Home and Community-Based Health Services Service Standard

Texas Department of State Health Services, HIV Care Services Group—HIV/STD Program | Texas DSHS

Subcategories	Service Units
Durable Medical Equipment	Per item
Home and Community-Based Health Services	Per visit
Para-Professional Care	Per visit
Professional Care	Per visit

Health Resources & Services Administration (HRSA) Description:

Home and Community-Based Health Services (HCBHS) are provided to an eligible client in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services
- Skilled nursing medication administration including intravenous and aerosolized therapy
- Routine lab specimen collection and testing services

Program Guidance:

HRSA does not consider inpatient hospitals, nursing homes, and other long-term care facilities integrated settings to provide Home and Community-Based Health Services.

Limitations:

Agencies cannot fund services provided in the following facilities: inpatient hospital facilities, nursing homes, and other long-term care facilities.

Services:

Home and Community-Based Health Services are therapeutic, nursing, supportive, or health services provided by a licensed and certified home health agency in a licensed and certified home or community-based setting (e.g., adult daycare center) in accordance with a written, individualized plan of care established by a licensed physician.

Home and Community-Based Health Services include:

- **Para–professional care**: services by a home health aide, personal caretaker, or attendant. This also includes assistance with cooking and cleaning activities to help clients remain in their homes.
- **Professional care**: services in the home by licensed providers for mental health, development health care, or rehabilitation services.

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

Universal Standards:

Services providers for Home and Community-Based Health Services must follow HRSA and DSHS Universal Standards 1-52 and 86-91.

Service Standards and Measures:

The following standards and measures are guides to improving health outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

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<tr><th>Standard</th><th>Measure</th></tr>
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Initial Orders and Assessment: Staff will contact the client within 1 business day of agency receipt of referral with orders from a licensed medical provider.
Agencies must initiate services per orders specified by the referring licensed medical care provider or within 2 business days of receipt of the referral with orders, whichever is earlier.
Initiation of service must consist of a comprehensive assessment of the status of the client’s physical, psychosocial, and home safety.
Components of assessments:

Past medical history relevant to services to be provided
Acute or chronic health conditions
Current system of support to meet basic needs and activities of daily living
Fall risk
Cognition and level of consciousness
Access to food and emergency assistance
Access to primary and specialty medical care
Ability to self-manage prescribed therapies

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Percentage of clients with documentation of a referral for services from a licensed medical provider prior to initiation of services. (Pilot Measure)
Documentation that a comprehensive assessment was completed by the Home and Community-Based Health Services provider within 2 business days of receipt of the referral with orders for assessment or at the time specified by the ordering provider.

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• Skilled nursing services require a head-to-toe assessment • Current regimen and response to prescribed symptom management and prevention • Current medication list • Emergency contact(s) • Home and environmental safety	
Implementation of Care Plan: Staff will be complete a care plan based on the primary medical care provider's order that includes: • Current assessment and needs of the client, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities) • Need for Home and Community-Based Health Services • Types, quantity, and length of time services are to be provided The care plan is updated at least every 60 calendar days.	3. Percentage of clients with documentation of a client-centered care plan that follows the primary medical care provider's orders as written. 4. Percentage of clients with documentation of review and update to their care plan every 60 calendar days at a minimum.
Coordination of Services and Referrals: If referrals are deemed necessary the agency will: • Assist clients in making informed decisions on choices of available service providers and resources to meet their individual needs. • Coordinate referrals to ancillary services as appropriate and approved by the client and the client's primary care provider. • Ensure and document care coordination across the multidisciplinary team as applicable to the client.	5. Percentage of clients with referrals to ancillary services that have documentation of consultation with the client or primary caretaker, and the primary care provider to ensure coordination of care and mutual approval of the plan of care. (Pilot Measure)

Transfer and Discharge: A transfer or discharge plan must be developed for any of the following circumstances: • Agency is not able to meet the level of care required by the client. • Client transfers services to another service program. • Client discontinues services. • Client relocates out of the service delivery area. • The agency determines the clients' home or current residence is not physically safe or appropriate for the provision of Home and Community-Based Health Services. All services transferred must be accompanied by a referral to an appropriate service provider.	6. Percentage of clients transferred or discharged from services with documentation of a transfer or discharge plan developed in coordination with the client or client's designated caregiver to facilitate a safe transfer, handoff, or discharge from services.

References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients.* Health Resources and Services Administration, June 2022.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients*. Health Resources and Services Administration, June 2022.

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration, October 2022.

Centers for Medicare and Medicaid Services (CMS), Home and Community-Based Services. *Home- and Community-Based Services | CMS*. Centers for Medicare & Medicaid, January 2023.