

## **Home and Community-Based Health Services Standards of Care**

### **Definition:**

Home and Community-Based Health Care Services is defined as skilled health services furnished in the home of an HIV-infected individual, based on a written plan of care prepared by a case management team that includes appropriate health care professionals. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help clients with disabilities remain in their homes.

### **Limitations:**

Non-allowable services include inpatient hospital services, nursing home and other long term care facilities

### **Services:**

Home and Community-Based Health Care Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following:

- **Para-professional care** is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help clients remain in their homes.
- **Professional care** is the provision of services in the home by licensed health care workers such as nurses.
- **Specialized care** is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies. physical therapy, social worker services

Home and Community-Based Health Care Providers work closely with the multidisciplinary care team that includes the client's case manager, primary care provider, and other appropriate health care professionals.

Allowable services include:

- Durable medical equipment
- Home health aide and personal care services
- Day treatment or other partial hospitalization services

- Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy)
- Routine diagnostic testing
- Appropriate mental health, developmental, and rehabilitation services
- Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities

## Agency/Personnel /Staff Training

Staff Qualification	Expected Practice
<p><b>Agency Qualifications</b> The agency shall be licensed and certified by the State of Texas to provide home health service or certified as a Special Care Facility.</p>	<p>License and /or certification is posted in a conspicuous place at the agency's main office.</p>
<p><b>Agency System of Care</b> The agency shall provide access to its system of care HIV/AIDS clients twenty-four (24) hours a day and must provide mechanisms for urgent and/or emergency care.</p>	<p>Documented policy on operation and procedures to contact agency after hours for urgent and/or emergency care.</p>
<p><b>Agency Policies and Procedures</b></p>	<p>The agency shall have policies/procedures for the following:</p> <ul style="list-style-type: none"> <li>-Client rights and responsibilities, including confidentiality guidelines</li> <li>-Client grievance policies and procedures</li> <li>-Client eligibility and admission requirements</li> <li>-Referral resources and procedures that ensure access to a continuum of services</li> <li>-All appropriate consent forms (e.g., consent to share information, shared client data/registration system (ARIES), HIPAA requirements)</li> <li>-Consent to treatment signed by the client annually</li> <li>-Data collection procedures and forms, including data reporting</li> <li>-Quality assurance/quality improvement</li> <li>-Guidelines for language accessibility</li> </ul>
<p><b>Staff Credentials - Professionals</b> Professional staff, including but not limited to Registered Nurse, physical therapists, social workers, occupational therapists, respiratory therapists, should have appropriate licenses and/or credentials set forth by the State of Texas.</p>	<p>All agency professional staff, contractors, and consultants who provide direct-care services, and who require licensure, shall be properly licensed by the State of Texas, or documented to be pursuing Texas licensure while performing tasks that are legal within the provisions of the Texas Medical Practice Act (or in the case of a nurse, the Nursing</p>

	Practice Act), including satisfactory arrangements for malpractice insurance with evidence of such in the personnel file.
<p><b>Staff Credentials - Paraprofessionals</b> All agency paraprofessional staff and contractors who provide direct-care services shall be appropriately certified, if required, by the State of Texas with evidence of such in the personnel file.</p>	<p>Paraprofessional home health care providers (home health aides, personal care attendants) should have:</p> <ul style="list-style-type: none"> <li>-Appropriate certification, if required by State regulations (e.g., Home Health Aide Certification issued by the State of Texas)</li> <li>-Experience providing homemaker services (for in-home supportive service providers)</li> <li>-Experience providing home health attendant services (for home health aides)</li> <li>-Skill and comfort working with men who have sex with men, women, transgender, people of color, substance users, homeless and/or individuals with mental illness</li> <li>-Preferred: Bilingual</li> <li>-Preferred: Experience working and/or volunteering in direct client services within the HIV community or related social service experience.</li> </ul>
<p><b>Staff Experience</b> Agency shall employ clinical staff who are experienced regarding their area of clinical practice as well as knowledgeable in the area of HIV/AIDS clinical practice.</p>	<p>Personnel records/resumes/applications for employment will reflect requisite experience/education. Provider will document training received according to professional licensure requirements.</p>
<p><b>Education</b> The agency shall keep abreast of current treatment methodologies as outlined in the most recent version of the Public Health Service guidelines for persons living with HIV/AIDS.</p>	<p>Provider will document provision of in-service education to staff regarding current treatment methodologies and promising practices.</p>
<p><b>Billing Requirements</b> Home and Community Based Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third party payers.</p>	<p>Provider will provide evidence of third-party billing.</p>

## Standards of Care

Standard	Measure
<p><b>Intake and Service Eligibility</b>            According to the HRSA HIV National Monitoring Standards, eligibility for services must be determined.</p>	<p>The primary medical care provider has deemed home and community-based home health care services necessary.</p> <p>-The referring primary medical provider must:</p> <ul style="list-style-type: none"> <li>• Provide signed orders in writing to the agency prior to the initiation of care</li> <li>• Act as that client's primary medical care provider</li> <li>• Maintain a consistent plan</li> <li>• Communicate changes from the initial plan directly to the agency.</li> </ul> <p>In the event that the referring medical care provider is unable to continue the provision of primary health care services, the medical care provider must be willing to transfer the client to the care of a willing provider.</p> <p>Eligibility information will be obtain from the primary medical provider/case manager that includes</p> <ul style="list-style-type: none"> <li>-Contact and identifying information (name, address, phone, birth date, etc.)</li> <li>-Language(s) spoken</li> <li>-Literacy level (client self-report)</li> <li>-Demographics</li> <li>-Emergency contact</li> <li>-Household members</li> <li>-All current health care and social service providers, including case management providers</li> <li>-Pertinent releases of information</li> <li>-Documentation of insurance status</li> <li>-Documentation of income (including a “zero income” statement)</li> <li>-Documentation of state residency</li> <li>-Documentation of proof of HIV positivity</li> <li>-Photo ID or two other forms of identification</li> <li>-Acknowledgement of client’s rights</li> </ul> <p>Consent for treatment and signed release for sharing information with other providers will be obtained to ensure coordination of services.</p> <p>The client's eligibility must be recertified for the program every six (6) months.</p>

<p><b>Refusal of referral</b></p>	<p>The home or community-based health agency may refuse a referral for the following reasons only:</p> <ul style="list-style-type: none"> <li>-Based on the agency’s perception of the client’s condition, the client requires a higher level of care than would be considered reasonable in a home/community setting. <ul style="list-style-type: none"> <li>• The agency must document the situation in writing and immediately contact the client’s primary medical care provider.</li> </ul> </li> <li>-The agency has attempted to complete an initial assessment and the referred client has been away from home on three occasions. <ul style="list-style-type: none"> <li>• The agency must document the situation in writing and immediately contact the referring primary medical care provider.</li> </ul> </li> <li>-The client’s current residence must be determined physically safe (if not residing in a community facility) before services can be offered or continued.</li> </ul>
<p><b>Initial Assessment</b> A preliminary needs assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care.</p>	<p>Client will be contacted within twenty-four (24) hours of the referral, and services should be initiated at the time specified by the primary medical care provider, or within forty-eight (48) hours, whichever is earlier.</p> <p>A comprehensive evaluation of the client’s health, psychosocial status, functional status, and home environment should be completed to include:</p> <ul style="list-style-type: none"> <li>-Assessment of client’s access to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for skilled nursing or rehabilitation services.</li> <li>-Information to determine client’s ability to perform activities of daily living and the level of attendant care assistance the client needs to maintain living independently.</li> </ul>
<p><b>Implementation of Care Plan</b> According to the HRSA National Monitoring Standards, all services are provided based on a written care plan signed by the clinical health care professional, case manager if applicable and the home/community-based health care professional responsible for the care.</p>	<p>In coordination with the medical care coordination team that includes the client’s primary medical care provider and case manager, a care plan will be completed based on current assessment and needs of the client.</p> <ul style="list-style-type: none"> <li>-Need for home and community-based health services</li> <li>-Types, quantity and length of time services are to be provided <ul style="list-style-type: none"> <li>• All planned services are allowable within this service category</li> <li>• Care plan is signed by both case manager</li> </ul> </li> </ul>

	<p style="text-align: center;">and clinical health care professional.</p> <p>Professional staff will:</p> <ul style="list-style-type: none"> <li>-Provide nursing and rehabilitation therapy care under the supervision and orders of the client's primary medical care provider.</li> <li>-Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation.</li> <li>-Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services).</li> <li>-Monitor changes in client's physical and mental health, and level of functionality.</li> <li>-Work closely with client's other health care providers and other members of the care team in order to effectively communicate and address client service related needs, challenges and barriers.</li> <li>-Participate in the development of individualized care plan with members of the care team.</li> <li>-Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate.</li> </ul> <p>Paraprofessionals (home health aides, attendant, homemakers) must provide care in coordination with the medical coordination care team and under the supervision of a registered nurse, or rehabilitation therapist (OT/PT) or case manager.</p> <ul style="list-style-type: none"> <li>-Provide homemaking services including meal preparation, grocery shopping, house cleaning, laundry, running errands, accompanying client to scheduled medical or related appointments, and other household tasks and services.</li> <li>-Provide attendant care services which include taking vital signs and assisting client with activities of daily living (bathing and personal hygiene care, prescribed exercises).</li> <li>-Under guidance and supervision assist client's self-administration of medication.</li> <li>-Promptly report to supervisor any problems or questions regarding the client's adherence to medication.</li> <li>-Report any changes in the client's condition and needs.</li> <li>-Complete appropriate client records as required by the supervisor.</li> </ul>
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<p><b>Provision of Services</b> Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community based health services.</p>	<p>Progress notes will be kept in the agency's client's record.</p> <p>Care Providers will update the plan of treatment at least every sixty (60) days.</p> <p>The agency will maintain ongoing communication with the medical coordination care team, to include the primary medical care provider and case manager in compliance with Texas Medicaid and Medicare Guidelines.</p> <p>The Home and Community-Based Provider will document in the agency's progress notes throughout the course of the treatment, the client is not in need of acute care.</p>
<p><b>Coordination of Services and Referrals</b> Coordination and referrals include identification of other service providers or staff members with whom the client may be working.</p>	<p>The agency will:</p> <ul style="list-style-type: none"> <li>-Make sure that service for clients will be provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and encouraging client access to integrated health care.</li> <li>-Consistently report referral and coordination updates to the medical coordination care team.</li> </ul> <p>Clients will be provided with accurate information on available resources.</p> <ul style="list-style-type: none"> <li>-Consult with case managers/care coordinators to facilitate appropriate referrals to programs and services that can successfully meet the client's needs.</li> <li>-Assist clients in making informed decisions on choices of available service providers and resources.</li> </ul> <p>Address client's spectrum of needs in a comprehensive way while minimizing duplication of services.</p>
<p><b>Transfer/Discharge</b> Transfer and discharge of clients from home and community-based home health care services should result from a planned and progressive process that takes into account the needs and desires of the client and his/her caregivers, family, and support network.</p>	<p>A transfer or discharge plan should be developed when one or more of the following criterion are met:</p> <ul style="list-style-type: none"> <li>-Agency no longer meets the level of care required by the client.</li> <li>-Client moves out of the area.</li> <li>-The client no longer medically requires home. and community-based health care as determined by the agency or the primary medical provider.</li> <li>-Client wishes to discontinue services (with or</li> </ul>

	<p>against medical advice).</p> <ul style="list-style-type: none"> <li>-Client transfers services to another service program</li> <li>-The client is not stable enough to be cared for outside of the acute care setting as determined by the agency and the client's primary medical care provider.</li> <li>-The client no longer has a stable home environment appropriate for the provision of home health services as determined by the agency;</li> <li>-Client is unable or unwilling to adhere to agency policies.</li> <li>-An employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a client's home, in the company of an escort or not. The agency may discontinue services or refuse the client for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within 24 hours and followed by a written report. A copy of the police report is sufficient, if applicable.</li> </ul> <p>All services discontinued under above circumstances must be accompanied by a referral to an appropriate service provider agency.</p>
<p><b>Documentation in Clients Chart</b></p>	<p>The following will be documented in the agency's clients record:</p> <ul style="list-style-type: none"> <li>-Documentation of proof of HIV positivity</li> <li>-Proof of residency</li> <li>-Verification of financial eligibility, if appropriate</li> <li>-Client demographics</li> <li>-Intake and assessment information</li> <li>-The types, dates, and location of services</li> <li>-Documentation that services provided were consistent with the treatment plan</li> <li>-Signature of the professional who provided the service at each visit</li> <li>-Case conferencing occurred periodically with the medical coordination care team.</li> <li>-Documentation that primary care provider was updated periodically on client's progress.</li> <li>-Documentation of reason for case transfer/discharge.</li> </ul>

## References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A  
April 2013, p. 14-16.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B  
April, 2013, p. 13-15.

Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS  
Standards of Care for HIV/AIDS Services 2009

San Francisco EMA Home-Based Home Health Care Standards of Care February 2004

Texas Administrative Code, Title 40, Part 1, Chapter 97, Subchapter B, Rule 97.211

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