Home and Community Based Health Services

Health Resources and Services Administration Definition: Home and Community Based Services:

Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. The main elements of Home and Community-based Health Services must include Physician order; Home visit with a nursing Assessment; Development of a written care plan, signed by physician; and appropriate referrals to meet needs identified in nursing assessment. Services include:

Allowable activities 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 in the home

Program Guidance:

Note: Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Eligibility: Clients shall meet eligibility requirements as defined in the System-Wide Service Standards.

1.0 Treatment Guideline Standards and Measures

The agencies shall ensure compliance with the most current U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Guide for HIV/AIDS Clinical Care – 2014 Edition as cited in the following standards.

1.0 Treatment Guideline Standards and Measures	
Standards	**Measure**

1.1	~~Client's Notice of Eligibility (NOE) shall indicate that the client's income is between 100% and 400% of the Federal Poverty Level (FPL).~~	~~1.1~~	~~Documentation of NOE in approved electronic database system.~~
1.2	Agencies shall submit a request to the Recipient/Lead Agency for payment for client cost sharing expenses with appropriate documentation. Subrecipients must make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients	1.2	Documentation in client's electronic health record.
1.3	Agency must ensure clients have a written plan of care established by a medical care team under the direction on a licensed clinical provider. Re-evaluation of the care plan at least every 60 days with adaptations as necessary.	1.3	Documentation in client's electronic health record.
1.4	Agency must ensure client have a ~~written~~ prescription or referral for the requested service or durable medical equipment.	1.4	Documentation in client's electronic health record.
1.5	Annual DME limit up to $750.00 per year per eligible client.	1.5	Documentation in client's electronic health record.
1.6	Durable Medical Equipment is limited to Medicare/ Medicaid approved items. Equipment must be obtained from a Medicare approved provider at the Medicare approved rate.	1.6	Documentation in client's electronic health record.

1.7	Clinicians shall develop/update plan of care at each home visit. Problem list documented.	1.7	Documentation in client's electronic health record.
1.8	Agencies shall maintain Memoranda of Understanding/Agreements or contracts that demonstrate coordination with other local, state, and/or private organizations that strengthen the care system for PWH and establishes a full range of service referrals.	1.8	MOUs, contracts, agreements available for review.

2.0 Scope of Services *(These are program specific policies and procedures)*

Agencies shall comply with all of the requirements outlined in this Service Standard, unless otherwise specified in their contract.

2.0 Scope of Services			
	Standards		**Measures**
2.1	~~Eligibility screening including assessing payer of last resort conducted every six (6) months or when a change has occurred that impacts a client's eligibility for services~~	~~2.1~~	~~Policies and procedures available for review.~~
2.2	Home and Community-Based Health Providers work closely with the client's case manager, primary care provider, and other appropriate health care professionals.	2.2	Documentation of verification of location in place.
2.3	**Initial Assessment:** A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care. Client will be contacted within one (1) business day of the referral, and services should be initiated at the time specified by the primary medical care provider, or	2.3	Percentage of clients with documented evidence of needs assessment completed in the client's primary record. Percentage of clients with documented evidence of a comprehensive evaluation completed by the Home and Community-

	within two (2) business days, whichever is earlier. A comprehensive evaluation of the client's health, psychosocial status, functional status, and home environment will be completed to include: • Assessment of client's access to primary care • Adherence to therapies • Disease progression • Symptom management and prevention, and • Need for nursing, caregiver, or rehabilitation services • 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.		Based Health Agency Provider in the client's primary record.
2.4	**Implementation of Care Plan:** A care plan will be completed based on the primary medical care provider's order and will include: • 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 Care plan is updated at least every sixty (60)-calendar days.	2.4	Percentage of clients with documented evidence of a care plan completed based on the primary medical care provider's order as indicated in the client's primary record. Percentage of clients with documented evidence of care plans reviewed and/or updated as necessary based on changes in the client's situation at least every sixty (60)-calendar days as evidenced in the client's primary record.
2.5	RWHAP services shall be integrated with other services and coordinated with other programs (including Medicaid) to enhance the continuity of care and prevention services for PWH.	2.5	Policies and procedures for the coordination of services available for review.

2.6 **Transfer/Discharge:** A transfer or discharge plan shall be developed when one or more of the following criteria are met: • Agency no longer meets 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. • When applicable, the client home or current residence is determined to not be physically safe (if not residing in a community facility) and/or appropriate for the provision of Home and Community-Based Health Services as determined by the agency. • When applicable, 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 one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable. All services discontinued under above circumstances must be accompanied by a referral to an appropriate service provider agency involvement, stakeholder involvement, **and** a CQM program evaluation mechanism.	2.6 Percentage of clients with documented evidence, as applicable, of a transfer plan developed and documented with referral to an appropriate service provider agency as indicated in the client's primary record. Percentage of clients with documented evidence of a discharge plan developed with client, as applicable, as indicated in the client's primary record..