SAN FRANCISCO EMA RYAN WHITE HIV 2024 STANDARDS OF CARE UPDATE PROJECT

HOME AND COMMUNITY BASED HEALTH SERVICES STANDARDS OF CARE

NOTE: The draft standards below describe only service elements specific to Ryan White-funded home and community-based health services. Overarching standards common to all programs - such as standards related to client eligibility, insurance and benefits screening, facility standards, staff qualifications, evaluation, incorporation of harm reduction, and use of Ryan White funds as the payor of last resort - will be included in a separate Common Standards document. This document will also be more fully formatted in a future version.

OVERVIEW AND PURPOSE OF HOME AND COMMUNITY-BASED HEALTH SERVICES STANDARDS:

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Home and Community-Based Health Services Standards of Care is to ensure consistency, service equity, and a high degree of quality among home and community-based services provided as part of our region's Ryan Whie continuum of care for low-income persons living with HIV. Home and Community-Based Health Services are provided to a client with HIV in a residential 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 funded under Home and Community-Based Health Services include:

- Appropriate mental health, developmental, and rehabilitation services;
- Day treatment or other partial hospitalization services;
- Purchase of prescribed durable medical equipment; and/or
- Home health aide services and personal care services in the home.

The objective of Home and Community-Based Health Services is to provide needed services in a home, apartment, group home, or other location in which a low-income person with HIV is residing in order to reduce the risk of hospitalization, prevent entry into a skilled nursing or other long-term care facility, and improve the health, wellness, and quality of life of functionally impaired individuals with HIV.

DESCRIPTION OF HOME AND COMMUNITY-BASED HEALTH SERVICES:

Home and Community-Based Health Services are provided to a client living with HIV in a residential or transitional assisted living 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. Inpatient hospitals, nursing homes, and other permanent long-term care care facilities are **not** considered a residential setting for the purposes of providing home and community-based health services. Services must be provided where the client resides such as own home, apartment or group home.

Key activities of Home and Community-Based Health Services include:

- Eligibility screening and intake;
- Comprehensive assessment and regular reassessment of each client's service needs;
- Development and ongoing revision of a comprehensive, individualized service plan;
- Service plan implementation, which may include:

  - ✓ Benefits and entitlements counseling and referral;
  - ✓ Support services;
  - ✓ Durable medical equipment;
  - ✓ Skilled nursing services by a Licensed Vocational Nurse (LVN) or Registered Nurse (RN);
  - ✓ Home Health Aide and personal care services;
  - ✓ Day treatment, one day stay, and partial hospitalization services;
  - ✓ Intravenous and aerosolized drug therapy;
  - ✓ Diagnostic testing; and/or
  - ✓ Mental health, developmental, and rehabilitation services;

- Re-evaluation of the service plan with the client at least every 6 months with revisions and adjustments as necessary; and
- Development of follow-up and discharge plans.

UNITS OF SERVICE:

- **A Home and Community-Based Health Unit of Service is defined as:**

  - ✓ One patient day, equal to 8 hours of care

  OR

  - ✓ One 15-minute contact between a client and a professional or paraprofessional service provider, or a single item of durable medical equipment.

HOME AND COMMUNITY-BASED HEALTH CARE SERVICE REQUIREMENTS:

Home and Community-Based Health Services must be offered in a manner that addresses barriers to needed care and uses resources and that supports clients remaining in their own homes as long as possible. All Home and Community-Based Health Services must include the key activities listed below:

- **Orientation:**

Each new client enrolled in Home and Community-Based Health Services must receive an orientation to the services at the first visit; this orientation must be documented in the client file.

- **Intake and Needs Assessment:**

The Home and Community-Based Health Services provider must conduct a comprehensive face-to-face intake and needs assessment with each client **within 30 days** of referral. The intake / needs assessment may be conducted by a nurse, social worker, or other professional Home and Community-Based Health Services staff member, and will describe the client's current status and inform the treatment plan. The intake process, at minimum, involves:

- Reviewing client rights and program services with resident; and
- Obtaining resident consent for treatment, including a signed release for sharing information with other providers to ensure coordination of services.

The comprehensive needs assessment must be conducted by an assigned Nurse Case Manager or Social Work Case Manager and must include at least the following components:

- Overall functional status;
- Current medical care, treatment plan, and providers;
- Assessment of overall client health, including adherence to therapies, disease progression, symptom management, and prevention issues;
- Client's ability to perform activities of daily living and level of assistance required;
- Income, benefits, and health insurance;
- Mental health and psychosocial care and providers;
- Family / social support system and availability;
- Living situation / environment;
- Mental health screening, including outlook and stressors;
- Substance use assessment / screening; and
- Other factors affecting ability of the client to access needed health and social services.

- **Comprehensive Service Plan and Service Plan Revision:**

A comprehensive service plan must be developed in coordination with the client's medical and psychosocial services team **within 30 calendar days** of the client's referral and re-evaluated **at least every six months** thereafter with adaptations as needed. Home and Community-Based Health Services providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input;
- Identifies and prioritizes the client's specific home health care needs;
- Incorporates the client's overall Care Plan, if available;
- Addresses the client's medical, social, mental health, environmental, and cultural needs, including referral and linkage to other relevant providers such as case managers, mental health providers, physicians, and housing specialists;
- Involves the input of existing family members and caregivers;
- Specifies the types of services needed, and the quantity and duration of services to be

provided, including the need for any durable medical equipment that is determined to be of therapeutic benefit to the client and prescribed by a medical provider; and
- Is signed and dated by the provider.

Throughout the care process, Home and Community-Based Health Care providers will 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. Staff will also advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services) and will continually monitor changes in client's physical and mental health and incorporate those changes into revised versions of the care plan. Providers will offer nursing care, including medication administration, under the supervision and orders of the client's primary care provider, while administering medications as required or indicated. Providers will notify the resident's primary care provider if resident refuses to comply with prescribed medication regimens and will work closely with members of the care team to effectively address client needs. Providers will also participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate.

Additionally, providers will give clients accurate information on available resources to address current and emerging health and psychosocial needs and will consult with case managers and care coordinators to facilitate appropriate referrals to programs and services that can successfully meet client needs. Providers will also assist clients in making informed decisions on choices of available service providers and resources and will address each client's spectrum of needs in a comprehensive way while minimizing duplication of services.

- **Discharge Plan:**

A discharge plan will be prepared for all clients who no longer require Home and Community-Based Health services. Discharge of clients should result from a **planned and progressive process** that takes into account the needs and desires of the client and the client's caregivers, family, and support network. A transfer or discharge plan is developed when criteria such as the following are met:

- Home-based providers no longer meet the level of care required by the client;
- Client wishes to discontinue services (with or against medical advice); or
- Client transfers services to another service program or a licensed care facility.

Agencies can consider using the IDEAL model of home-based care discharge planning, which includes the following elements:[1]

- **Include** the patient and caregivers, if present, as full partners in the discharge planning process;
- **Discuss** with the patient and caregivers key areas to prevent problems at home;

[1] https://www.axxess.com/blog/home-care/ideal-discharge-planning-in-home-health/

- **Educate** the patient and caregivers in plain language about the patient's condition, the discharge process, and next steps at every point in the discharge planning discussion;
- **Assess** how well clinicians have explained client diagnosis, conditions, and next steps in the patient's care to the patient and caregivers by having patients repeat key information and providing additional education as needed; and
- **Listen** to and honor the patient and caregiver's goals, preferences, observations and concerns.

Providers shall notify all relevant client medical and psychosocial providers regarding changes in home health status, and ensure that the decision to terminate Home and Community-Based Care Services in made in termination with the client's primary medical care team.

PROGRAM AND STAFFING REQUIREMENTS:

Professional diagnostic, therapeutic, rehabilitation, and other treatment services under this service category must be provided by trained and certified practitioners and professionals such as:

- Registered Nurses (RNs);
- Licensed Vocational Nurses (LVNs);
- Marriage and Family Therapists (MFTs);
- Licensed Clinical Social Workers (LCSWs);
- Physical Therapists (PTs);
- Occupational Therapists (OTs);
- Social Workers; and
- Medical Case Managers.

Through these providers, clients may receive day treatment of other partial hospitalization services where appropriate, as well as home-based intravenous and aerosolized drug therapy and prescription drugs administered as part of such therapy. Professionals staff may also perform routine diagnostic testing while mental health, developmental, and rehabilitation services may be provided by qualified and licensed staff.

Paraprofessional staff may provide services appropriate for their level of training/education, as part of a care team under the supervision of a licensed or certified clinician. These include but are not limited to:

- Home Health Aides
- Attendants
- Homemakers

Paraprofessional staff should be experienced in providing the services required and have all certifications required by State regulations (e.g., Home Health Aide Certification issued by the State of California). Home Health Aides, Attendants, and Homemakers may monitor vital signs,

support activities of daily living, and provide services such as meal preparation, grocery shopping, house cleaning, running errands, and accompanying clients to scheduled medical or related appointments. Attendant care services can also include assisting clients with activities of daily living such as bathing and personal hygiene care and prescribed exercises. Paraprofessional staff will promptly report to the Supervising RN any problems or questions regarding the client's adherence to medication and report any changes in the client's condition and needs, while completing appropriate client records as required by the Supervising RN.

All staff providing Home and Community-Based Health Services must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed **within 60 days** of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention;
- Privacy requirements and HIPAA regulations;
- Communicating effectively and sensitively with clients and caregivers;
- Ensuring communication with the client's medical and psychosocial service team; and
- Awareness and navigation of the local system of HIV care.

Ongoing individual supervision and guidance must be routinely provided to all staff.