Home & Community-Based Health Services

Health Resources and Services Administration Definition: 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. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment (DME)
- Home health aide services and personal care services in the home

Program Guidance: 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.

Note: In the Orlando Service Area, only durable medical equipment is funded; however, other allowable activities under this service category may be approved on a case-by-case basis by the Ryan White HIV/AIDS Program (RWHAP) Part A Recipient or the RWHAP Part B Lead Agency.

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		Measures
1.1	Agencies must ensure clients have a written plan of care established by a a licensed clinical provider. Initial plans of care shall be established within seven (7) calendar days of the initial visit. Re-evaluation of the plan of care should occur at least every sixty (60) calendar days with adaptations as necessary.	1.1	Documentation in client's electronic health record.

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1.2	Agencies must ensure that the client's plan of care indicates whether the DME is temporary or permanent.	1.2	Documentation in client's electronic health record.
1.3	Agencies must ensure that clients have a written prescription or referral for the requested service or durable medical equipment.	1.3	Documentation in client's electronic health record.
1.4	Provider shall comply with the Home & Community Based Health Service Standard Exception Request process and guidelines when a client reaches the annual maximum for the fiscal year **Note:** The annual maximum is determined by the Recipient or Lead Agency.	1.4	Documentation in client's electronic health record should include the following: • Exception request letter • Treatment plan • Medical history including medication list • Any other documentation requested by the Recipient or Lead Agency
1.5	Durable Medical Equipment (DME) is limited the allowable items on the approved fee schedule. Equipment must be obtained from a provider who will accept the approved rates on the fee schedule.	1.5	Documentation in client's electronic health record.
1.6	Home Health Aide Providers shall develop/update plan of care at each home visit. Problem list should be documented.	1.6	Documentation in client's electronic health record.

2.0 Scope of Service (*Program Specific Policies & Procedures*)

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

2.0 Scope of Service

	Standards		Measures
2.1	Home and Community-Based Health Providers work closely with the	2.1	Documentation of verification of location in place.

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	client's case manager, primary care provider, and other appropriate health care professionals.		
2.2	**Initial Assessment:** A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care. Clients 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 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.	2.2	Documentation in client's electronic health record.
2.3	**Implementation of Plan of Care:** A plan of care 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	2.3	Documentation in client file of plan of care after seven (7) calendar days. Client's needs assessment on file in their electronic health record.

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	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 A plan of care should be developed within seven (7) days of the initial visit. The plan of care is updated at least every sixty (60)calendar days.		Documentation of the services provided.
2.4	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 people with HIV (PWH).	2.4	Policies and procedures for the coordination of services available for review.

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3.0 Discharge

Clients who are no longer engaged in Home & Community Based Health Services or have achieved self-sufficiency should have their cases closed based on the criteria and protocol outlined in the Agency's Policies and Procedures Manual.

3.0 Discharge/Graduation

	Standards		Measures
3.1	**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.	3.1	Documentation of case closure and 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. Documentation of a discharge plan developed with the client, as applicable, as indicated in the client's primary record.

• Has achieved all goals listed on the plan of care • Has become ineligible for services • Is deceased • Decides to discontinue services • The agency is unable to contact the client • Is found to be improperly utilizing the service and/or is asked to leave the agency All services discontinued under the above circumstances must be accompanied by a referral to an appropriate service provider agency involvement, stakeholder involvement, **and** a CQM program evaluation mechanism.	

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