, and other observations made of the consumer.
- b. Consumer information must be maintained in a confidential manner.
- c. A separate record must be maintained for each consumer. The record must include:
 - (1.) the physician order;
 - (2.) AAA Service Authorization Form;
 - (3.) the plan of care established by the nurse and/or therapist;
 - (4.) the nurse or therapist assignment to the home health aide;
 - (5.) a record of supervisory visits for the home health aide;
 - (6.) documentation of each visit made to the consumer (to include changes in a consumer's condition) through a report to the Care Management Unit;
 - (7.) Pertinent consumer information obtained during the supervisory visits and home health provider contact must be included in agency reports shared with the PCA Service Coordinator and physician of record;
 - (8.) Individual time slips signed by the consumer or family member/caregiver and the field staff worker to document each unit of service billed.

7. ACTIVITIES FOR NURSING CARE

- a. Providing either a basic general nursing evaluation or a specialty nursing evaluation of the consumer (by a registered nurse only).
 - (1.) Basic General Nursing Evaluation: a basic general nursing evaluation completed by the Medicaid provider's registered nurse to evaluate and monitor the general health and medical needs of the consumer in order to make recommendations and develop a nursing care plan for the registered nurse, licensed practical nurse, and/or home health aide to carry out the physician's recommended health care plan, and to carry out teaching for implementation of the health care plan. This nursing evaluation includes but not limited to: living conditions, health history, current health status (including taking of vital signs and any other "hands-on necessary to complete the evaluation), medication review, review of systems, etc. This general nursing evaluation is usually completed initially and then on an on-going basis, as needed, as part of the home health and is considered an integral part of the unit of service provided by the home health workers. The information obtained from the nursing evaluation is documented and shared with the PCA Service Coordinator and the physician of record.
 - (2.) Specialty Nursing Evaluation: a specialty nursing evaluation completed by a registered nurse with specialty training, education, experience and knowledge to make specialty recommendations and develop a nursing care plan to carry out the physician's approved plan of care or to carry out intensive teaching in a special area (e.g., incontinence training, ostomy care, wound care). This nursing evaluation includes, but not limited to the above areas, including any "hands-on" with concentration on specific areas related to the reason for the request, and the specialty nurse contracted to perform this type of evaluation, would generally make only one or two visits and the evaluation is contracted for at the discretion of the AAA site. Again, the information obtained from the evaluation is documented and shared with the PCA Service Coordinator and physician of record.
- b. Developing a nursing care plan (by a registered nurse only). Licensed practical nurses may assist and participate in the development and planning of nursing care.
- c. Implementing a nursing care plan.
- d. Administering of physician's prescribed medications.
- e. Teaching and training activities which require the skills and knowledge of a nurse, e.g., special diet, medication management, insulin administration, enteral or parenteral feeding, decubitus care, ostomy care, and catheter care.
- f. Performing medical treatments as order by the physician.
- g. Performing nursing skills and procedures which are usual, customary practice as permitted by the "Professional Nursing Law" for licensed nurses and for which the nurse assigned can demonstrate educational preparation, experience and knowledge.
- h. Maintaining clinical documentation of all nursing activities and visits.

- i. Obtaining new medical orders (by a registered nurse only) from the consumer's physician as indicated.
- j. Monitoring of consumer's physical and mental status in order to prevent hospitalization and regression of consumer status and to report any changes in condition of needs to the PCA Service Coordinator and physician of record.

8. NURSING STANDARDS

- a. Nursing Care is provided by an individual currently licensed to practice in Pennsylvania as a registered nurse or a licensed practical nurse under the direction of a registered nurse.

9. RECORDS AND DOCUMENTATION

(Same as Home Health Aide)

10. ACTIVITIES FOR OCCUPATIONAL THERAPY

- a. Develop a restorative and/or maintenance therapy plan of treatment with physician approval.
- b. Implement therapeutic tasks and activities to restore sensory-integration functions (perceptual problems due to loss of vision, touch, hearing, etc.).
- c. Teach consumers ways to protect joints from injury while doing activities of daily living and instrumental activities of daily living.
- d. Design, fabrication, and application of splints not including orthotic devices or prostheses.
- e. Teach compensatory techniques to improve the level of independence in activities of daily living and instrumental activities of daily living.

11. OCCUPATIONAL THERAPIST STANDARDS

- a. Occupational therapy is provided by a therapist currently licensed to practice in the Commonwealth. The occupational therapist is responsible for consulting, evaluation, teaching and providing occupational therapy procedures to consumers under physician direction.

12. RECORDS AND DOCUMENTATION

(Same as Home Health Aide).

13. PHYSICAL THERAPY ACTIVITIES

- a. Develop a restorative and/or maintenance therapy plan of treatment (common treatment procedures include hot packs, paraffin baths, gait training, ultra-sound, range of motion testing, therapeutic exercises, etc.) with physician approval.
- b. Teach positioning and proper body mechanics for lifting and transferring consumers.

14. PHYSICAL THERAPISTS STANDARDS

- a. Physical therapy is provided by an individual currently licensed as a physical therapist by the Commonwealth. The physical therapist is responsible for consulting, evaluating, teaching, and providing physical therapy procedures to consumers under physician direction.

15. RECORDS AND DOCUMENTATION

(Same as Home Health Aide).

16. ACTIVITIES FOR SPEECH THERAPY

- a. Develop a restorative and/or maintenance therapy plan of treatment with physician approval.
- b. Evaluate and develop a treatment program for speech problems.
- c. Evaluate and develop a treatment program to address problems of dysphagia (difficulty swallowing).

17. SPEECH THERAPIST STANDARDS

- a. Speech therapy is provided by an individual currently licensed in speech and language therapy by the Commonwealth. The therapist is responsible for consulting, evaluating, teaching and providing speech therapy procedures to consumers under physician direction.

18. RECORDS AND DOCUMENTATIONS

(Same as Home Health Aide)

19. SERVICE REPORTING

Persons providing Home Health Care services must comply with all reporting requirements as specified by the Area Agency on Aging.

20. SCHEDULING

Days and times schedules for Home Health Care must be consistent with the Care Plan provided by the AAA.

21. CONFIDENTIALITY

All agencies who provide Home Health Care services and comply with all federal, state and local laws relating to research on home subjects and consumer confidentiality.

Agencies must provide all Service Coordinators with consent forms and approval from all appropriate review boards for those consumers who wish to be part of a research study.

D. 1. HOME HEALTH CARE - SERVICE SPECIFIC OPERATIONAL PROCEDURES

These Operational Procedures are a supplement to the Home Health Care Standards, and as such they delineate “best practices” for Home Health Providers giving skilled home health care to PCA consumers. When there is a difference between the Home Health Care Standards and these Service Specific Operational Procedures, the more stringent requirement prevails.

NOTE: Home Health Agency (HHA) refers to the skilled Medicare certified Home Health Provider

1. INTAKE

- a. When making a referral, the LTC staff will indicate the type of service and time frame in which the visit is to be made.

If the Home Health Agency is not able to meet the request, the LTC staff person will refer to another Home Health Agency selected by the consumer.

- b. The LTC staff will discuss with the HHA intake staff the source of payment for the visit(s). **Pennsylvania Department of Aging (PDA) mandates providers to exhaust all other insurance, including Medicare and Medicaid (MA), before payment can be authorized. Note: providers must obtain prior authorization from MA for all medically necessary home health visits for eligible consumers.**

In cases where the LTC staff requests a skilled evaluation visit and it is agreed that the consumer services will not be covered by third party payers, PCA will reimburse for the visit. The LTC staff person will take under advisement a request by a nurse for a second visit to assess a consumer fully, consistent with CMS regulations.

- c. **Skilled care visits paid by PCA may occur only after the skilled home health agency has received a service order. The date this service order is received becomes the referral date for all skilled services.** Service Coordinators may note in the special instructions the time frame within which the visit must occur. If a visit is needed within twenty-four hours the service order will be preceded with a telephone call to the provider and the visit made prior to receiving the service order.
- d. PCA service orders constitute payment authorization for services delivered.

2. COORDINATION & DELIVERY OF CARE

- a. **The LTC Programs expect all of the skilled home health evaluations to follow CMS/OASIS/PPS regulations and PCA specifications.** This includes a thorough assessment, plan of treatment, and nursing care plan. The skilled services will follow a care plan or critical pathway, which meets consumer goals. Since LTC consumers have both acute and chronic illnesses PCA expects that the HHA staff will be knowledgeable and skilled in defining, monitoring and intervening with any health issues or concerns that impact on LTC consumers. Such health issues may include the following: incontinence, nutrition, depression, polypharmacy, pressure ulcer management and impaired mobility.
- b. The LTC programs expect that care will be provided to consumers using an interdisciplinary

team approach. HHA staff needs to communicate with the Service Coordinator to keep him/her informed of any changes in the consumer's health status. **The HHA is expected to communicate with the Service Coordinator at the following times:**

- (1.) Within one business day after completion of the initial assessment, the HHA's RN must contact the Service Coordinator to establish the payer of service and the recommended visit pattern.
 - (2.) When the agency completes an episode of care and recertifies the consumer for a second episode of care or discharges the consumer from skilled home health care. (Please note this change from previous requirements).
 - (3.) When there is a significant change in the consumer's health condition.
 - (4.) When there are any consumer complaints regarding health-related aspects of their care.
 - (5.) **When other agencies are not performing or delivering requested care such as personal care, transportation, meals, or adult day care.** This primarily is the consumer's responsibility, except when dementia or caregiver absence exists and non-performance impacts on consumer's safety or health status.
 - (6.) When the consumer is hospitalized or experiences a health emergency.
 - (7.) When there is a professional conflict regarding the delivery of care between HHA's and other professionals.
 - (8.) When the HHA expects to discharge the consumer from third party payer services or resume PCA paid services.
 - (9.) Reports from HHA's RN are to be given to the Service Coordinator regarding all clinical issues. If the Service Coordinator is not available, voice mails messages can be left, and in an emergency the Service Coordinator Supervisor can be contacted.
- c. LTC programs have a Supervisor on-call from 8:30-5:00 Monday through Friday to address any problems or concerns that may arise in the Service Coordinator's absence.

3. PLAN OF TREATMENT

- a. All care given by Home Health Agency staff will be under the direction of the consumer's physician.
- b. It is expected that the Home Health Agency will follow all the Medicare Regulations in providing care to LTC consumers under third party payer conditions of participation. This includes the need for CMS defined homebound status.

4. REPORTING/PROGRESS NOTES.

- a. The Home Health Agency is required to keep records on each consumer according to CMS Guidelines and the Home Health Care Standards. **Reporting requirements remain the same for all LTC skilled nursing and physical therapy consumers authorized to a PCA provider, irrespective of reimbursement source.** The LTC Program needs to receive copies of the initial assessment from all disciplines, initial plan of treatment (485), and discharge summary no later than one week after care was delivered. **The following Reporting Guidelines must be followed for Skilled Nursing and PT visits:**
 - (1.) The reports to PCA shall contain:
 - (a.) Initial (485) Plan of Treatment;

- (b.) Initial Skilled Progress Note or last page of OASIS with summary of findings;
- (c.) Discharge Summaries for PCA and third party payers.

Please Note: All PCA Service Coordinator initiated transfers or discharges must allow the home health agency an appropriate visit for closure under that episode of care.

Contents of verbal reports to the Service Coordinator should include the following:

- (i.) Consumer name;
 - (ii.) Name of RN making the visit;
 - (iii.) RN's agency name;
 - (iv.) Date of most recent visit;
 - (v.) Vital signs and changes of any significance based on ranges being reported per 485;
 - (vi.) A summary of diagnoses and treatments as they relate to the current episode of care. This summary will include any observation noted in the Summary, along with Care Plan interventions.
- (2.) Review of payor sources:
- (a.) Current visit pattern;
 - (b.) Type of payer source (potential third party);
 - (c.) Primary diagnosis for episode of care;
 - (d.) Goals of episode of care and were the goals achieved;
 - (e.) Anticipated date of discharge from episode of care and anticipated number of recertification under any payer source.
- (3.) The PCA Service Coordinator may request additional documentation needed to support care management ISP decisions.
- (4.) Reports are required for the one visit paid by PCA and all third party billed visits under Medicare, MA, and any HMO. Additional reports may be requested when warranted due to any significant changes in the consumer's status. Reports may be made by e-mail, phone or fax to the Service Coordinator.
- b. The Home Health Agency is required to maintain clinical records for PCA consumers in accordance with Medicare licensing regulations.
- c. **Verbal reports** to the designated Service Coordinator for all Physical Therapy, Occupational Therapy, and/or Speech Therapy consumer visits, which **must include the following, where applicable:**
- (1.) Therapeutic rehabilitative goals based on a thorough and complete functional assessment.
 - (2.) An assessment of any potential third party payer reimbursable diagnoses and treatments.

- (a.) Anticipated outcomes of your therapeutic interventions.
 - (b.) DME equipment needs of the consumer (both PCA and those paid by third party payer).
 - (c.) Anticipated safety check follow-up visit for all equipment ordered and/or installed.
 - (d.) Anticipated discharge date whether by PCA or third party payers.
- d. Documentation must be available to the Service Coordinators and their supervisors upon request. The request will include the current episode of care only.
- e. The Home Health Agency staff **will submit a discharge summary**, by discipline, which outlines the following:
- (1.) Admission and discharge dates.
 - (2.) Summary of care that was provided listing initial goals and final outcome.
 - (3.) Consumer's condition at discharge including medications, vital sign range, activity level, and cognitive status.
 - (4.) Signature of the consumer verifying that he/she has been advised of discharge.
- f. The Home Health Aide **will** keep a dated record of each contact with the consumer and record services provided observations of consumer and supervisory visit when it is made by the home health agency staff. **This record is to be dated and signed by the consumer and home health aide.**

5. STAFF QUALIFICATIONS

The Home Health agency will select staff to deliver care to LTC consumers who have attended PCA's orientation to its programs and meet the criteria established for Medicare. PCA's experience has shown that relationships and communications are enhanced when a core group of provider staff are assigned to work with the LTC consumers.

- a. PCA offers provider support training for agencies contracted to provide skilled home health services. Providers will be informed of the training schedule at the start of each Fiscal Year: registration is required.
- b. The Home Health Agency will assume responsibility for the supervision of its staff, as well as subcontracted specialists to assure the delivery of quality care. The RN will provide supervision of the Home Health Aide according to CMS Guidelines.

6. COMMUNICABLE DISEASES

- a. PCA expects provider agencies to follow procedures recommended in the Center for Disease Control (CDC) guidelines and OSHA regulations. Agencies are responsible to provide appropriate In-services regarding these universal precautions. (A training tape is available from CDC upon request. The CDC toll-free number is 1-800-232-4636).

Home Health agencies are also required to provide appropriate protective articles such as, but not limited to, aprons, gloves, masks, and gowns as needed.

- b. The provider shall notify the PCA Service Coordinator upon determining or learning from

another source that a consumer has a communicable disease.

- c. Before being assigned to a case, and annually, all consumer-contact employees shall have a Mantoux Intracutaneous PPD test according to CDC recommendations and, if the results are positive, it will be followed by appropriate physician directed treatment.

In order to continue employment, the employee must be free of active TB. Verification by a physician that the employee is free of TB must be in the personnel file and updated annually. Chest X-rays are required based on physician's advice.

E. PEST CONTROL / FUMIGATION: STANDARDS

(Please Note: Not accepting new Providers).

The Provider must ensure that Pest Control / Fumigation workers:

- a) Be 18 years of age or older.
- b) Have the ability to carry out the tasks outlined in the consumer's care plan authorized by the AAA.
- c) Have the required skills to perform pest control / fumigation services as specified in the consumer's service plan.

All pest control / fumigation services provided must be consistent with the care plan authorized by the AAA.

The provider must have a system in place to verify dates, times and tasks performed by the pest control / fumigation worker and that the information is consistent with the consumer's care plan.

1. DESCRIPTION OF ACTIVITIES

- a. Pest Control / Fumigation Services - service should only occur to ensure the consumer's health or welfare;
- b. Heavy cleaning;
- c. Dumpster rental - Dumpster rental may be required on a temporary job specific basis for the purposes of intensive home repair, ground maintenance, or major clean up. Monthly maintenance fees would not be covered;

2. STANDARDS FOR PEST CONTROL / FUMIGATION WORKERS

- a. Qualifications and selection of pest control / fumigation workers must follow personnel policies that include:
 - (1.) Pest Control / Fumigation workers must have the ability to understand and carry out simple instructions.
 - (2.) A personal interview and follow-up of references provided by the workers. Documentation of follow up must be incorporated into the worker's personnel file. Appropriate references include:
 - (a.) one verifiable work reference indicating a minimal length of employment of two years or,
 - (b.) one verifiable work reference if employed less than two years plus one verifiable personal reference,
 - (c.) two verifiable personal references.
 - (3.) In recruiting, there must be assurance of compliance with Title VI of the Civil Rights Act of 1964.

- (4.) Agencies that provide pest control / fumigation services must assure that pest control / fumigation workers comply with federal, state and local health requirements related to communicable diseases. All field staff must receive a PPD test - the results of which are maintained in their files.
- (5.) There must be documentation that any worker who transports consumers in the line of duty possesses a currently valid driver's license and appropriate insurance.
- (6.) Workers must receive a copy of a job description, personnel policies and wage scale for the position.

3. TRAINING STANDARDS

- a. Pest Control / Fumigation Workers must be oriented to the purpose and background of AAA Programs.
- b. No specific pre-service training is required of pest control / fumigation workers, however, they must demonstrate knowledge and ability to perform the activities assigned. Methods for determining this include but are not limited to:
 - (1.) previous job experience,
 - (2.) verification by previous employer,
 - (3.) of a questionnaire testing the worker's knowledge.
- c. Providers must establish regular in-service training for staff. Topic areas must include:
 - (1.) principles of cleanliness and home safety,
 - (2.) communication with older persons,
 - (3.) understanding aging and functionally impaired persons,
 - (4.) observing, appraising and reporting changes in consumers' situations.
- d. Documentation of demonstrated skill and in-service training must be maintained as part of the worker's personnel record.

4. RECORDS AND DOCUMENTATION

- a. Providers must maintain service records that include a service order for tasks to be performed and a report form requiring a consumer's signature verifying the length of time spent and satisfactory completion of the service.
- b. Report form for the pest control / fumigation workers to document changes or other observed consumer problems.
- c. AAA must maintain records required by the Department of Aging for program and financial reporting.

- d. AAA (or its subcontractor) must maintain service records that include a service order for tasks to be performed and a report form requiring a consumer's signature verifying the length of time spent and satisfactory completion of the service.

5. SERVICE REPORTING

Persons providing pest control / fumigation services must comply with all reporting requirements as specified by the Area Agency on Aging.

6. SCHEDULING

Days and times scheduled for pest control / fumigation must be consistent with the Care Plan provided by the AAA.

7. CONFIDENTIALITY

All agencies who provide pest control / fumigation services must comply with all federal, state and local laws relating to research on human subjects and consumer confidentiality.

Agencies must provide all Service Coordinators with consent forms and approval from all appropriate review boards for those consumers who wish to be part of a research study.

E. 1. PEST CONTROL / FUMIGATION - SERVICE SPECIFIC OPERATIONAL PROCEDURES

Pest Control/Fumigation services will be provided via both Providers with OPTIONS agreements and by Consumer Reimbursement. To be eligible for reimbursement, the provider chosen by the consumer must be a licensed Pesticide business as outlined in “7 PA Code Chapter 128 – Pesticides”. The Care Manager or other designated AAA staff person must inspect the consumer’s home upon completion of this service prior to reimbursement to determine that the work has been completed in a satisfactory manner.

For OPTIONS Providers, the following Operational Procedures delineate further expectations and “best practices” for Providers serving Philadelphia Corporation for Aging (PCA) consumers.

Note: Pest Control/Fumigation service will not be provided to LTC consumers residing in public housing, subsidized housing, etc. as these entities are responsible for providing this service for their residents.

1. SCHEDULING

- a. Once the referral is made, the provider must contact the Service Coordinator within 24 hours if unable to meet the request for service. After accepting a referral, completion of the service is expected within fifteen working days maximum of receipt of a service order. Any anticipated delay will be immediately communicated to the Service Coordinator.
- b. PCA expects prompt and courteous service to be provided to consumers. Completion of the service is to be within five (5) working days, of receipt of the service order. The provider will notify the Service Coordinator of the date that the job is to be performed at the consumer’s residence. The Service Coordinator must be notified immediately if performance will be delayed.
- c. No Pest Control/Fumigation service is to be performed by the provider without the service order. Immediate requests for service may be referred to a provider through a verbal authorization; however, a service order must be initiated.
- d. The specific time and day for which service is scheduled shall be at the consumer’s convenience. There is no restriction on providing service on Saturdays and Sundays, assuming full consumer agreement; however, PCA will not reimburse at a higher unit cost for such service.
- e. Providers are required to notify the Service Coordinator and document when a consumer has refused service, not available for service, or when access to the property has been denied.
- f. Should the provider not adhere to the follow-up schedule, PCA may deny payment for follow-up units invoiced by the provider that is not consistent with the authorized service delivery pattern.

2. IDENTIFICATION OF PEST CONTROL/FUMIGATION WORKERS

All Pest Control/Fumigation workers will be given provider issued photo identification cards. Photo identification must be shown prior to entry into consumers' homes and must be visible at all times when in consumers' homes.

3. ASSESSMENT/ESTIMATE

- a. The provider must complete an initial assessment of the problem area and provide an estimate for correction of the pest infestation. The assessment/estimate visit must occur within three (3) working days of the referral. The provider's assessment must include identification of the problem, the proposed plan of treatment, and the expected duration of treatment. The provider will follow up with the Service Coordinator within three (3) working days of the assessment/estimate visit to discuss their findings. The Service Coordinator will generate a service order based on an agreed upon course of action based on the findings of the estimate visit. The Service Coordinator will help with any special arrangements needed, such as the consumer leaving for a period of time, preparation of the consumer for expected disruption, arrangements for others to be there during the job, arrangements to get into the home, etc.
- b. Special consideration is to be given to the type of supplies used in relation to their potential for causing allergic or other reactions. If a consumer cannot be removed during the Pest Control/Fumigation, the provider shall have alternate treatments available.
- c. If, during the assessment visit, the provider observes work needed, but not requested by PCA, they will contact the Service Coordinator to discuss the observations. The Service Coordinator, prior to the provision of service, must approve any deviation from the plan outlined during the evaluative visit by subsequently issuing a modified service order.
- d. Pest Control/Fumigation supplies, and any other usual equipment needed, shall be the responsibility of the provider agency and shall be reflected in the unit price negotiated with the Business Administration Department of PCA.

4. PEST CONTROL/FUMIGATION SERVICE

Pest Control/Fumigation service is defined as an intervention required to eliminate infestation of roaches and related household insects, fleas, lice, mites, maggots, termites, and rodents. Pest Control/Fumigation is a service that can be provided directly by a provider or through a subcontractor. Pest Control/Fumigation may be requested exclusively or along with other service such as heavy cleaning. Pest Control/Fumigation service consists of several categories of treatment identified as follows:

- a. **Assessment/Estimate:** An overall estimate and assessment of the pest infestation, to be completed prior to any authorized Pest Control/Fumigation service. An assessment report (form) must be completed, identifying the problem, the proposed plan of treatment, the expected duration of treatment, and outcomes leading to the problem's resolution.

- b. Initial Pest Control/Fumigation - Authorized intervention based on the plan of treatment proposed as a result of the assessment that can include:
1. Baseboard / Crack and Crevice Treatment – spray application of liquid type, low odor insecticide, usually of a non-petroleum base, in all rooms in household.
 2. Gel Application - Consists of thick brown gel, with a sweet odor that roaches find appetizing. Gel bait advantages:
 - Food and dishes do not have to be removed from cabinets.
 - Odorless application is used so that consumer does not need to leave premises.
 - Gel has a longer residual effect than a liquid application.
 3. Rodents
 - (1.) Treatment to place baits and glue traps in rodent pathways.
 - (2.) Seal rodent entry holes with a foam sealant, mesh, or plugs.
 4. Baiting – Baiting for roaches, water bugs, ants, etc., used when a consumer cannot leave the house for a fogging/bombing, or has a respiratory problem.
 5. Gnats and flies – require special catcher traps and different surface applications. PCA expects Pest Control/Fumigation providers to treat the entire home in order to maximize effectiveness of the intervention.
- c. Follow up Pest Control/Fumigation: An authorized repeat of the Pest Control/Fumigation treatment, on a pattern basis, until the problem is resolved.
- d. Special Pest Control/Fumigation: Special Pest Control/Fumigation is a prior approved intervention to be used when a severe infestation of the types of pests identified under the Initial Pest Control/Fumigation (B. above) is present. Note: a Special Pest Control/Fumigation service is defined as an intervention that requires a completion time of between three (3) and eight (8) hours. The provider will document the start and stop time of this service through the use of time-slips or work logs. Special Pest Control/Fumigation is authorized only after the completion of an assessment, which identifies the problem, the proposed plan of treatment, and is subject to LTC's policy and procedures regarding the ordering of the service. Special Pest Control/Fumigation services should consist of a different form of treatment and/or a different type of application.

Special Pest Control/Fumigation Problems and Treatments

- (1.) Fogging/bombing – Fogging and bombing treatments, used especially in such instances of severe infestation of roaches, fleas, mites, etc. The fogging chemical is used to saturate and cover the area being treated. Consumer precautions with this intervention include:

- (a.) Removal of foods and dishes from cabinets and cupboards.
- (b.) Close all windows and extinguish all pilot flames.
- (c.) Cover any fish tanks; remove all pets and clear baseboards for application.
- (d.) Remain out of premises for three (3) to four (4) hours.
- (e.) Upon entering, ventilate household before re-entering.
- (f.) In the treatment of fleas, the following additional actions must be taken:
 - (i.) All floors must be swept or vacuumed.
 - (ii.) All carpets and furniture must be sprayed.
 - (iii.) For maximum results, two treatments, seven to ten days apart, are recommended.

Note: treatment for flea infestation also requires the consumer and/or caregiver to make arrangements for “dipping” all household pets, however this would not be the responsibility of the Pest Control/Fumigation provider.

(2.) Termites: Wood destroying insects require putting a chemical barrier around the premises, both interior and exterior. This process involves both drilling and trenching, and any other intervention as deemed appropriate in the industry’s certification standards. The provider must detail all proposed activity of the intervention/treatment.

(3.) Bed Bugs: Both chemical and heat treatments can be available for this type of infestation. The provider must detail all proposed activity of the intervention treatment. The provider must insure the safety of all occupants and protect all household items as well as adhere to all industry certification standards.

e. Heavy Cleaning

(1.) Heavy cleaning is cleaning requiring substantial effort. Generally, moderate to severe dirt has accumulated in normally used living areas, and extremely uncomfortable conditions and/or extraordinary filth may be present. Such conditions may be due to uncontrolled pets, lice or fleas, and/or waste or debris build-up. Window cleaning and/or a severe rug problem may also exist. Heavy cleaning is done for persons who have been unable to meet independently the cleaning needs relating to a sanitary environment and where no resource in the family or community exists. The tasks requested by PCA will vary from case to case.

Note: general outside cleaning may include collection and disposal of trash and window cleaning. It does not include gardening or snow removal.

(2.) Needed cleaning supplies shall be provided by the provider agency, unless during the estimate visit, it has been determined and agreed that the consumer would prefer to provide these supplies. If a consumer cannot be removed during cleaning, the provider shall have available a range of cleaning materials. Special consideration is to be given to the type of supplies used in relation to their potential for causing allergic or other reactions.

(3.) Hours of Service

(a.) Ordering - PCA will order heavy cleaning and indicate whether a dumpster (or hauling) is needed. The provider is expected to provide and schedule the ordered service based on the exact requests. Any difference of opinion should be communicated immediately to the appropriate PCA staff person, as any deviation in service or billing, not approved by PCA, will result in non-payment of the invoiced hours.

(b.) 21-Hour Limit - Any job estimate that exceeds 21 hours (22 hours or more) must be approved by the Service Coordinator Supervisor before work is begun.

(c.) Hourly Rate Computation - The estimated hours represent person hours. For example, three people working together for eight hours would be 24 person hours for a 24-hour estimate. The hourly rate is the charge per person, per hour. Actual person-hours are to be documented through the use of time-slips.

Note: Hourly costs for estimating and inspection shall be included (loaded) in computing the hourly rate and shall not be billed as hours worked.

f. Hauling

(1.) Hauling is requested only with Heavy Cleaning and is to be billed separately, at a prior approved, individualized price, based on prices quoted as part of price negotiations.

(2.) Hauling is only considered appropriate when it requires the use of a dumpster/special truck for removal of extreme accumulations of trash. When requesting approval, the nature of the material to be removed shall be specified as substantiation for the size of the dumpster/truck indicated.

g. Work Inspection

(1.) A home visit to the consumer after completion of the work shall be made by an identified person from the cleaning provider to inspect and certify that the work performed meets the original plan, has corrected the initial conditions and is of high quality. Any variances from the requested plan found at inspection shall be corrected prior to final certification by the provider agency.

(2.) It is expected that if, at the time of the inspection, the work does not meet quality standards, the provider will take action immediately to correct the situation. If the desired level of correction has not been met through extenuating circumstances, not related to the provider, the Pest Control/Fumigation provider will communicate the observations to the consumer's Service Coordinator.

h. Work Completion Notification

(1.) The consumer's Service Coordinator shall be called to report that the work has been completed, including any other appropriate observations, within 24 hours of verifying that the work performed meets the quality standards of the Pest Control/Fumigation provider.

(2.) If direct contact cannot be made, the Service Coordinator's Supervisor shall be notified. If suitable contact cannot be made within the required time frame, a written message shall be sent immediately to the Service Coordinator.

i. Follow-up

(1.) The Service Coordinator is expected to visit, or contact when appropriate, the consumer within 5 days of completion of the job to verify the results and determine if the work requested satisfies the purposes defined in the consumer's care plan. If the results are unsatisfactory, the Service Coordinator will contact the provider directly and work out a resolution.

(2.) If tasks not originally requested are identified, a follow up service order will be arranged with the provider, following normal procedures.

5. REPORTING REQUIREMENTS

a. Service Activity Reports

(1.) A consumer-by-consumer listing of all cases referred for service, estimated for service, or completed during the week, shall be completed by the provider.

(2.) The report is to be kept on file at the agency for review by PCA during regular monitoring, or it may be reviewed as a separate audit. Should there be a concern or specific issue observed at the consumer's home, it may be indicated on the service report, and the provider may forward it to the Service Coordinator.

(3.) Issues requiring immediate follow up should be communicated to the Service Coordinator. In their absence, the Service Coordinator Supervisor, or the Supervisor on call should be contacted. It is expected that reporting requirements will be strictly adhered to.

(4.) Service Activity Reports shall be the basis for invoicing submitted by the provider agency. Figures on the Pest Control/Fumigation Service Activity Report are to be based on dated time slips signed by the consumers and workers, which show actual hours of work provided to each consumer, as indicated on the service order. Appropriate information, including time slips, is to be maintained in the

provider agency's records for justification of the reports submitted, and is subject to periodic review by PCA staff.

(5.) The provider shall obtain the consumer's signature (or that of other authorized representative) on a time slip or other standardized form each time a service is delivered to a PCA consumer. Consumers must be given a copy of the signed form as a confirmation of delivery of service. It is recommended that providers utilize multi-part forms so that the consumer can receive their copy as an acknowledgement of the receipt of service on the given day.

b. The provider agency is encouraged to report any concerns it may have about a consumer based on worker/supervisor observations. The report may be verbal or written, and is to be submitted to the Service Coordinator and the PCA Contract Manager.

6. STAFF QUALIFICATIONS

a. Exterminators:

(1.) All Exterminators must pass the required state exam, possess a state license with the category identified, i.e. commercial, pest control and/or termite, and possess State registration. Exterminators must maintain Environmental Protection Agency (EPA) tickets on file for all work done.

(2.) Good physical and mental health, sensitivity to feelings and needs of others, and maturity of attitude toward work assignment.

(3.) Ability to work under supervision as an employee of the agency.

(4.) Ability to communicate orally with the consumer.

(5.) Honesty and good personal grooming habits.

(6.) Assurance that there is no communicable disease.

b. Administrative Staff:

(1.) All of the above qualifications for Exterminators.

(2.) Ability to complete required assessment forms, estimates and ancillary forms accurately.

(3.) Ability to give direction and training to assure compliance with PCA standards, procedures, etc.

(4.) Ability to organize and track the scheduling and completion of work.

7. TRAINING

The Pest Control/Fumigation provider is expected to provide orientation for new workers before assignment to a PCA case. This may be done on a one-to-one basis, or in a group

session. The orientation must include a description of the policies of the provider agency, and an introduction to the LTC Program. Particular emphasis must be provided on the role of the Service Coordinator in developing the care plan and managing the consumer's services. Ongoing communication with the Service Coordinator must also be highlighted.

8. ADMINISTRATIVE CHANGES

When changes occur on the administrative level, the PCA Contract Manager is to be notified in writing, in advance, if known, or immediately upon such change.

9. COMMUNICABLE DISEASES

a. When caring for consumers with communicable diseases, PCA expects providers to follow procedures recommended in the Center for Disease Control (CDC) guidelines and OSHA Regulations. Agencies are responsible to provide appropriate in-services regarding universal precautions. (A training tape is available from CDC upon request. The CDC toll-free number is 1-800-232-4636.)

The provider is also required to provide appropriate protective articles such as, but not limited to aprons, gloves, masks, and gowns as needed.

b. Based on CDC guidelines, the provider shall develop a written policy regarding communicable diseases. That policy must meet State/Federal requirements.

c. The provider must follow CDC and OSHA Guidelines regarding the disposal of contaminated needles.

d. The provider shall notify the PCA Service Coordinator upon determining or learning from another source, that a consumer has a communicable disease.

e. Before being assigned to a case, and annually, all consumer-contact employees shall have a Mantoux Intracutaneous PPD test according to CDC recommendations, and if the results are positive, it will be followed by the appropriate Physician directed treatment.

In order to continue employment, the employee must be free of active TB. Verification by a Physician that the employee is free of TB must be in the personnel file and updated annually. Chest X-rays are required based on Physician advice.

f. All employees must be offered and/or receive the Hepatitis B Vaccine as designated by OSHA Regulations.

F. PERSONAL CARE AND HOME SUPPORT: STANDARDS

Consumers receiving Personal Care services must need some degree or amount of hands on Personal Care service to assist with the completion of activities of daily living (ADLs) during each authorized visit. This requirement does not preclude the simultaneous provision of home support services; however, it serves to ensure that personal care service is the primary service being provided during the authorized visit.

Consumers receiving Personal Care services must reside in a private home or apartment.

The AAA must only enter into contracts with Personal Care providers who are in compliance with “28 PA Code Chapter 51 (General Regulatory Requirements)” and “28 PA Code Chapter 611 (Home Care Agencies and Home Care Registries)”.

All personal care services provided must be consistent with the care plan authorized by the AAA.

The provider must have a system in place to verify dates, times and tasks performed by the personal care worker and that the information is consistent with the consumer’s care plan.

The provider must have documentation to support services delivered including date, time, and what actual services were delivered.

Training Standards for Personal Care Workers:

The Provider is responsible for ensuring that all personal care/home care workers receive the basic training that includes competency requirements as listed in “28 PA Code Chapter 611 Home Care Agencies and Home Care Registries” and ensure that the worker receives specific training for tasks identified in the consumer’s care plan.

1. ACTIVITIES

Personal Care is the provision in a consumer’s home of “hands-on” care related to a personal hygiene or functional activity of daily living that an individual cannot meet independently. Personal Care may only be provided in accordance with the care plan developed. The following list of activities can be considered in provision of this service:

- a. Bathing - assistance to the consumer with bathing in the tub, shower or bed. (Totally dependent, bedridden consumers who are unable to direct the bathing activity by the Personal Care worker, and/or are unable to provide any assistance in washing themselves or are unable to move independently in bed are not appropriate for bathing by a Personal Care worker. However, when care is under nurse management, a Personal Care worker can augment the medically supervised care as long as the Personal Care tasks are limited to those allowed under the Personal Care definition.)
- b. Skin Care - the routine application of lotion to unbroken, uninfected, disease-free skin surface.
- c. Mouth Care - assistance in care of teeth and mouth including care of dentures.

- d. Dressing - includes assistance with clothing as well as application of previously self-applied prostheses.
- e. Grooming - includes hair care, shaving, cleaning and filing of nails. (The diabetic consumer's toe nails may not be cared for by the Personal Care workers.)
- f. Toileting - includes assistance with transfers on and off commode or toilet, emptying commodes and catheter bags.
- g. Ambulation and Transfer - includes steady support and supervision to assist a consumer with walking and transferring.
- h. Change of Position or Turning Consumer - does not include range of motion exercises, except when such care is under nurse management.
- i. Feeding - which may also include mashing of food for easier management and/or assistance in preparation and serving a meal.
- j. Medication - assistance with self-administered medication. Assistance is limited to reminding the consumer to take medications, placing medication within consumer's reach, obtaining the necessary equipment, pouring water for oral medication, opening bottle caps, checking dosage, storing the medication and reassuring the consumer that he/she has obtained and taken the correct dosage.
- k. Observation - reporting of changes in consumer conditions and needs as observed during performance of personal care.
- l. Instruction to Informal Caregivers - in the delivery of the above-listed activities.

Personal Care service may also include provision of supplemental home support services as long as the primary service rendered is for personal care. These activities may include:

- washing dishes and clean-up after meal preparation,
- making beds and linen change for the consumer,
- shopping for the consumer,
- washing the consumer's personal laundry,
- light housekeeping essential to maintaining a healthful living environment for the consumer,
- preparing and serving nutritious meals,
- assistance with home and simple money management.

2. STANDARDS FOR PERSONAL CARE PROVIDERS

Persons providing Personal Care services are usually Personal Care Aides, but can be Home Support Workers, who have been properly trained, Home Health Aides or Licensed Practical Nurses.

- a. Qualifications and selection of Personal Care workers shall follow personnel policies that include:

- (1.) A personal interview and required follow-up of personal and employment references must be completed.
- (2.) Recruited workers must provide appropriate references:
 - (i.) one verifiable work reference indicating a minimal length of employment of two years;
 - (ii.) one verifiable work reference if employed less than two years plus one verifiable personal reference;
 - (iii.) two references from instructors and/or supervisors from an acceptable homemaker training program;
 - (iv.) two verifiable personal references.
- (3.) There must be assurance of compliance with Title VI of the Civil Rights Act of 1964, as amended, in recruiting.
- (4.) There must be assurance of applicant's ability to read, write and follow simple instructions.
- (5.) In order to make available a variety of competencies, efforts should be made to recruit Personal Care workers with knowledge of language and/or skills which address the special needs of older chronically ill individuals.
- (6.) Agencies that provide Personal Care services must assure that Personal Care workers comply with federal, state and local health requirements related to communicable diseases. All field staff must receive a PPD test - the results of which are maintained in their files.
- (7.) Personal Care workers shall receive a copy of a job description, personnel policies and wage scale for workers at the time of their employment and when there is a revision or change in these policies.
- (8.) Wage scale shall be in conformity with applicable minimum wage laws. Compensation for overtime work shall be provided in accordance with current federal and state law.
- (9.) The AAA is responsible for assuring that provider agencies will schedule and serve all consumers authorized for service without regard to race, religion, national origin, age, physical condition, functional limitations or medical diagnosis.

3. TRAINING STANDARDS

Each person providing Personal Care service shall be trained for all services to be performed.

- a. Such training shall be given in an organized course and include content related to:

- (1.) orientation to the service,
 - (2.) interpersonal skills and understanding family relationships,
 - (3.) working with older persons,
 - (4.) personal care and rehabilitative care skills,
 - (5.) care of the home and personal belongings,
 - (6.) safety and accident prevention,
 - (7.) home, time and money management,
 - (8.) food nutrition and meal planning.
- b. For each broad area of the training an appropriate professional shall provide instructions. A registered nurse (RN) must provide the skills training in personal care techniques.
- c. Evidence of proficiency in skills and competency exam shall be documented in the Personal Care worker's personnel file.
- d. No Personal Care service may be rendered by a Personal Care worker prior to demonstration of his/her competency in performing the specific service assigned.

4. SUPERVISION STANDARDS

A Registered Nurse must be included in the supervision of all Personal Care workers. A nurse supervisory review visit is made to the consumer's home, on assignment of the Personal Care Aide to the consumer, then every sixty days (if licensed as a health care agency) or ninety days (if licensed as a home care agency) thereafter.

The purpose of the on-site, in-person nursing supervisor review visit is to review the status of the consumer, to review the services recommended by the site, to identify special care instructions or training requirements for the aide assigned to the case, to be able to establish schedules and give assignments to the aide, to monitor aide performance, to provide for continuity of care with other involved caregivers and to review specific consumer needs with service implications.

As part of the nurse supervisory review visit, the R.N. is responsible for identifying changes in the consumer's status and/or needs and a review of the provider's plan of service to include a professional recommendation on the appropriateness of the service rendered. This portion of the report should be shared with the Service Coordinator and the physician of record. The report should also include a Personal Care worker daily log of service which indicates arrival and departure time, specific services provided and tasks performed and comments and observations about the consumer's response to service. This portion of the report should also be shared with the Service Coordinator.

When there is more than one agency involved in providing care to the consumer, combined supervisory visits with the Home Health Agency Registered Nurse may be made with the aide(s) to provide for coordination of care.

5. RECORDS AND DOCUMENTATION

Records shall be maintained for each individual for whom the service is provided and shall be maintained in a confidential manner. All entries by the Personal Care worker and the supervisor shall be signed and dated. Individual time slips must be signed by the consumer or family member/caregiver and the personal care worker to document each unit of service billed.

a. The record should contain:

- (1.) data that identify the consumer,
- (2.) current care plan,
- (3.) the written assignment to the worker,
- (4.) Personal Care worker daily log of service which indicates arrival and departure time and specific services provided,
- (5.) worker's comments and observations concerning the consumer's condition and his/her response to service including the reporting of changes and/or problems to the supervisor,
- (6.) a record of supervisory visits,
- (7.) statements of any change in consumer's condition as observed and reported by the Personal Care Workers and acknowledged by the supervisor;
- (8.) statements of follow up taken by the supervisor, including reporting to the Care Management Unit of the AAA.

6. SERVICE REPORTING

Persons providing Personal Care services must comply with all reporting requirements as specified by the Area Agency on Aging.

7. SCHEDULING

Days and times scheduled for Personal Care services must be consistent with the Care Plan provided by the AAA.

8. CONFIDENTIALITY

All agencies who provide Personal Care services must comply with all federal, state and local laws relating to research on human subjects and consumer confidentiality.

Agencies must provide all Service Coordinators with consent forms and approval from all appropriate review boards for those consumers who wish to be part of a research study.

F. 1. PERSONAL CARE AND HOME SUPPORT - SERVICE SPECIFIC OPERATIONAL PROCEDURES

These Operational Procedures are a supplement to the Personal Care and Home Support Standards. They delineate further expectations and “best practices” for providers administering care to Philadelphia Corporation for Aging (PCA) consumers. When there is a difference between Personal Care or Home Support Standards and the PCA’s Service Specific Operational Procedures, the more stringent requirement prevails. (For consistency, the providers’ Personal Care and Home Support workers are herein referred to as “aides”).

Personal Care Agencies and other providers must be licensed/registered by the Pennsylvania Department of Health as required under Act 69 of 2006 and Title 28 Pa. Code Chapter 51 and 611.

1. INTAKE

- a. The Service Coordinator contacts the provider, selected by the consumer, to make the initial referral. The request for service will be based on a plan of care developed by the Service Coordinator in conjunction with the consumer and/or caregiver. The plan will identify tasks to be performed and specific days and times for service. **Once a referral is made, provider must contact the Service Coordinator within two (2) business days if unable to meet the request.**

NOTE: Providers must keep the PCA Contract Manager current on their capacity to provide services. They must notify the PCA Contract Manager immediately when having difficulty providing service in their designated service area(s), experiencing staffing problems, or when experiencing any other problems that impact their ability to accept referrals and/or deliver service to PCA consumers.

- b. LTC staff will telephone personal care providers to make the initial referral. A service authorization – Service Order, will be forwarded to the provider upon acceptance of the referral.
- c. A copy of the LTC Personal and Home Management Care Plan will be left in the consumer’s home, and a copy will be forwarded to the provider electronically, with the service order, via the PCA website. This plan includes the tasks to be performed and the specific days and times for the visit. Any errors or questions regarding the information on both the Service Order and the Personal and Home Management Care Plan must be immediately brought to the attention of the PCA Service Coordinator. Please note: care plans will only be sent with the initial or modified Service Orders. Also, Personal care services cannot be provided at the same time as Personal Assistance Service, Home Support Service or Home Health Aide Service.
- d. PCA will order service for specific blocks of time, i.e. number of hours and number of days per week, to provide specific personal care tasks. Generally, it is expected that service will be provided in one, two, three, or four hours blocks of time, depending on the actual needs of the consumer. Service will usually be requested between the hours of 8:00 a.m. and 6:00 p.m.; however, on occasion, service will be requested before or after the latter times, and PCA expects the provider agency to have the capacity to meet this need.

- e. For consumers who are authorized to receive Home Support only, the frequency for the ongoing support activities should not (in most cases) be more than once or twice per month.

2. SCHEDULING

- a. If the provider cannot meet the service request within 5 working days from receipt of the service order, the Service Coordinator will refer the consumer to another personal care or home support agency of the consumer's choice.
- b. It is expected that service will be provided on Saturdays, Sundays, holidays, and evenings if requested. Reimbursement is at the same rate as daily service. Service must be rendered to consumers in accordance with the care plan and service order.
- c. The initial visit must occur within a maximum of five working days from receipt of the service order. The provider agency will notify the Service Coordinator of the start date and the name of the worker. In cases where the initial visit will be delayed, notification of the delay shall be reported to PCA immediately.
- d. Aides must continue on the same case at the days and times ordered. Should the aide fail to provide service at the assigned time, the provider agency is expected to provide a substitute worker on the day, and at the approximate time scheduled. **When changes are made, both the consumer and the Service Coordinator must be notified.**
- e. Should additional time be needed than what is authorized, the provider must call the Service Coordinator for authorization and an updated service order. **The provider will only be reimbursed for authorized delivered service. Providers may not invoice for staff travel time to and from a consumer's home.**
- f. **Aides must not be assigned to relatives and friends in the provision of service to PCA consumers. Service cannot be provided by a legally responsible person, relative, or legal guardian.**
- g. **No scheduling arrangements are to be negotiated between aides and consumers/caregivers. It is expected that all modifications to the schedule be done by the appropriate administrative personnel.**

3. IDENTIFICATION AND CONDUCT OF STAFF

- a. **All field staff is required to wear professional attire, and be given provider issued photo identification cards. Photo identification must be shown prior to entry into consumers' homes.**
- b. Aides are not permitted to bring family members or friends to the consumer's home.
- c. Aides are not permitted to disseminate neither the consumer's telephone number nor any other personal information.

- d. Aides are not permitted to eat consumers' food, use toiletries, or use other personal items. Use of consumers' phones must be restricted to business use only, with permission from consumer, and used sparingly. No personal calls are allowed.
- e. Aides are not permitted, under any circumstances, to reside with PCA consumers.
- f. Transportation: aides are not permitted to transport a consumer in either the worker's car or a consumer's car. When it is necessary for an aide to use public transportation or her/his own car to perform required duties, and it is agreed upon by the consumer, the consumer is responsible for paying the transportation costs, if additional expense is incurred. (Those costs shall not exceed SEPTA's current round trip bus fare, and the trip must be within a 10-block radius.)

4. SUPERVISION

- a. Supervision of the aides shall be performed directly by a Registered Nurse (RN) Field Supervisor, who is capable of demonstrating and teaching all personal care or home support activities, as ordered on the care plan. The RN must have two years of professional work experience in a health care related capacity. If less than two years, the RN must provide one work reference and one personal reference.

Note: in those instances where the consumer is receiving Home Support Services only, **field supervision can be provided by a designated person** with appropriate training and work experience related to the service being provided.

- b. **The RN, or designated Field Supervisor for Home Support Services, is required to visit each new consumer's home on the first day of service to review the care plan and to observe the worker providing care.** A new consumer is one who is new to the provider agency, and/or to the aide.

PCA requires supervision of the aide, with the worker present during supervision, at a minimum of every 60 or 90 days (depending on licensure); this is also applicable for those receiving Home Support Services only. The RN Field Supervisor or designated field supervisory staff visits each consumer to determine the effectiveness of service given, including:

- (1.) Assuring the worker arrives at and leaves the consumer's home as scheduled;
 - (2.) Making sure the worker satisfactorily accomplishes the tasks outlined in the care plan;
 - (3.) Being aware of changes in the consumer's needs/and or circumstances, and reporting these changes promptly to the provider agency and the Service Coordinator.
- (a.) **In instances where the RN or designated Field Supervisor is unavailable to supervise the aide on the first day of service, and the aide is available to staff the case, the provider may accept the referral. However, the RN or designated Field Supervisor must be present during one of the first three visits to supervise the aide.**

Both the aide and the RN or designated Field Supervisor must be present during that supervisory visit.

- c. Home Health providers involved in the provision of personal care service are expected to continue supervising aides in a manner consistent with the Centers for Medicare and Medicaid Service guidelines, as well as any other regulatory guidelines governing Home Health agencies. In such instances, supervision of aides is expected every 60 days.

A report must be completed by the RN or designated Field Supervisor for each consumer, on the effectiveness of activities carried out by the personal care worker (aide). The report includes changes noted by the aide and observed by the Field Supervisor in the consumer's home. It is expected that the consumer or caregiver, the RN and the aide sign the report. This report will be used to ascertain provider agency compliance with each care plan, monitor consumer progress, and document that the Supervisor visited each consumer. The report must be kept on file at the agency for review by PCA during regular monitoring, or it may be reviewed as a separate audit. Should there be a concern or specific issue observed at the consumer's home, it may be indicated on a Personal Care Supervisory Report, and the provider may forward it to the PCA Nurse Consultant. **Items requiring immediate follow up should be communicated to the Service Coordinator.** In their absence, the Service Coordinator Supervisor, or the Supervisor on call should be contacted. The Supervisor on call is available from 8:30 a.m. - 5:00 p.m. Monday through Friday, to address any concerns that may arise in the Service Coordinator's absence.

- d. Collaboration between the RN or designated Field Supervisor and the PCA Service Coordinator is expected, to ensure quality care. Communication is expected when there is a significant change in the consumer's condition, as well as in the following conditions:
 - (1.) When there are complaints;
 - (2.) When other services such as meals, transportation, etc. are not received;
 - (3.) When the consumer is hospitalized; or
 - (4.) When there is an incident.
- e. PCA requires supervision of Home Support workers at a minimum of every 90 days, with the worker present, as indicated above for aides.
- f. Care Management staff reserves the right to request that a provider conduct more frequent supervision of staff, on a case by case basis, as needed.
- g. Each provider is expected to have established clear policies related to the supervision of staff. The above supervisory requirements are in no way intended to waive a provider's responsibility for supervision of staff and being accountable for its staff.

5. PERSONAL CARE TASKS (Activities of Daily Living - ADLS)

- a. Before assigning an aide to perform tasks, their competency and judgment to perform the tasks safely, effectively, and completely must be evaluated and affirmed

by their RN Field Supervisor. A RN evaluation of an aide's competency and judgment prior to assignment is not necessary for licensed CNA staff.

- b. For a detailed listing of allowable tasks, please refer to the Personal Care and Home Support Standards.

6. HOME SUPPORT TASKS

Personal Care or Home Support service may also include provision of supplemental housekeeping service, as long as the primary service rendered is for personal care. These tasks are provided to persons who are unable to perform some or all of the tasks needed to manage their home, where no resource (or only partial help) in the family or community exists. As with personal care tasks, these tasks will vary from case to case, as indicated on the care plan, and can include:

- a. Meal preparation and serving;
- b. Housekeeping - maintenance of areas used by consumer, to keep the environment in state of cleanliness and safety;
- c. Damp-mopping floors;
- d. Dusting and sweeping;
- e. Vacuuming;
- f. Changing bed linens;
- g. Day-to-day cleaning of the refrigerator (including routine defrosting and assisting the consumer in discarding spoiled food), stove, oven and other appliances;
- h. Cleaning of kitchen and bathroom (including portable commodes);
- i. Trash and garbage disposal;
- j. Personal laundry, including bed linens and towels, washed in the most efficient way, at the closest suitable location for the aide, if there is no washer/dryer;
- k. Marketing, in the most suitable location with consideration to economy and efficiency;
- l. Local errands and/or assistance with food shopping within the neighborhood;
- m. PCA does not expect the worker to assist consumers with financial management.
Aides are not permitted to cash, write, or deposit checks for consumers, purchase money orders, use consumer credit/debit cards for purchases, or be given more than \$50.00 at one time to market or assist with local errands. Receipts must be presented to consumers for any purchase made.
- n. Escort, as identified and/or arranged by the Service Coordinator. **Note: aides are not permitted to transport a consumer in either the worker's car or a consumer's car.**

7. SERVICE VERIFICATION

- a. PCA requires that subcontractors obtain a sample, for verification purposes, using a staff member other than the person providing service, of each consumer's signature at the time service is initiated. If the consumer cannot sign, the signature of a person authorized to sign is to be obtained. The authorized person must sign their own name each time and indicate they are signing for the consumer. An aide signing the consumer's name to a slip will be considered fraud and is strictly prohibited.

- b. **The provider shall obtain the consumer's signature (or that of other authorized representative) on a time slip or other standardized form each time a service is delivered to a PCA consumer. Consumers must be given a copy of the signed time slip or form as a confirmation of delivery of service. It is recommended that providers utilize multi-part forms so that the consumer can receive their copy as an acknowledgement of the receipt of service on the given day.**

Note: provider use of electronic / telephony systems in place of the consumer signature process, described throughout this section, is possible only with PCA prior written approval.

- c. These signed receipts are to be cross-checked with the sample signature and be kept in consumer files or with the billing documents at the subcontractor's office as this requirement will be reviewed by PCA's. No payment claim is to be submitted to PCA without a signed receipt for each individual item or service. Any questionable or missing signatures during a review by PCA or other authorized agent will result in a deduction in the amount billed from the next invoicing period.
- d. The time slip must clearly identify the consumer served, the worker providing the service, the time service started and ended, **including whether A.M. or P.M.**, the dates of service, and consumer's signature each time service is rendered. Time slips for consumers receiving multiple services must clearly indicate service time for the specific service provided.
- e. **Providers are required to use a scheduling system for each aide visiting PCA consumers. That schedule shall identify the aide's name, each consumer to be visited, date, starting and ending time, travel time between visits and break time. Each aide's schedule, combined with the daily time sheets, must back-up that worker's payroll records and hours billed to PCA and/or MA.**

8. STAFF QUALIFICATIONS AND TRAINING

Please note: These training requirements are subject to, and superseded by, the competency, health screening and training requirements in Act 69 of 2006 and Title 28 Pa. Code Chapter 611 for Home Care Agencies.

- a. **All aides** must have good physical and mental health, as evidenced by a Statement of Good Health, from a Physician, which will be made part of the personnel file; and they must demonstrate maturity of attitude toward work assignment.
- b. **Orientation: Personal Care workers (aides) assigned to PCA consumers must meet State standards of certification and have experience with the elderly. The provider agency is expected to provide orientation for new aides before assignment to a case. This may be done on a one-to-one basis, or in a group session. The orientation must include a description of policies of the provider agency, and an introduction to the PCA LTC Program, with particular emphasis on the care plan and the need for strict adherence to tasks/days/hours/and role of the Service Coordinator.**

(5.) **In-Service Training**

- (a.) In-service training sessions must be offered to all aides at least quarterly. The training curriculum should be kept on file and will be reviewed by PCA during regular monitoring.
- (b.) In-service training should include:
 - (i.) Follow-up in content areas introduced in certificate training;
 - (ii.) Relevant trends in service delivery;
 - (iii.) Content areas based on identified problems of aides in providing service;
 - (iv.) Programs on agency policies and procedures are necessary but should not constitute the majority of the sessions.
- (c.) In-service sessions may be conducted by the agency or may include attendance at outside seminars.

9. ADMINISTRATIVE STAFF QUALIFICATIONS

- a. Sufficient administrative staff shall be employed to insure the efficient and effective provision of service. Experience has shown that a ratio of 100 to 125 consumers per Office Coordinator (and Field Supervisor) allows for provision of adequate service.
- b. Coordinators and Field Supervisors are expected to be familiar with the aged and chronically ill, and be sensitive to consumer needs and living situations; thus assuring awareness and ability to match aide with consumer needs. Specific requirements for the RN Field Supervisor are listed under "Supervision" on page 3.

10. STAFFING

- a. When a change occurs on the administrative level, the PCA Contract Manager is to be notified in writing, in advance if known, or immediately upon such change. When the change involves a change in administrative or supervisory personnel, curriculum vitae for the new employee shall be included with the written notification.
- b. The provider agency shall maintain sound personnel policies to minimize personnel turnover, which would adversely affect the delivery of service. Experience has shown that turnover may be minimized by providing competitive wages commensurate with the required job skills, as well as incentives (in the form of bonuses and/or fringe benefits) for workers who have given continuous and satisfactory performance.
- c. **Providers must submit any exceptions to PCA staff requirements to the Contract Manager in the Business Administration Department for review.** Submissions may be done by mail, e-mail, or fax. Staff is not to be assigned to provide services to PCA consumers until an exception has been reviewed and approved.

- d. PCA reserves the right to request the provider to remove individual staff from providing care to specific consumers, or from seeing any PCA consumers.

11. RECRUITMENT OF STAFF

- a. Providers shall establish an effective ongoing program of staff recruitment procedures. Experience has shown that face-to-face involvement between the Scheduling Coordinator and aide, during the recruitment process, facilitates the best provision of service.
- b. When recruiting staff, applicants who meet the following requirements, shall be given priority: public assistance recipients and individuals of minority groups, including men and elderly persons.
- c. Aides may be recruited for either full or part-time service in accordance with the demands of the agency, and the ability of the aide to meet full or part-time assignments.
- d. Individuals with special knowledge, such as different cultural backgrounds, languages, or experience with various groups of older or chronically ill persons, shall be sought by the provider in order to make available a variety of competencies to meet special situations.

12. COMMUNICABLE DISEASES

- a. When caring for consumers with communicable diseases, PCA expects provider agencies follow procedures recommended in the Center for Disease Control (CDC) guidelines and OSHA regulations. Agencies are responsible to provide appropriate In-services regarding universal precautions. (A training tape is available from CDC upon request. The CDC toll-free number is 1-800-232-4636.)

Provider agencies are also required to provide appropriate protective articles such as, but not limited to, aprons, gloves, masks, and gowns as needed.

- b. Based on CDC Guidelines, the provider shall develop a written policy regarding communicable diseases. That policy must meet State/Federal requirements.
- c. The provider shall notify the PCA Service Coordinator upon determining or learning from another source, that a consumer has a communicable disease.
- d. The provider must follow CDC and OSHA Guidelines regarding the disposal of contaminated needles.
- e. Before being assigned to a case, and annually, all consumer-contact employees shall have a **Mantoux Intracutaneous PPD test according to CDC recommendations.** If the results are positive, it must be followed by appropriate physician directed treatment.

In order to continue employment, the employee must be free of active TB. Verification by a Physician that the employee is free of TB must be in the personnel

file and updated annually. Chest X-rays are required based on physician's advice.

- f. All employees must be offered and/or receive the **Hepatitis B Vaccine** as designated by OSHA Regulations.

G. **PERSONAL ASSISTANCE SERVICE (PAS) - SERVICE SPECIFICATIONS**

(Please Note: Not accepting new Providers).

1. Definition

Personal Assistance Service (PAS) is in-home personal care and other approved support activities for consumers with functional disabilities who need assistance to accomplish daily living tasks. The service consists of those basic and ancillary services, which enable eligible consumers to live in their own homes and communities rather than institutions and to carry-out functions of daily living, self-care, and mobility. Primarily, the consumer if he/she were physically able, or family/friends, if available, would carry out these activities.

2. Program PAS Standards

Personal Assistance Service is in-home personal care and other approved support activities for consumers with functional disabilities who need assistance to accomplish daily living tasks. The service consists of those basic and ancillary services, which enable eligible consumers to live in their own homes and communities rather than in institutions and to carry out functions of daily living, self-care and mobility. Primarily, the consumer if he/she were physically able, or family/friends, if available, would carry out these activities.

Personal assistance service is consumer directed care, in which a consumer chooses a service delivery model and is given the opportunity to control the delivery of service prescribed in the care plan.

a. **Standards:**

- (1.) An individual with an assessed need for personal assistance service shall have a choice of directing a portion of his or her care or having an agency direct his or her care.
- (2.) Individuals who are assessed as being cognitively capable to direct a portion of their own care, and are willing to do so, may manage certain aspects of their care or choose to have a caregiver direct their care.
- (3.) An individual who is assessed as being cognitively impaired must not direct his or her care. Such an individual who is assessed as being cognitively impaired may have a caregiver who is willing and able to direct his or her care. Consumers who have objections to being assessed as cognitively impaired shall have immediate and full access to the PCA and PDA hearings and appeals process.
- (4.) An individual consumer, or legally authorized surrogate, may direct the care. "Legally authorized surrogate" is defined as an individual legally appointed to speak, act, and make decisions for the consumer; i.e., power of attorney and /or guardian. The legally-authorized surrogate may not be a paid personal assistance worker.

b. **Services**

- (1.) The individual must currently experience functional disabilities, which result in a substantial loss of capability to perform one or more of the following basic activities associated with the personal care of one's self, and require "hands-on" assistance to fulfill these needs:
 - (a.) Getting in and out of bed, wheelchair, or motor vehicle;
 - (b.) Ambulating, with or without mechanical aids, inside the home;
 - (c.) Routine bodily functions, including eating or feeding (including meal preparation and clean-up) and toileting;
 - (d.) Bathing, dressing, personal hygiene and grooming; and
 - (e.) Health maintenance activities.

NOTE: The need for "hands-on" assistance in completing these basic activities must be the individual's primary need for formal services in order for personal assistance to be the appropriate service response.

The individual must reside in a private home or apartment or be able to reside in a private home or apartment if personal assistance is provided.

- (2.) In addition, personal assistance services may include the following activities, if these activities are ancillary to the above "hands-on" activities which establish the primary need for personal assistance service:
 - (a.) Home Support services including, but not limited to, shopping, laundry, cleaning and seasonal chores.
 - (b.) At the direction of the consumer, assistance with household management tasks.
- (3.) Backup Services - For those consumers who choose to direct their care and not opt for the Agency Employed Model, PCA shall require the consumer to take primary responsibility for arranging backup services. The use of family, friends, and neighbors shall be encouraged since these sources are dependable and usually available on short notice. In the event the consumer is unable to arrange for backup services, PCA or its subcontractor will only be responsible to provide basic services, as defined earlier in the definitions section of this policy, to the consumer until the regular attendant returns. A written statement describing the consumer's arrangement of backup services must be included in the care plan.
- (4.) Supplemental Services - Supplemental services necessary to support personal assistance assessments and service delivery may be appropriate in specific situations. When the services listed below are not otherwise available, PCA may provide them as follows:
 - (a.) Home Health Services, other than those performed by a PAS worker pursuant to the definition of Health Maintenance Activities in this document.
 - (b.) Rehabilitative Therapy for disabled persons, when medically

prescribed for a specific consumer's needs, if PCA has have exhausted all possibilities for obtaining such therapy under other community or third party resources.

- (5.) In addition to being made available during normal weekday working hours, services will be made available to meet individual needs on weekends and before or after normal working hours.
- (6.) The scheduling of personal assistance services shall, to the extent feasible, respond to the special needs of the individual for personal assistance at specific times.

c. **PAS Worker Specifications**

Personal assistance workers are usually neither licensed nor registered nurses. A personal assistance worker is someone chosen by the consumer or appropriate caregiver to meet his/her individualized service needs. Personal assistance workers may be friends and/or relatives of the consumer, but may not be spouses (including common-law spouse), minor children, legal guardian, or power of attorney. All personal assistance workers, including friends and relatives, must meet the qualifications outlined below:

- (1.) Be 18 years of age or older;
- (2.) Have the required skills to perform personal assistance (attendant care) services as specified in the consumer's service plan;
- (3.) Possess a valid Social Security number;
- (4.) Be willing to submit to and pass a criminal record check; and
- (5.) When required by the consumer, must be able to demonstrate the capability to perform health maintenance activities specified in the consumer's service plan or be willing to receive training.

d. **Service Delivery Options**

Based upon their assessed ability and competency, personal assistance consumers should be given the option of choosing a service delivery model which best meets their needs.

(1.) **Consumer Directed Model:**

- (a.) The consumer chooses certain aspects of his/her personal assistance service to manage and PCA or a subcontractor of PCA is responsible for providing the consumer with the remaining aspects of care.

(b.) **Support Coordination:**

When requested by a personal assistance consumer and determined appropriate through the assessment process, PCA will be responsible for making available (either directly or arranged through another source) the elements necessary to support a consumer who chooses the combination service delivery model. These elements include but

are not limited to assistance in performing the following: recruiting and screening attendants; training consumers and personal assistance workers; managing and supervising personal assistance workers. If requested by the consumer, PCA or a subcontractor of PCA will also be responsible to assist those consumers who choose the combination service delivery model for a period of time until the consumer acquires the skills necessary to perform the requisite employer functions independently.

(c.) **Financial Management Services (FMS)**

Financial Management Services (FMS) are supportive services provided only to participants (consumers) who use Combination Model services for some or all of their individual service plan hours. When FMS is provided, the participant is the common law employer of the direct care worker employed under the consumer-employer model. FMS agencies reduce the employer-related burden of participants using the consumer-employer model of services through the provision of appropriate fiscal and supportive services. FMS agencies must have a separate Employer Identification Number (EIN) for FMS.

FMS includes performing the following tasks with the participant's authorization:

- (1.) On behalf of the participant employer, enrollment of the participant into all applicable taxing authorities;
- (2.) Assisting participant to understand their responsibilities as an employer;
- (3.) On behalf of the participant employer, processing employment application package and documentation for prospective individual to be employed (including verifying their workers' qualifications and clearances);
- (4.) On behalf of the participant employer, establishing and maintaining a record for each individual employed and process all employment records;
- (5.) On behalf of the participant employer, preparing and disbursing payroll;
- (6.) On behalf of the participant employer, securing workers' compensation or other forms of insurance and managing the claims;
- (7.) On behalf of the participant employer, withholding, filing, reporting and depositing federal, state, and local income taxes in accordance with federal IRS, state Department of Revenue Services, and local tax bureaus rules and regulations;
- (8.) On behalf of the participant employer, withholding, filing, reporting, depositing and maintaining compliance with the claims and appeals with the Pennsylvania and Federal Unemployment Compensation Bureaus rules and regulations;
- (9.) On behalf of the participant employer, generating and

- distributing IRS W-2's, wage and tax statements and related documentation annually to all member-employed caregivers who meet the statutory threshold earnings amounts during the tax year by January 31st;
- (10.) On behalf of the participant employer, acting on behalf of the participant receiving supports and services for the purpose of payroll reporting;
 - (11.) On behalf of the participant employer, distributing, collecting and processing provider time sheets and attendance data as summarized on payroll summary sheets completed by the participants;
 - (12.) On behalf of the participant employer, establishing and maintaining all FMS related participant records with confidentiality, accuracy, and appropriate safeguards;
 - (13.) Participating in the Commonwealth of Pennsylvania's quality management strategy;
 - (14.) On behalf of the participant employer, purchasing other forms of insurance, including healthcare, as appropriate;
On behalf of the participant employer, verifying weekly service hours in relationship to payroll in order to ensure correct billing, problem resolution, and alternate billing procedures;
 - (15.) On behalf of the participant employer, processing judgments and wage garnishments and requests for employee wage information;
 - (16.) Rescinding or revoking all authorizations when a participant leaves the program;
 - (17.) Maintaining compliance with all applicable regulations and statutes, such as the Bureau of Program Integrity's (BPI) fraud and abuse policies; and
 - (18.) Providing reports and documentation to the Department as requested.

The following forms can be used/modified for these and other related PAS activities: **Fiscal Agent Function, Fiscal Agent and Employment Related Forms, Consumer Selection Option, Service Agreement Between Consumer and Contractor/Provider, Consumer Designation of Primary Responsibility, Consumer/Employer Appointment of Agent, List of Services Agreed to be Provided by Fiscal Agent, Application for Employment, Criminal Record Check Policy for Consumers/Employers, Agreement Between Consumer and Attendant, Time Sheet, Payroll Form, Status Form, Notice of Discontinued Employment, Taxing Agency Forms.**

NOTE: The Fiscal Agent duties described above are currently included in the Monthly Coordination fee for those in the consumer directed Combination Model of service.

- (2.) **Agency Model** - The consumer is not responsible for managing any aspects of his or her personal assistance service. PCA or a subcontractor of PCA

would employ the attendant and manage all aspects of the consumer's personal assistance service.

Supervisory visits must be made to the consumer's home to monitor the performance of the PAS worker. This includes the requirement for the frequency of supervisory visits to be made at a minimum of 60 or 90 days (depending on licensure). In addition, providers and their subcontractors will adhere to those additional supervisory requirements as outlined in PCA's Service Specific Operational Requirements for Personal Care and Home Support, hereby included by reference.

The selected service delivery option will be described in the consumer's plan of care. Supervision of personal assistance worker basic and ancillary activities is controlled by the consumer to the extent specified in the consumer's plan of care. A registered nurse, on staff or in a consultant arrangement with a provider agency, must be available as needed by consumers and/or by the provider agency responsible for delivering the personal assistance service and for ensuring the health and safety of the consumer. Appropriate professional staff must be available to provider agency staff and to consumers to assist in training and to provide consultative support in personal assistance service delivery as needed to ensure the health, welfare, and safety of consumers.

The personal assistance service is necessary to prevent institutionalization and to provide optimum conditions for participating consumers to live as integrated members of society.

e. **Health Maintenance Activities**

Health Maintenance Activities are those activities which are necessary to maintain the consumer's optimum health, as directed by the physician responsible for the consumer's medical/health plan of care. These activities would be carried out primarily by the consumer if he/she were physically able, or family members if available. These activities include, but are not limited to:

- (1.) Catheter irrigations;
- (2.) Administration of medication, enemas, and suppositories; and
- (3.) Wound Care.

f. **Supervision**

Supervision of PAS workers in the Combination Model is to be performed directly by the consumer. It shall be the responsibility of the consumer to supervise the PAS worker in regards to the specified tasks. That responsibility also extends to decisions to discharge the PAS worker, when deemed appropriate.

Note: in those instances where the consumer lacks the necessary skills to properly supervise the PAS worker, PCA or the contract provider will be responsible until the consumer can perform the requisite employer functions independently.

Supervision of the PAS worker in the Agency Model is not the responsibility of the consumer. The contract provider or their designated subcontractor will employ the PAS worker and manage all aspects of the consumer's PAS service. Providers and their subcontractors will adhere to those supervisory requirements as outlined in PCA's Service Specific Operational Requirements for Personal Care and Home Support, hereby included by reference.

g. **Special Program and Cost Concerns**

Health Maintenance Activities - In cases where the personal assistance service (PAS) worker will be assisting the consumer with health maintenance activities, it is required that the consumer have a "medical home"; i.e., that the consumer is enrolled and being seen regularly by a primary care physician in a clinic, HMO or a primary care center responsible for the consumer's medical/health plan of care.

If the consumer chooses to direct his/her health maintenance activities and his/her primary care physician makes a determination that the consumer is capable of directing his/her health maintenance activities, then the PAS worker may perform health maintenance activities under the conditions listed below:

- (1.) The consumer has indicated that he/she has been adequately instructed by the appropriate health professionals and is thereby qualified and able to instruct and supervise his/her attendant in Health Maintenance Activities. A written statement to this effect must be included in the care plan. This statement must be signed by the appropriate health professional (preferably the consumer's physician).
- (2.) The PAS worker is instructed and monitored in Health Maintenance Activities by the consumer, the consumer's physician and/or a health professional (usually a nurse or therapist) as appropriate.
- (3.) The PCA Service Coordinator will monitor Health Maintenance Activities which are part of the care plan to assure that the services are being provided as ordered by the physician. The Service Coordinator will also monitor the consumer's satisfaction with the PAS worker's performance of Health Maintenance Activities, either through routine monitoring visits or through periodic consultation and input from the consumer regarding his/her satisfaction with the service. The Service Coordinator will not monitor the PAS worker's performance of the health maintenance activity. This is the consumer's, consumer's physician and/or health professional's responsibility as appropriate.
- (4.) Disposable items or devices are used in caring for the consumer whenever they are obtainable.
- (5.) The PAS worker's prior experience and work history do not indicate unsafe performance of such activities.
- (6.) The consumer has appropriate arrangements in place to respond to health emergencies; a statement to this effect is included in the care plan.

Information on the arrangements for health emergencies is also made available to the PAS worker(s) either by PCA, its delegate or by the consumer.

- (7.) PCA and consumer must document in the Care Plan who is responsible for providing Health Maintenance Activities and that these persons, if PAS workers, have been trained in the performance of these activities as approved by the consumer's physician.
- (8.) When there is an indication that the Health Maintenance Activities are not being carried out as ordered by the physician, PCA has the right and responsibility to intervene and provide appropriate corrective measures. Corrective measures could involve contacting the physician to make him or her aware of the problem and requesting additional training and/or direction.

h. **Care Management**

Consumers receiving personal assistance service must receive care management in accordance with the program instructions contained in PCA policy.

H. **PERSONAL EMERGENCY RESPONSE SYSTEM (PERS): STANDARDS**

All Personal Emergency Response System (PERS) units need to be certified as meeting the standards for safety and use as outlined in the “National Electric Code, NEC requirements (see Appendix F)”.

The PERS will be leased from an emergency medical response system vendor. Included as part of the monthly charge, the vendor shall, either directly or through subcontracting with another vendor, provide for ongoing provision of on-line emergency response center services for each consumer authorized. This shall include:

- a) Response to consumer testing and daily provider testing.
- b) Self-auditing and quality control.
- c) Repair and replacement.
- d) 24-hour staffing by trained operators of the emergency response center 365 days a year.

Each system shall include:

- a) Installation in the consumer’s home, including any needed phone jack modifications and devices.
- b) Two-way voice communication.
- c) Inactivity timer.
- d) Average range, waterproof, portable help button.
- e) Ability to self-test on-line status of all functions.

All services provided must be consistent with care plan authorized by the AAA.

1. **SERVICES TO BE PURCHASED**

PCA will lease Personal Emergency Response System (PERS) from an emergency medical response system manufacturer (herein called vendor). Units leased will be maintained and guaranteed by the vendor, and will be updated, at no cost to PCA, as technology improves performance.

2. **CERTIFICATION, STANDARDS AND SAFETY**

All PERS installed, shall be certified as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, communications, consumer or other standards, rules or regulations that may apply.

3. **INSTALLATION**

It shall be the vendor's responsibility to deliver and install each PERS unit that is leased. The vendor agrees to complete installation within five working days of receipt of the service order. Services will be billed in the month that PERS units are ordered and installed.

- a. The PCA Service Coordinator will notify the vendor by phone of a request for installation. The vendor shall arrange with the consumer for a mutually convenient appointment within five working days of the vendor's notification by the Service Coordinator.

- b. The vendor shall notify the Service Coordinator of the installation appointment and shall notify the Service Coordinator to confirm that installation has been completed.
- c. The vendor immediately shall notify the Service Coordinator if it is unable to schedule or complete an installation within the required time frame.
- d. The vendor shall provide all parts and equipment necessary for installing an emergency medical response system unit, whether purchased or leased, into a functioning telephone system.
- e. The vendor shall instruct the consumer in the use and maintenance of the PERS and shall provide the consumer with simple written instructions, including how to report a malfunction of the PERS.
- f. The vendor shall, upon request of the consumer or Service Coordinator, provide additional follow-up instructions to the consumer on operating and maintaining the PERS.
- g. The vendor shall forward to the Service Coordinator, within five working days of the installation either by mail or by facsimile, a form signed by a vendor representative or employee and by the consumer or consumer's representative confirming the date of the installation and the consumer's understanding of the use and maintenance of the PERS.
- h. The vendor shall provide the Service Coordinator, consumers, and other persons (as needed to assure care), instructional materials and orientation in the operation of the PERS, stated in simple and understandable language.
- i. If any applicable regulatory, industry, or manufacturer standards are changed, resulting in improvements or updating of equipment, the Service Coordinator shall be notified and each on-line consumer with leased equipment immediately shall be provided with said new equipment.

4. MAINTENANCE OF EQUIPMENT AND SERVICE

- a. Vendor shall maintain all installed PERS in proper working order.
 - (1.) The vendor shall make provision to insure that each installed PERS is operating properly at least once every 24 hours.
 - (2.) Provision for the daily testing will preferable be automated and cause the least possible inconvenience for the consumer.
 - (3.) The vendor shall follow up with the consumer and notify the Service Coordinator within 24 hours, or the next business day of any PERS that is not operating properly. Malfunctioning equipment shall be repaired or replaced within 24 hours of notification or identification.

5. PROVISION OF SERVICE

Vendor shall maintain, either directly or through subcontract, a 24-hour Emergency Response Center staffed with trained emergency response operators. The Emergency Response Center shall perform the activities that follow:

- a. Receive, acknowledge, and establish immediate two-way communication in responding to emergency signals from consumers. The vendor immediately upon receiving a signal from a consumer's PERS, will retrieve the consumer's automated data records, establish immediate two-way voice contact directly with the consumer via the incoming signal, and contact the consumer's representative, or take other emergency action as prescribed in the consumer's record.
- b. Be capable of responding to multiple emergency signals simultaneously.
- c. Respond immediately to any and all signals from consumer's PERS and maintain appropriate contact until termination of the emergency situation.
- d. Notify a third party, consumer-designated representative, (e.g. neighbor, police, Emergency Medical System (EMS), etc.), to respond to an emergency via immediate telephone contact and without interrupting or terminating direct voice contact with the consumer.
- e. The Emergency Response Operator will monitor the provision of emergency service to verify that it has been provided and that the emergency situation no longer exists at the consumer's residence.
- f. Verify resolution of the emergency situation, document the incident, as below, for future reference, and notify the Service Coordinator of the incident within 24 hours or the next business day.

6. SUSPENSION AND TERMINATION OF SERVICE

The decision to remove a PERS is at the sole discretion of the Service Coordinator. For all PERS removals, notification will be by telephone from the authorized Service Coordinator. Written authorization to terminate PERS service will be sent to the vendor on the same day as the telephone notification. If the vendor is notified directly by a consumer's family or other representative to remove the PERS, authorization must first be obtained from the Service Coordinator.

- a. When a consumer with a PERS no longer requires such services, regardless of the reason, the Service Coordinator will discuss with appropriate staff, as needed, and contact the vendor, so that the PERS may be transferred or removed.
- b. When a consumer's services are suspended because of the consumer's admission to the hospital, the Service Coordinator will notify and/or authorize the vendor to take the unit off line. Services will be resumed to the consumer, only after the Service Coordinator notifies the vendor. Payment for leased equipment will be made at the standard unit price as long as a unit remains in the home of a consumer.
- c. The vendor shall disconnect/remove a PERS from a consumer's residence within five working days of notification by the Service Coordinator.

7. SUPERVISION

The vendor shall supervise all staff providing services covered by this contract, at a minimum of once a month. It is expected that there will be a supervisor available during working hours.

8. STAFFING AND QUALIFICATIONS

a. Line Staff Employees Shall Possess:

- (1.) Ability to work under supervision as an employee of the agency;
- (2.) Ability to communicate orally with the consumer and resource personnel with whom they must work, and both orally and in writing with their supervisor;
- (3.) Ability to read, write, follow written instructions, and to converse easily on the telephone;
- (4.) Training and/or paid or volunteer experience of one year or more, specifically related to the skills required to perform as an Emergency Response Center employee;
- (5.) Ability to provide references as follows:
 - (a.) Two verifiable work references, or
 - (b.) One verifiable work reference indicating a minimum length of employment of one year, or
 - (c.) Two references, total, from a supervisor and/or instructors from an acceptable training program.
- (6.) A written test shall be administered to all consumer contact employees, by the vendor, pertaining to proper operation of the system and response to emergencies, or installation and repair of equipment, prior to being assigned on the job.

b. Supervisors

- (1.) Supervisors shall be capable of demonstrating and teaching all job skills needed to perform all aspects of the jobs of their employees.
- (2.) Supervisors shall receive regular supervision by a designated administrative staff person.

c. Administrative Staff

Sufficient administrative staff shall be employed to insure the efficient and effective provision of service under the contract.

d. Consultant Staff

Appropriate other staff shall be available for consultation regarding response, operation, training, or other matters requiring professional input

e. General

The vendor will maintain sound personnel policies to minimize personnel turnover which would adversely affect the delivery of service.

9. TRAINING

- a. In-service training sessions must be offered to all direct consumer contact employees. Subject areas covered should relate to relevant aspects of service delivery, trends or advances in the field, or identified problems or gaps in knowledge. Programs on vendor policies and procedures are necessary but should not constitute the majority of any session.
- b. The vendor will use and have on file, written training materials and procedures.
- c. For staff with demonstrated personal characteristics and abilities, training in how to work with consumers having special mental health or other complex needs, is encouraged.

10. SERVICE REPORTING

Persons providing Personal Emergency Response services must comply with all reporting requirements as specified by the AAA.

11. SCHEDULING

Days and times schedules for Personal Emergency Response services must be consistent with the care plan provided by the AAA.

12. CONFIDENTIALITY

All agencies who provide Personal Emergency Response services must comply with all federal, state, and local laws relating to research on human subjects and consumer confidentiality.

Agencies must provide all Service Coordinators with consent forms and approval from all appropriate review boards for those consumers who wish to be part of a research study.

I. **OVERNIGHT SHELTER: STANDARDS**

This service is intended to serve as a temporary measure to improve the consumer's situation until a more permanent solution can be determined. Nursing Homes providing Overnight Shelter must have an appropriate current license.

1. **GENERAL INFORMATION**

- a. Overnight Shelter is a temporary (generally 24 – 72 hours) and emergent service.
- b. All Overnight Shelter Service providers are trained in the following areas prior to rendering services:
 - (1.) Consumer Rights
 - (2.) Overnight Shelter Service Provider Responsibilities
 - (3.) Fire and Safety
 - (4.) First Aid
 - (5.) Basic Nutrition/Medication Training
 - (6.) Program Philosophy/Mission

2. **STAFF QUALIFICATION**

Agencies that provide Overnight Shelter services must assure that Overnight Shelter workers comply with federal, state and local health requirements related to communicable diseases. All field staff must receive a PPD test, the results of which are maintained in their files.

3. **RECORDS AND DOCUMENTATION**

Overnight Shelter provider must be able to provide documentation of service delivery upon request.

4. **SERVICE REPORTING**

Overnight Shelter providers must comply with all reporting requirements as specified by the Area Agency on Aging.

5. **SCHEDULING**

Days and times scheduled for Overnight Shelter must be consistent with the care plan provided by the AAA.

6. **CONFIDENTIALITY**

All agencies who provide Overnight Shelter services must comply with all federal, state and local laws relating to research on human subjects and consumer confidentiality.

Agencies must provide all Service Coordinators with consent forms and approval from all appropriate review boards for those consumers who wish to be part of a research study.

7. **EXCLUSIONS FROM FFP**

Room and Board

- (1.) Pursuant to 42 CFR 441.10 (a) (3), service providers shall only be reimbursed for room and board costs when Overnight Shelter services are provided in the following facilities:
 - (a.) Medicaid Certified Hospitals and Nursing Facilities;

I. 1. OVERNIGHT SHELTER - SERVICE SPECIFIC OPERATIONAL PROCEDURES

These Operational Procedures delineate further expectations and “best practices” for providers delivering services to Philadelphia Corporation for Aging (PCA) consumers. Where there are differences between these procedures and Pennsylvania Department of Health license requirements and regulations, the more stringent requirement prevails.

1. **Overnight Shelter - Defined**

- a. Overnight Shelter is the intermittent provision of room, board, supervisory and supportive care in a protective setting outside of the consumer’s usual place of residence, which is necessary to maintain the health and safety of the consumer.
- b. Such care must be provided in an **institutional** - Nursing Facility (NF) setting, reflecting the needs of the individual and the regulatory requirements of the setting.
- c. The availability of overnight shelter arrangements are based on individual agreements with service providers, based on a contracted daily rate. Every effort should be made to utilize existing reimbursement sources, such as Medical Assistance, Medicare, and third party payors, PCA shall be the payer of last resort.

2. **Service Authorization**

The need for overnight shelter arrangements must be precipitated by an emergency; such circumstances can include:

- a. The provision of Overnight Shelter in the event that a primary caregiver will be absent for at least eight (8) hours a day, due to health needs of the caregiver and/or an unscheduled event.
- b. The need for a temporary living arrangement, on an emergency basis, to maintain the health and safety of the consumer;
- c. The need to identify permanent housing.

The Service Coordinator or Protective Services Investigator can facilitate placement of a consumer in an overnight shelter arrangement based on the availability of beds at a given facility. Placement can occur during regular work hours, at night, or on weekends. The Service Coordinator will remain actively involved with the consumer, the family, and the facility throughout the placement so as to assure a timely transfer out of the placement and appropriate resolution of the consumer’s circumstances. Supervisory approval is required for use of this service.

3. **Facility Specifications**

- a. **License** - PCA will seek overnight shelter arrangements only with those facilities that are fully licensed by their respective licensing authority:
 - (1.) **Nursing Homes** - such facilities must have current license from the Commonwealth of Pennsylvania Department of Health (DOH),

b. **Standards of Care**

PCA expects that facilities make available to consumers in overnight shelter arrangements the same type and quality of services offered to permanent residents consistent with Federal and State regulatory requirements.

c. **Admission Agreements**

(1.) **PCA - Facility**

PCA's intent is to establish admission agreements with any and all licensed facilities that are willing to provide temporary shelter arrangements, **based of course on the availability of beds**, for appropriate consumers. In order to facilitate appropriate referrals, facilities will need to clearly indicate admission criteria, limitations, ability to accept placements during normal business hours and weekends, and any other limitations.

In instances where the overnight shelter arrangement requires nursing home care, PCA will attempt whenever possible to assure that all individuals referred will have been examined and diagnosed free of an acute mental health disorder, as a primary diagnosis, and be free of tuberculosis or other communicable diseases. Moreover, in **all** instances, PCA will attempt whenever possible to assure individuals needing psychiatric interventions or care will have been directed into appropriate mental health facilities. Whenever possible individuals will also be screened by health care providers and certified that they are not in need of admission to an acute care facility.

PLEASE NOTE: There may be occasions where the Older Adults Protective Services (OAPS) will not have immediate or complete consumer assessment information as described above, e.g. emergency interventions to alleviate immediate risk to a consumer. In such instances, these departments will work with the facility where the placement is being requested to secure appropriate and timely consumer assessment/diagnostic information.

(2.) **Facility - Consumer**

PCA recognizes that every facility has its own admission procedure, which may include a formal admission agreement. Such admission agreements should stipulate the terms of the stay in the facility, and contain a list of those services included in the daily rate and those services for which there are additional charges. Unless informed otherwise by the PCA Service Coordinator at the time of a consumer placement, facilities are not to seek "Financial Guarantee" agreements with consumers, families or caregivers.

3. **Payment Provisions/Invoicing**

It is anticipated that most overnight shelter arrangements will be private pay. However, PCA will request the cooperation of facilities to make every effort to utilize existing reimbursement sources such as, Medicare, Medical Assistance, and other third party payors.

a. **Service Orders**

When a client has been placed in a facility, PCA will forward to that facility a Service Order which represents a written authorization for payment for the anticipated number of days of service. For those Medical Assistance or Medicare eligible consumers, it is expected that the facility or its providers will bill Medicare or MA for any covered services.

b. **Invoices**

Units of service are invoiced on a monthly basis. Claims for consumers will be submitted to PCA via the Automated Billing System (ABS). The invoice will indicate units of service delivered. The daily reimbursement is an all-inclusive rate; no miscellaneous or ancillary charges will be paid without prior approval by the Service Coordinator. Any such approved charges must be supported by appropriate documentation, e.g. receipts, vendor invoices, etc. NOTE: all co-pay billing of services reimbursable by Medicare or Medical Assistance or other insurances must be done through the monthly invoice, unless otherwise noted by the Service Coordinator.

4. Financial Statement

Providers entering into contracts with PCA must be financially solvent and able to demonstrate an ability to meet daily operational expenses. Should a provider enter into bankruptcy proceedings, the Contract Manager must be notified immediately.

J. SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES: STANDARDS

In certain cases when reimbursement for equipment or supplies has been denied by Medicare or other third parties because it does not match the coverage conditions of the insurance, the equipment or supplies can be paid for under the OPTIONS Program if the consumer's physician makes the determination that it is necessary.

The AAA must identify and develop reasonable, appropriate standards for reimbursement for specific services or items and apply these standards consistently in all cases.

1. Conditions

The equipment and/or supply provided is above and beyond those already supplied under the approved state plan.

2. Fiscal Management

Procurement of durable medical equipment, medical supplies and adaptive devices must be achieved by the Service Coordinator in the most cost effective manner available. The decision to rent or purchase equipment from an enrolled provider may vary greatly, depending on types of equipment and consumers.

J. 1. DURABLE AND CONSUMABLE MEDICAL EQUIPMENT (DME) - SERVICE SPECIFIC OPERATIONAL PROCEDURES

The following procedures are a supplement to the Durable Medical Equipment and Supplies (DME) service standards. They delineate further general expectations and “best practices” for providers serving consumers.

1. Provider Eligibility

- a. PCA will certify and contract with only DME providers who are enrolled providers in both the Medicare and Medical Assistance programs. Participation as a service provider is contingent on the following:
- b. Willingness to provide MA/Medicare covered items at the lower of either the provider’s charge to the self-paying public or the respective MA or Medicare fee schedule prices and, when applicable, to use the MA/Medicare prior approval process.
- c. Willingness to provide several non-MA or Medicare covered items at the established prices on the PCA DME list.

2. DME List

- a. Selected items, only, from the Medical Assistance (MA) Program, Medical Supplier Fee Schedule product list will be utilized by PCA. Consumers, independent of the PCA Service Coordinator, may wish to purchase, **on their own or covered by MA, Medicare, or a third party payment source**, items needed as part of their care by a skilled provider or to increase their safety.
- b. PCA’s DME List establishes a limited range of non-MA/Medicare covered equipment (hand held showers, grab bars, air conditioners, a microwave, a fan) that may be ordered for consumers to enable them to remain in their homes. The items on the list are identified by their PCA item number, manufacturer code - where applicable, the item description, and designated price. The list also includes those commonly used MA Fee Schedule items, identified by their PCA number, HCPCS code, and MA rate.
- c. Occasionally a consumer may wish to privately pay for items not on the PCA DME list. In such instance, providers are requested to provide the item at the MA rate or a fair market price and to install it for the same price as indicated in our DME price list. **Items not on the PCA DME price list may not be billed to PCA.**

3. Service Orders

- a. All orders on the PCA DME list will be placed through PCA personnel, only, subject to an established medical necessity and will have been prescribed or ordered by the consumer’s primary physician or other health professional designated by PCA, within the scope of their practice.

- b. If the consumer is eligible to receive the item under Medical Assistance or Medicare, the provider must bill that third party source, using the designated prior approval process – when applicable.
- c. **The provider must have the service order before a delivery can be made or, if applicable, the required authorization under the prior approval process.** In the event the service order is unclear or erroneous, the Service Coordinator must be contacted immediately to discuss the problem. The Service Coordinator will make any needed corrections in the care plan and generate a new service order.

4. **Third Party Billing**

- a. PCA is mandated by the Pennsylvania Department of Aging to pursue all other payment sources for consumers such as Medicare, Medical Assistance, and other third party payers. **Therefore, providers must be knowledgeable about third party billing requirements and are expected to process the necessary forms, including the prior approval process for items whose individual cost is over \$100.00, and contacting the consumer’s physician, as needed.**
 - (1.) Upon the initial contact by the Service Coordinator, the provider must inform them if the item requested can be billed to a third party such as Medicare or Medical Assistance.
 - (2.) Care managers will provide the necessary insurance information and name of the physician, including license number, at the time the order is placed. PCA will not retroactively reimburse a provider if the claim is rejected by such third party payers.
 - (3.) If an item is needed in amounts greater than those allowed or covered by third party, (e.g., MA fee schedule), the excess amount may be ordered by the Service Coordinator and billed to PCA, at the established MA/Medicare fee schedule rate.
- b. It is expected that providers will accept third party reimbursement as full payment for the item delivered, except as mandated for copayment requirements.

5. **Delivery**

- a. The provider must have the capacity to deliver, **within 3 business days**, to the homes of PCA consumers citywide after receiving prior approval and/or the service order from PCA. PCA may request next day delivery on a regular basis for certain items, such as incontinence products. **PCA requires that subcontractors receive a signed receipt for every item delivered to a PCA consumer.** No payment will be made without a signed receipt for each individual item. Delivery charges are included in the prices for all items on the LTC - DME SUPPLY LISTS.
- b. If a provider is temporarily out of stock of a particular item, the PCA staff person ordering the item(s) must be notified by the provider within 2 hours of receipt of the request or service order issued from PCA. The provider may substitute a comparable item of the same or higher quality for the same price, but must discuss this first with

the PCA staff person placing the order. If the item ordered is covered by Medical Assistance or Medicare, the substituted item may NOT be billed to PCA.

- c. PCA requires that providers make NO partial deliveries. Since a follow up visit for medical equipment is often made to instruct the consumers in the use of the equipment, the entire order must be delivered at the same time. If this requirement cannot be met for any reason, the Service Coordinator needs to be contacted immediately to weigh the consequences of the delay, make any changes needed in the order, make any necessary changes in the consumer's care plan, and issue a new service order.
- d. Delivery of the item shall be inside delivery to the client's home and to a specific location inside the home if warranted (for instance assemblage of toilet seat onto toilet).
- e. If the equipment is delivered and the consumer refuses it, PCA needs to know why the equipment was refused (for instance cosmetic reason, consumer no longer wants item, etc.).
- f. Certain items from List C (Incontinence items like diapers or chux) may be delivered by UPS where indicated. **The provider must get the Service Coordinator's approval in all cases where UPS delivery is considered.**

6. Installation and Assembly of Equipment

All providers must agree to install and assemble medical equipment, when necessary, in consumers' homes throughout the city of Philadelphia. PCA defines installation and assembly as follows:

- a. **Installation** - This refers to the installing of air conditioners, microwaves, and wall mounted grab bars and hand held shower hoses. Separate fixed prices for installation of the grab bars and shower hoses are included on page 1, List A. Non-Consumable Medical Supplies.
 - (1.) Air Conditioners and Microwaves:
 - (a.) The air conditioners will be securely installed in the consumer's window, as identified by the Service Coordinator. Packing material will be removed from the consumer's home
 - (2.) Grab Bars: PCA requires the installing of grab bars or shower hoses. PCA relies on the judgment of the installer to determine if an installation can safely be made. If the installer feels that it is structurally unsafe to install wall mounted grab bars where marked by a PCA subcontract therapist, the provider must notify the Service Coordinator immediately. For safety reasons, PCA asks providers **not** to install any wall grab bars on encased shower stalls or bathtub enclosures that are made of fiberglass.
 - (3.) Shower Hoses: PCA asks that providers install shower hoses into the wall and not use the adhesive backing. We also ask the provider to carry washers

and adapters on the truck at the time of doing such installations. Whenever an order for a shower hose is placed, the provider must also take along the Portable hand held shower which fits over faucet because the ordered hose may not fit or the shower head cannot be removed. Please read the third paragraph under “Assembling” concerning the process for billing such an installation charge.

b. **Assembly**

- (1.) Assembling of equipment means putting together any parts of an item and placing it in the designated area where it is to be used (e.g. the raised toilet seat is to be assembled and placed over the toilet per the instructions of the specific order).
- (2.) Assembly of equipment must be provided at no extra charge to PCA or the consumer. If wall mounting of grab bars or shower hoses for consumers is requested, it will be reimbursed according to the LTCO DME Supply List, on page 1 of List A Non-Consumable Medical Supplies (Item A-01-0010 for the first grab bar/shower hose installation at a visit, and item A-01-0020 for each additional grab bar/shower hose installation at the same visit).
- (3.) In the process of assembling an item, it sometimes turns out that it does not fit. In that case, the assembler is not to leave the item at the consumer's home, but to take it back to the provider. The provider must call the Service Coordinator who placed the order, and discuss the nature of the problem and recommend a substitute. In these instances, the consumer's care plan will need to be changed and a new service order with the new price will be faxed to the provider.

7. **Invoicing**

- a. Specific billing instructions and information will be provided by PCA.
- b. **All orders must be billed in the month they are delivered to a consumer. No payment will be made for any item for which the provider does not have a service order.** Any back billing beyond the normal invoice period is not allowed. The Service Coordinator must be notified about any item that was not delivered in the month it was ordered, as this must be corrected in the consumer's care plan. PCA will then generate a new service order to the provider. **It is very important that the provider notifies the Service Coordinator of these changes as they affect invoicing and payment to the provider.**
- c. **PCA requires that providers receive a signed receipt for every item delivered, regardless of payer source, to a PCA consumer. These signed receipts are to be kept in consumer files or with the billing documents at the provider's office as this requirement will be reviewed by PCA. No payment will be made without a signed receipt for each individual item. The mailing of copies of signed delivery slips to PCA is NOT required; however, they must be retained in the provider's records for review purposes.**

8. Warranty and Repairs

- a. The provider must warrant all equipment for satisfactory performance for the period of the manufacturer's warranty, from date of installation. Defective equipment under warranty must be replaced and installed at no cost to PCA or the consumer.
- b. Prior to repair requests, the Service Coordinator will attempt to identify which DME provider supplied the item(s) in question, and direct the repair request accordingly to that provider. Whether the repair request is directed to the original DME provider or another (because the original provider is not known or available), the PCA Service Coordinator will authorize the evaluation for repairs via an initial Service Order that will indicate one unit of the RPAR service code at a cost of \$1.00.

Providers will evaluate the DME item in question for repairs, including a confirmation for warranty coverage – when applicable, and will notify the PCA Care Manger with the estimate of the repair costs. Third party payor sources for repair costs are to be exhausted prior to billing PCA. The cost of replacement parts, not covered under warranty, will be based on MA Fee schedule rates, when applicable. As needed, the authorization for the repair cost will be forwarded by the Service Coordinator via a modified Service Order. Labor costs for repairs will be based on the rate established by MA Fee schedule.

J. 2. STAIR ELEVATOR - SERVICE SPECIFIC OPERATIONAL PROCEDURES

These Operational Procedures delineate specifications and “best practices” for vendors of stair elevators provided to Philadelphia Corporation for Aging (PCA) consumers.

1. Services to be Purchased:

- a. PCA will lease a stair elevator unit from a stair elevator manufacturer or supplier (herein called Vendor). Units leased will be maintained and guaranteed by Vendor. Vendor will provide installation, removal, service and repairs for each leased unit in all areas of Philadelphia.
- b. Vendor shall service a stair elevator that is reported by a consumer to be non-operating within 24 hours of the earliest call provided such call is received between 8 a.m. Monday and 4 p.m. Saturday; calls received between 4 p.m. Saturday and 8 a.m. Monday shall be serviced no later than 12 p.m. Monday. Vendor shall make all other service calls within 48 hours of the call to Vendor.

2. Certification Standards and Safety

All installed stair elevators shall be certified by Vendor as meeting standards for safety and use, as may be promulgated by any governing body, including any electrical, manufacturing, consumer or other standards, rules or regulations that may apply.

3. Service Tasks

PCA will be responsible for referring all consumers to be served under the contract, and will retain complete control of consumer eligibility determination and service authorization. PCA will also be responsible for monitoring and evaluating Vendor's performance.

4. Consumer Screening and Referral

- a. PCA is responsible for screening and referring any consumer for leasing a stair elevator. PCA will refer consumers to Vendor who have been determined by PCA to be eligible and who elect to participate in leasing a stair elevator unit for their residence. However, Vendor reserves the right to refuse installation in cases where its own assessment reveals that the consumer and/or caregiver would be at undue risk.
- b. Before the Service Coordinator can make the referral, the PCA Service Coordinator Supervisor must approve the referral based on the consumer information on the “Stair Elevator Order/Removal Form”. PCA will provide Vendor with pertinent data for each consumer who is referred; data shall include the consumer's name, address, telephone number, and other pertinent information that may impact on serving, including medical condition and diagnoses if deemed necessary. After Vendor has completed its evaluation in Subsection 4.c., d., e. below, an Occupational Therapist (OT) will document the assessment for a stair elevator.
- c. LTC staff will fax a “Stair Elevator Order/Removal Form” requesting Vendor to evaluate the consumer's home to determine if the home is suitable for a stair elevator.

Vendor shall arrange with the consumer for a mutually convenient appointment within five (5) working days of PCA's request to evaluate the home, and if the home is suitable for a stair elevator, Vendor will arrange for an installation date and time with the consumer. Vendor agrees to complete installation within ten days following the home evaluation if the home is suitable for a stair elevator or within ten days following the time the home has been made suitable for a stair elevator.

- d. Vendor shall notify PCA within three (3) days after the evaluation whether a home is suitable for a stair elevator and whether an installation date has been scheduled. If additional work is recommended in order to make the home suitable for a stair elevator, Vendor will inform PCA of its recommendations for making the home suitable for a stair elevator.
- e. The eligibility screening by PCA under Section 4.a. above relates only to clinical and fiscal matters, not construction, manufacture, design, installation, and safety and use matters. Without limiting the responsibility of Vendor under Section B above and elsewhere in the agreement between PCA and Vendors as to Vendor's responsibility for compliance with all applicable law, and without limiting the right of Vendor to refuse an installation under Section 4.a. above, in connection with Vendor's evaluation of whether a particular home is suitable for a stair elevator as required above in this section 4., Vendor shall not install any stair elevator in any particular home if the installation, following any additional work or modifications recommended by the Vendor, will not meet all standards for construction, manufacture, design, installation, safety and use, whether promulgated by governing authorities or independent bodies, such as but not limited to model building code developers and standards-developing organizations, including but not limited to electrical, mechanical, engineering, manufacturing, consumer and other industry standards, requirements of insurance companies and underwriters, and other reasonable standards. Vendor will not recommend or install a lift if it does not meet such standards. Further, all work performed shall be in good and workmanlike manner, exercising Vendor's professional expertise, being fully informed by legal requirements, such standards, warranty and manufacturers' certification requirements. PCA may withdraw any Stair Elevator Order/Removal Form, or fail to issue a Service Order, for any or no reason at any time. However, during the evaluation, installation, and promptly after the installation is completed, and at any time thereafter when Vendor visits the consumer's home or becomes aware of a problem with the lift or the consumer's use of it, notwithstanding any evaluation by the OT, the Service Coordinator, or others at any time, Vendor shall have the responsibility to determine not only whether a particular home is suitable, but whether a particular consumer or other user is able to operate the lift safely and the lift is appropriate for the consumer.

5. Installation

- a. When the home is ready to accept the stair elevator and there is a confirmed installation date, PCA will generate written authorization called a Service Order. The order details the date of installation, the type of stair elevator, and other appropriate information. Vendor will receive a service order for each consumer when the service is initiated.

- b. It shall be Vendor's responsibility to deliver and install each stair elevator. Vendor agrees to complete installation at the date specified. Vendor will obtain consumer signature on Client Lease Agreement form at time of installation.
- c. Vendor shall immediately notify PCA if it is unable to schedule or complete an installation within the required time frame.
- d. Vendor shall instruct the consumer in the use of the stair elevator and shall provide the consumer with simple written instructions, including how to report a malfunction of the stair elevator.
- e. The Client Lease Agreement/Acknowledgement Form is dated and signed by the consumer or consumer's representative at time of installation, and a copy shall be left with the consumer. The Vendor retains a copy in their files.

6. Termination of Service

- a. The decision to remove a stair elevator is at the discretion of PCA. For all removals, notification will be by telephone from authorized PCA staff. Written authorization to terminate service will be provided to the Vendor on the same day as the telephone notification.
- b. If the Vendor is notified directly by a consumer's family or other representative to remove the stair elevator, the Vendor must contact PCA for approval.
- c. When a consumer with a stair elevator no longer requires such services, regardless of the reason, the Service Coordinator will discuss the circumstances with appropriate staff, as needed, and contact the Vendor, so that the stair elevator can be removed.
- d. The Vendor shall, upon instruction by PCA, arrange with the consumer or consumer's representative for a mutually convenient appointment to remove the stair elevator within five (5) working days of notification by PCA.
- e. The Vendor will verify to PCA by telephone and in writing that the stair elevator has been removed.
- f. Upon removal of the equipment, Vendor shall plug or patch the holes made at the time the equipment was installed. PCA is aware that this is not intended to restore the property to its original condition or color.

7. Reimbursement and Billing

- a. PCA will reimburse Vendor for all authorized service for consumers.
- b. No payment will be made for any service for which the Vendor does not have a service order.
- c. PCA will require Vendor to submit invoices electronically to PCA.

8. Financial Statement

Providers entering into contracts with PCA must be financially solvent and able to demonstrate an ability to meet daily operational and payroll expenses. Should a provider enter into bankruptcy proceedings, the Contract Manager must be notified immediately.

SECTION V.

APPLICATION FORMAT AND FORMS

A. LETTER TO APPLICANTS

Dear Applicant:

Thank you for your interest in providing services to PCA's Long Term Care consumers. Please refer to the enclosed Uniform Application Procedures and Standards for background information requirements. Following this cover letter, you will find all the forms necessary to apply for and to initiate a PCA contract, effective initially during the July 1, 2016 to June 30, 2019 fiscal years.

In order to apply for a PCA contract for any one of the specified services, you must submit a completed application packet that consists of all the required provider information and in format/order referenced on the check list.

Upon receipt of your completed application package, we will review all of the material submitted. If your application is incomplete in any way, a PCA Contract Manager will contact you to clarify or work out plans to obtain any missing information. You may withdraw or modify your application at any time during this process. Application documents are to be sent to:

Philadelphia Corporation for Aging
Business Administration Department
642 N. Broad Street
Philadelphia, PA 19130-3409

If you are not approved for a PCA contract you will be notified of any appeal options available to you.

B. PROVIDER APPLICATION

SUBMISSION FORMAT / CHECK LIST

NOTE: Application must be submitted in the format order listed below:

<u>SECTION</u>	<u>REQUIRED INFORMATION</u>
1. ____	Agency Profile Form, Operating Officers Form and Board Members Form (updated as needed).
2. ____	Complete organizational description, including organizational structure, related procedures, service capabilities, internal controls, and fee schedules/price lists.
3. ____	IRS Tax Label.
4. ____	Articles of Incorporation.
5. ____	Copy of Personnel Manual detailing agency's recruitment, hiring, supervision policies/procedures, and copy of Job Descriptions for all staff.
6. ____	Price Certification form(s) for the service(s) you wish to provide.
7. ____	Profile forms for Personal Care Service (if applicable).
8. ____	Signed Assurances form.
9. ____	Copy of your agency's most recent Financial Statement.
10. ____	Current copy of Licenses, i.e. Department of Health License (if applicable).
11. ____	Resumes for all professional staff, including licenses (if applicable).
12. ____	The supervisory report form utilized for documenting supervision of direct care staff (if applicable).
13. ____	Your agency's skills and competency tests, and the tools used for staff evaluation (if applicable).
14. ____	A copy of your On-Call procedures (if applicable).
15. ____	Your Conflict of Interest policy.
16. ____	Copies of all forms participants are expected to sign, including the time slip (if applicable).
17. ____	Current Certificate(s) of Insurance.

C. CERTIFICATION FORM/AGENCY PROFILE

(Include one form for each applicant office)

LOCAL OFFICE: (complete Operating Officers & Board Members forms as applicable) Attachments? Y / N

1. Contact Person Name and Title: _____
2. Telephone Numbers Office: (____) _____ Fax: (____) _____ E-Mail _____
3. Local Administrator Name and Title: _____
4. Office Name: _____
5. Street Address: _____
6. City State and Zip Code: _____

7.		Provider Number	Date of Action
	IRS Number		
	Medicare Certification		
	DPW/MA Enrollment, Certification		
	Joint Commission Accreditation (JCHO)		

PARENT COMPANY: (complete Operating Officers & Board Members forms as applicable) Attachments? Y / N

8. Company Name: _____
9. Street Address: _____
10. City, State and Zip Code: _____
11. Agency Status (circle all that apply)

A.	(1) Profit	(2) Non-Profit	(3) Public
B.	(1) Corporation	(2) Privately Owned	(3) Publicly Traded
	(4) Sole Proprietor	(5) Limited Liability Corp.	(6) Other
12. Agency Type (circle one):

(1) Educational Institution	(2) Product Vendor
(3) Organization/Agency	(4) Other Institution
13. Agency Data:

_____	_____	_____
(Company Founded)	(Initiation of this office)	(Number of Offices)
14. Total Unduplicated Persons served by this office during the last calendar year:

_____	_____
(Year)	(Number for year)
15. Total Number of Current Staff (This office Only):

_____	_____	_____	_____
(Administrative/Supervisory)	(Service)	(Other)	(Total)
16. Total IRS Gross Revenue:

_____	\$ _____	\$ _____
Filing Year: _____	(Total Company)	(This Office)
17.

_____	_____	_____
(Signature of Authorized Representative)	(Title)	(Date)

OPERATING OFFICERS (Photocopy, as needed)

A. NAME _____

TITLE _____

ADDRESS _____ ZIP CODE _____ PHONE _____

ETHNICITY (CIRCLE)

- | | | | |
|-------------------|--------------------|----------------|--------------------|
| 1. BLACK | 4. AMERICAN INDIAN | SEX
1. MALE | AGE
1. UNDER 60 |
| 2. HISPANIC | 5. WHITE | 2. FEMALE | 2. OVER 60 |
| 3. ASIAN AMERICAN | 6. OTHER | | |

B. NAME _____

TITLE _____

ADDRESS _____ ZIP CODE _____ PHONE _____

ETHNICITY (CIRCLE)

- | | | | |
|-------------------|--------------------|----------------|--------------------|
| 1. BLACK | 4. AMERICAN INDIAN | SEX
1. MALE | AGE
1. UNDER 60 |
| 2. HISPANIC | 5. WHITE | 2. FEMALE | 2. OVER 60 |
| 3. ASIAN AMERICAN | 6. OTHER | | |

C. NAME _____

TITLE _____

ADDRESS _____ ZIP CODE _____ PHONE _____

ETHNICITY (CIRCLE)

- | | | | |
|-------------------|--------------------|----------------|--------------------|
| 1. BLACK | 4. AMERICAN INDIAN | SEX
1. MALE | AGE
1. UNDER 60 |
| 2. HISPANIC | 5. WHITE | 2. FEMALE | 2. OVER 60 |
| 3. ASIAN AMERICAN | 6. OTHER | | |

D. NAME _____

TITLE _____

ADDRESS _____ ZIP CODE _____ PHONE _____

ETHNICITY (CIRCLE)

- | | | | |
|-------------------|--------------------|----------------|--------------------|
| 1. BLACK | 4. AMERICAN INDIAN | SEX
1. MALE | AGE
1. UNDER 60 |
| 2. HISPANIC | 5. WHITE | 2. FEMALE | 2. OVER 60 |
| 3. ASIAN AMERICAN | 6. OTHER | | |

BOARD MEMBERS (Photocopy, as needed)

A. NAME _____

TITLE _____

ADDRESS _____ ZIP CODE _____ PHONE _____

ETHNICITY (CIRCLE)

- | | | | |
|-------------------|--------------------|----------------|--------------------|
| 1. BLACK | 4. AMERICAN INDIAN | SEX
1. MALE | AGE
1. UNDER 60 |
| 2. HISPANIC | 5. WHITE | 2. FEMALE | 2. OVER 60 |
| 3. ASIAN AMERICAN | 6. OTHER | | |

B. NAME _____

TITLE _____

ADDRESS _____ ZIP CODE _____ PHONE _____

ETHNICITY (CIRCLE)

- | | | | |
|-------------------|--------------------|----------------|--------------------|
| 1. BLACK | 4. AMERICAN INDIAN | SEX
1. MALE | AGE
1. UNDER 60 |
| 2. HISPANIC | 5. WHITE | 2. FEMALE | 2. OVER 60 |
| 3. ASIAN AMERICAN | 6. OTHER | | |

C. NAME _____

TITLE _____

ADDRESS _____ ZIP CODE _____ PHONE _____

ETHNICITY (CIRCLE)

- | | | | |
|-------------------|--------------------|----------------|--------------------|
| 1. BLACK | 4. AMERICAN INDIAN | SEX
1. MALE | AGE
1. UNDER 60 |
| 2. HISPANIC | 5. WHITE | 2. FEMALE | 2. OVER 60 |
| 3. ASIAN AMERICAN | 6. OTHER | | |

D. NAME _____

TITLE _____

ADDRESS _____ ZIP CODE _____ PHONE _____

ETHNICITY (CIRCLE)

- | | | | |
|-------------------|--------------------|----------------|--------------------|
| 1. BLACK | 4. AMERICAN INDIAN | SEX
1. MALE | AGE
1. UNDER 60 |
| 2. HISPANIC | 5. WHITE | 2. FEMALE | 2. OVER 60 |
| 3. ASIAN AMERICAN | 6. OTHER | | |

D. ASSURANCES

By my initials next to each statement that follows and my signature below, I certify that:

___ I have the capacity to deliver all service orders accepted and will commit the resources at my disposal to assure provision of all services applied for.

___ I understand that PCA does not guarantee any minimum or maximum volume of service and that the total amount of actual reimbursement will be based on consumer choice, service orders placed by PCA, and actual service delivered and verified by consumer signatures.

___ I will carry and keep current insurance and provide evidence of such insurance, upon request.

___ I agree to maintain for 4 years and make available, for purposes of PCA monitoring and audit, documentation to verify service provision as invoiced and reimbursed.

___ I recognize the particular need for sensitivity in serving the elderly, and am committed to providing honest, thorough and responsive staff service in order to minimize consumer disruption and upset.

NAME: _____
(Signature) (Print name)

TITLE: _____

Name of organization: _____

Address: _____

City/State: _____ Zip: _____ Phone: _____ Date: _____

E. PROVIDER PRICE CERTIFICATION AND PROFILE FORMS

The following are the price certification forms for the various services; please note that the applicable program is clearly designated on each form. A Service Profile form (where included), must be submitted with the designated Price Certification Form.

PHILADELPHIA CORPORATION FOR AGING

PRICE CERTIFICATION FORM: ADULT DAY SERVICE

Provider Name: _____ **Provider E.I.N.:** _____

REIMBURSEMENT RATES					
OPTIONS PROGRAM – SERVICE CODE	CUSTOMARY AND USUAL CHARGE			ESTABLISHED RATE FOR PCA OPTIONS PROGRAM	
FULL DAY, including meal and 2 snacks. (unit = day) DAYM				\$59.80	
FULL DAY, including meal, 2 snacks, and bath. (unit = day) DABM				\$75.01	
HALF-DAY, including meal and one snack (unit = 1/2 day) DAHM				\$29.90	
	South	West	North Central	Northwest	Northeast
Service Areas Requested in Philadelphia					

PHILADELPHIA CORPORATION FOR AGING

PRICE CERTIFICATION FORM: COUNSELING SERVICE

Provider Name: _____ **Provider E.I.N.** _____

REIMBURSEMENT RATES					
OPTIONS PROGRAM - SERVICE CODE	CUSTOMARY AND USUAL CHARGE			ESTABLISHED RATE FOR PCA OPTIONS PROGRAM	
TELEPHONE SUPPORT GROUP (unit = session) CNOG					
	South	West	North Central	Northwest	Northeast
Service Areas Requested in Philadelphia					

PHILADELPHIA CORPORATION FOR AGING

PRICE CERTIFICATION FORM: PROFESSIONAL EVALUATION SERVICES

Provider Name: _____ **Provider E.I.N.:** _____

REIMBURSEMENT RATES					
OPTIONS PROGRAM - SERVICE CODE	CUSTOMARY AND USUAL CHARGE			RATE ESTABLISHED FOR LTC PROGRAM	
PSYCHIATRIC EVALUATION (unit = hour) PSYC					
MEDICAL EVALUATION (unit = hour) PHYS					
	South	West	North Central	Northwest	Northeast
Service Areas Requested in Philadelphia					

PHILADELPHIA CORPORATION FOR AGING

PRICE CERTIFICATION FORM: PROFESSIONAL EVALUATION SERVICES

Provider Name: _____ **Provider E.I.N.:** _____

REIMBURSEMENT RATES					
OPTIONS PROGRAM - SERVICE CODE	CUSTOMARY AND USUAL CHARGE			RATE ESTABLISHED FOR LTC PROGRAM	
PSYCHOLOGICAL EVALUATION (unit = hour) PSGY				\$127.74	
OBRA PSYCHOLOGICAL EVALUATION (unit = hour) OBAS				\$127.74	
	South	West	North Central	Northwest	Northeast
Service Areas Requested in Philadelphia					

PHILADELPHIA CORPORATION FOR AGING

PRICE CERTIFICATION FORM: HOME HEALTH SERVICES

Provider Name: _____ **Provider E.I.N.:** _____

REIMBURSEMENT RATES					
OPTIONS PROGRAM – SERVICE CODE	CUSTOMARY AND USUAL CHARGE			MA FEE SCHEULDE RATES	
NURSING , RN (unit = visit) NURS				\$66.20	
PHYSICAL THERAPY (unit = visit) HHPT				\$80.80	
OCCUPATIONAL THERAPY (unit = visit) HHOT				\$85.16	
SPEECH THERAPY (unit = visit) HHST				\$86.88	
HOME HEALTH AIDE (unit = visit) HHHA				\$21.52	
	South	West	North Central	Northwest	Northeast
Service Areas Requested in Philadelphia					

PHILADELPHIA CORPORATION FOR AGING

HOME HEALTH SERVICE PROFILE

As an adjunct to the enclosed Price Certification Form, the following statistical data is being requested for informational purposes.

APPLICANT _____ YEAR: _____

Agency Information

A. Home Health Service Level Last Calendar Year: _____

- 1. Average number of patients served on a weekly basis: _____
- 2. Average number of visits made on a weekly basis: _____
- 3. Total number of visits made last year: _____

B. Skilled Workers

- 1. Number of contracted skilled workers used by you at this time: _____
- 2. Number of skilled workers employed by you at this time: _____
- 3. Please break down in the chart below, the total included in 1 and 2: _____

Length of Employment and Status	Registered Nurses	Physical Therapists	Occupational Therapists	Enterostomal Nurses	Psychiatric Nurses
24 months & longer					
12 through 23 months					
6 through 11 months					
Less than 6 months					
Total number					
Employed Full Time					
Employed Part Time					
Contracted					

PHILADELPHIA CORPORATION FOR AGING

PRICE CERTIFICATION FORM: PEST CONTROL / FUMIGATION SERVICE

Provider Name: _____ **Provider E.I.N.** _____

REIMBURSEMENT RATES					
OPTIONS PROGRAM – SERVICE CODE	CUSTOMARY AND USUAL CHARGE			ESTABLISHED RATE FOR PCA OPTIONS PROGRAM	
HEAVY CLEANING (unit = hour) CHHC					
INITIAL EXTERMINATION (unit = visit) CHEX					
FOLLOW-UP EXTERMINATION (unit = visit) CHXF					
SPECIAL EXTERMINATION (unit = visit) CHXS					
RENTAL DUMPSTER (unit = daily fee) CHDR					
	South	West	North Central	Northwest	Northeast
Service Areas Requested in Philadelphia					

PHILADELPHIA CORPORATION FOR AGING

PRICE CERTIFICATION FORM: PERSONAL CARE AND HOME SUPPORT

Provider Name: _____ **Provider E.I.N.:** _____

REIMBURSEMENT RATES					
OPTIONS PROGRAM – SERVICE CODE	CUSTOMARY AND USUAL CHARGE	ESTABLISHED RATE FOR PCA OPTIONS PROGRAM	STARTING HOURLY RATE PAID TO WORKERS		
PERSONAL CARE (unit = hour, maximum 12 hours) PERS		\$18.00			
PERSONAL CARE FULL DAY (unit = over 12 hours of service) PCFD		\$229.39			
HOUSEKEEPING & HOME MGT (unit = hour) CHHK		\$18.00			
	South	West	North Central	Northwest	Northeast
Service Areas Requested in Philadelphia					

PHILADELPHIA CORPORATION FOR AGING

PERSONAL CARE SERVICE PROFILE

As an adjunct to the enclosed Price Certification Form, the following statistical data is being requested for informational purposes.

It is expected that data presented will relate to Personal Care Service only. If you are a Medicare Certified Home Health Agency, you may include information for comparable Home Health Aide services, but not OT, PT, Nursing, etc.

APPLICANT _____

YEAR: _____

I. Agency Status

A. Are you a Medicare Certified Home Health Agency?

___ Yes ___ No

B. Are you applying for, or intending to obtain Medicare Certification?

___ Yes ___ No

C. Information presented below relates to: (check one)

___ Personal Care Service only

___ Personal Care/Home Health Aide Service

II. Agency Information

A. Training

Do you currently have the following:

Certificate Training Yes ___ No ___ If yes, hrs./mo. _____

In-Service Training Yes ___ No ___ If yes, hrs./mo. _____

Orientation Yes ___ No ___ If yes, hrs./mo. _____

B. Personal Care Service Level Last Calendar Year: _____

1. Average number of consumers served on a weekly basis: _____

2. Average number of hours delivered on a weekly basis: _____

3. Total number of hours delivered last year: _____

C. Personal Care Workers

1. Number of personal care/home health aides employed:

Length of Employment	# of Personal Care Workers	# of Home Health Aides	# of Field Supervisors
24 months & longer			
12 through 23 months			
6 through 11 months			
Less than 6 months			
Total number			

2. How many personal care/home health aides currently employed, meet the training requirements detailed in the standards? \$ _____
3. What is your current starting salary for personal care workers \$ _____
4. What is the current average salary paid to these workers? \$ _____
5. If awarded a contract at the price requested, what would your starting salary be for personal care workers assigned to PCA cases? \$ _____
6. Number of hours per week worked by personal care workers/home health aides and field supervisors:

Hours Per Week	Under 9	10-19	20-29	30-39	40-49	50+
# of Personal Care/HH Aides						
# of Field Staff						

PHILADELPHIA CORPORATION FOR AGING
PRICE CERTIFICATION FORM: OVERNIGHT SHELTER

Provider Name: _____ **Provider E.I.N.:** _____

REIMBURSEMENT RATES	
OPTIONS PROGRAM - SERVICE CODE	MA Case Mix Rate (adjusted quarterly)
Overnight Shelter – Nursing Facility (unit = day, all inclusive) WRIN	

PHILADELPHIA CORPORATION FOR AGING

PRICE CERTIFICATION FORM: PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Provider Name: _____ **Provider E.I.N.:** _____

REIMBURSEMENT RATES					
OPTIONS PROGRAM - SERVICE CODE	CUSTOMARY AND USUAL CHARGE			ESTABLISHED RATE FOR PCA OPTIONS PROGRAM	
Personal Emergency Response System; installation cost - (unit = one installation) MEIN					
Personal Emergency Response System - Wireless / Cellular units installation cost - (unit = one installation) MEIC					
Personal Emergency Response System; monthly monitoring – (unit = monthly fee) MEMN					
Personal Emergency Response System- Wireless / Cellular Units; monthly monitoring – (unit = monthly fee) MEMC					
Personal Emergency Response System; maintenance, repair, or replacement – (unit = one repair) WMER					
	South	West	North Central	Northwest	Northeast
Service Areas Requested in Philadelphia					

PHILADELPHIA CORPORATION FOR AGING

PRICE CERTIFICATION FORM: DME – STAIR ELEVATOR

Provider Name: _____ **Provider E.I.N.:** _____

REIMBURSEMENT RATES					
OPTIONS PROGRAM - SERVICE DESCRIPTION SERVICE CODE	USUAL AND CUSTOMARY RATE			ESTABLISHED RATE FOR PCA OPTIONS PROGRAM	
Installation – all models SROC					
Front Rider – monthly rent WFRR					
Side Rider – fixed seat – monthly rent WFRR					
Side Rider – swivel seat – monthly rent WFRR					
Repairs RPSG					
	South	West	North Central	Northwest	Northeast
Service Areas Requested in Philadelphia					