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Introduction

This document describes the "Home and Community-Based Health Service" of core category under the Ryan White HIV/AIDS Program (RWHAP). It serves as a supplement to the Universal Standards of Care document (USOC) also released by the County of Santa Clara HIV Commission and County of Santa Clara Public Health Department. This document highlights each of the requirements and standards that apply to Home and Community-Based Health Services (HCBHS) and must be followed by any provider receiving RW funding. It is responsibility of the service providers to be familiar with the USOC. The Recipient is responsible for applying these standards through their service contracting process on an ongoing basis at the individual service provider level throughout the funding cycle.

Definition: HCBHS are provided to an eligible client living with HIV 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.

Purpose: The purpose of HCBHS is to maintain or improve the health and functional status and quality of life and meet the health-related needs of individuals with HIV/AIDS in Santa Clara County by having access to skilled and/or non-skilled services and equipment to remain at home.

Goals: The goals of HCBHS are to supply stable access to home-based medical care services and promote a client's independence and self-sufficiency to enable clients to remain in their own homes for as long as possible during illness.

Objective: The objective of Home and Community-Based Health Services is to supply services in the home and prevent the need for hospitalization or entry into a skilled nursing facility while improving the quality of health for functionally impaired individuals with HIV.

Program Guidance
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing HCBHS. Services must be provided where the client resides such as own home, apartment or group home.

Exclusions
Emergency room services, inpatient hospital services, nursing homes, and other long-term care facilities are not included as HCBHS.

Key Activities

- Eligibility Screening/Intake
- Comprehensive assessment and regular reassessment of the client's service needs
- Development and ongoing revision of a comprehensive, individualized service plan

Requirements

1.0 ARIES

Standards identified in Universal Standards of Care (USOC 1)

2.0 Intake

Standards identified in Universal Standards of Care (USOC 2)

3.0 Recertification

Standards identified in Universal Standards of Care (USOC 3)

4.0 Care and Treatment

4.1 Eligibility

HCBHS must be offered in a way that addresses barriers to accessing needed care and uses resources to support clients remaining in their own homes as long as possible.

#	Standard	Measure
4.1.1	**Identify Needs:** Immediate needs are identified during the client intake, recertification or clinical assessment. Provider has responsibility to complying with USOC 4.	Client chart
4.1.2	**Referral Process:** If a client has been referred by another RW provider to receive services, it is acceptable to note that eligibility and registration information were verified and exist at the referring RW provider. Registration information shall be sent or uploaded in ARIES from the referring provider to the provider receiving the referral.	Signed the ARIES share mandate form at both the agencies before eligibility information can be shared.
4.1.3	**Client Contact:** The agency shall ensure that phone contact is made with each client within **twenty-four (24) hours of the referral**, and services are initiated at the time specified by the RN, or **within forty–eight hours**, whichever is earlier.	Documentation of client contact within twenty-four (24) hours of initial referral
4.1.4	**Eligibility:** HCBS services may only be provided to clients using RW funds when they are: • Unable to reasonably attend healthcare services in a standard facility, or • Unable to pay for medically indicated skilled care through other means, or • Unable to perform their own house or personal care as a result of illness related to HIV	Documentation that client is eligible for HCBHS using Ryan White funds

Monitoring

Assessment – Performance of a timely initial assessment, along with complete documentation of assessment findings, and provision of applicable referrals/linkages, will be monitored via site visit chart review.

4.2 Treatment Plan

Patient needs identified through the intake assessment are prioritized and translated into an individualized Treatment Plan. The agency shall maintain initial care plan signed by referring provider in client's medical record. The Treatment Plan completed by unlicensed practitioner including interns, trainees, and Master's and Doctorate-level student interns will be co-signed by a licensed healthcare practitioner.

	Standard	Measure
4.2.1	**Assessment** should include Client's overall functional status, health status, medical care and providers, activities of daily living, mental health screening, substance use assessment/screening, income, benefits, social support, and health insurance status.	Documentation of Assessment in client file.
4.2.2	**Initial Treatment Plan**: Needs identified in the Intake/Assessment are prioritized and translated into a Treatment Plan. Diagnosis and prescription should be requested by the agency and made by the referring provider.	Client chart Treatment plan sign by a licensed RN.
4.2.3	**Treatment Plan:** the plan is developed in response to the assessment and is driven by the needs identified. It shall be **completed within two (2) weeks** of the completed assessment, including: • Statement of the problems, symptoms, or behaviors to be addressed in the treatment • Short term and long-term goals and objectives • Frequency and expected duration of services	Treatment Plan completed Client chart
4.2.4	**Update treatment Plan:** An update of the plan is required following a change in client circumstances. The plan will be reviewed and updated at each team meeting. The interdisciplinary team is inclusive of a physician, nurse, home health aide, social worker, and may include spiritual care provider and volunteers when desired by the patient and family.	Client medical record Team meeting records
4.2.5	**Evaluation/Re-assessments**: Monitor and review progress of the Treatment Plan and changes in a client's health **every 30 days** or as client condition requires until no longer needed.	Documentation of monthly review of Treatment Plan
4.2.6	**Written Treatment Plan:** All services are provided based on a written treatment plan signed by the licensed clinician and client.	Written treatment plan with appropriate signatures
4.2.7	**Safety Assessment:** Provider will provide a safety assessment of a client's home before services are offered to ensure the safety the client and provider.	Documentation of detailed assessment in client file.

4.3 Comprehensive Service Plan

Home and Community-Based Health Services providers developing an individualized treatment plan should ensure that the plan, at a minimum:	
4.3.1	• Incorporates client input, • Identifies and prioritizes the client's home health care needs, • Incorporates the client's overall care Plan, if available, • Is designed to address the client's medical, social, mental health, and environmental needs, including referral and linkage to other relevant providers (e.g., mental health providers, physicians, housing specialists) • Specifies the types of services needed, and the quantity and duration of services
4.3.2	• Is signed and dated by the provider unless documented via the Care Plan in ARIES (in which case the responsible staff person should be indicated in the record)

4.4 Allowed Services

4.4.1	**Activities of daily living provided by attendant or Home Health Aids (HHA):** • Bathing and other personal services, including skin and hair care, • Assisting in and out of bed and with walking, • Medication reminders for any medicines the client takes himself or herself, (the home health aide shall NOT administer medication of any kind), • Meal preparation, • Light housekeeping, • Accompanying the client to medical appointments, • Routine allowable diagnostic testing administered in the home, • Reporting changes in the individual's condition and needs to the supervising nurse or physician, and • Completing record regarding services provided.
4.4.2	**Skilled nursing services provided by an RN or LVN:** • Initial intake and assessment, • Pain management, • Education, treatment adherence, • Supervision of HHA or Attendance, • IV therapy, • Dressing changes, • Operation of durable medical equipment, • Changing colostomy bags, changing non-sterile dressings, taking vitals signs, and non-sterile bowel and bladder hygiene care.

4.5 Service Records

4.5.1	**Service Provision Records:** Service provision records will: • Document the types, dates, and location of services, • Include the signature of the professional who provided the service at each visit, and • Indicate that services are provided in accordance with allowable modalities and locations under the definition of home and HCBHS.	Documentation of service provision records includes the following: • Type of home services provided • Location of the service • Signature of the professional who provided the service at each visit

Monitoring
Service Plan Development – Development of comprehensive, individualized service plans will be monitored via review of client charts during in-person site visits, including whether paper plans are signed and dated by both client and provider. Service plans may be entered or uploaded to ARIES; however, this is not required.

5.0 Service Access, Management, and Closure

Standards identified in Universal Standards of Care (USOC 5)

6.0 Grievances

Standards identified in Universal Standards of Care (USOC 6)

7.0 Client Rights, Responsibilities, & Confidentiality

Standards identified in Universal Standards of Care (USOC 7)

8.0 Staff Requirements and Qualifications

8.1 Staff Requirements

Home and Community-based Health Services must be provided to the client in the client's home, based on a written plan of care, and provided by a case management team that includes appropriate health care professionals (registered nurse, licensed vocational nurse, home health aide or attendant).

All service providers of RWHAP are required to meet the minimum standard of care for staff training. Provider has the responsibility to comply with USOC 8.

#	Standard	Measure
8.1.1	All staff hired by provider agencies will possess the ability to provide developmentally and culturally appropriate care to clients living with and affected by HIV. All clinical staff will have previous experience or training utilizing appropriate treatments in practice.	
8.1.2	All agency staff, contractors, and consultants, who provide direct-care services and require licensure, shall be properly licensed by the State of California	
8.1.3	All hired staff will participate in orientation and training before treatment provision. Licensed providers are encouraged to seek consultation to address clinical, psychosocial, developmental, and programmatic issues, as needed.	
8.1.4	If providers are unlicensed, they must be clinically supervised in accordance with the requirements of the licensing board of their respective professions. Graduate-level interns must be supervised according to the requirements of their respective programs and to the degree that ensures appropriate practice.	

Monitoring:

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

8.2 Staff Qualifications

Services must be provided by a qualified practitioner, required qualifications are based on the services to be provided:

8.2.1	**Medical Doctors (MDs):** • MDs must complete a four-year medical school program and have a Doctor of Medicine • Medical Doctors must complete three to five years of residency • Medical Doctors are regulated by the Medical Board of California	
8.2.2	**Registered Nurses (RNs):** • Registered Nurses must receive a degree in nursing • Registered Nurses must pass the National Council Licensure Examination (NCLEX-RN) to earn licensure • Registered Nurses are regulated by the California Board of Registered Nursing	RN provider skilled nursing care, initial intake/assessment, and follow-up visit at least monthly
8.2.3	**Nurse Practitioners (NPs):** • Nurse Practitioners must receive a graduate degree in nursing • Nurse Practitioners must already hold and RN license in California and earn their National Certification through American Nurses Credentialing Center or American Academy of Nurse Practitioners (AANP) • Nurse Practitioners are regulated by the California Board of Registered Nursing	
8.2.4	**Physician Assistants (PAs):** • Physician Assistants must complete a PA training program approved by the Accreditation Review Commission for Education for the Physician Assistant (ARC-PA) • Physician Assistants must pass the Physician Assistant National Certifying Exam (PANCE) • Physician Assistants are regulated by California's Physician Assistant Board	
8.2.5	**Licensed Vocational Nurse (LVNs):** • Licensed Vocational Nurses must complete a state approved nursing program • Licensed Vocational Nurses must pass the National Council Licensure Exam for Practical Nurses • Licensed Vocational Nurses are regulated by the California board of Vocational Nursing and Psychiatric Technicians	LVN works under the supervision of RN to provide skilled nursing care

8.2.6	**Home Health Aides (HHAs):** • Home Health Aides must complete a Certified Nursing Assistance (CAN) training • Home Health Aides must receive certification from the California Department of Public Health • Home Health Aides are regulated by the Professional Certification Branch (PCB) and the Aide and Technician Certification Section (ATCS)	Attendant and HHA provides non-skilled care; Home Health Aides must be supervised by a RN at least monthly.
8.2.7	**Licensed Clinical Social Workers (LCSWs):** LCSWs must have a Master's degree in social work (MSW). • Licensed Clinical Social Workers are required to have accrued hours of post-Master's supervised therapy experience as required by the State of California for licensure and to attain and maintain licensure	

Monitoring:

Staff Education and Experience – Proof of required staff degrees, certification, licenses, permits, or other qualifying documentation must be available for review during site visits.

Compliance with minimum qualification for all providers offering diagnostic and therapeutic services will be monitored by review of personnel files during site visits.

9.0 Cultural and Linguistic Competency

Standards identified in Universal Standards of Care (USOC 9)

10.0 Fiscal Responsibility

Standards identified in Universal Standards of Care (USOC 10)

11.0 Licensure and Assurance

Standards identified in Universal Standards of Care (USOC 11)

12.0 Continuous Quality Improvement

Standards identified in Universal Standards of Care (USOC 12)

References and Published Guidelines:

1. Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds. HIV/AIDS Bureau Policy Clarification Notice 16-02
2. For a comprehensive overview of references, guidelines and resources please see the official WEB site for Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) at http://hab.hrsa.gov
3. San Jose, CA TGA – Definitions for Eligible Services *Ryan White HIV/AIDS Treatment Extension Act of 2009*, July 1, 2011, Definition of "Home- and Community Based Health Services" Page 3.
4. Home Health Standards of Care for Ryan White Act-Funded Services in Orange County, October 12, 2016.
5. Ryan White Program Service Area Standards: Home and Community-Based Health Services. September 8, 2015.
6. Ryan White HIV/AIDS Program Standards of Care for the Oakland Transitional Grant Area. June 2016.
7. Marion County Public Health Department Ryan White HIV Services Program Part A/MAI and Part C Standards of Care for HIV Services. March 15, 2017.