

Home Health Care Standards of Care

Definition:

Home Health Care is defined as support provided in the patient's home by licensed health care workers such as nurses.

Limitations:

Non-allowable services include inpatient hospital services, nursing home and other long term care facilities

Excludes personal care

Services:

Home Health Care are services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed primary medical care provider. Home health services include the following:

- The administration of intravenous and aerosolized treatment
- Parenteral feeding
- Diagnostic testing
- Other medical therapies

Agency/Personnel /Staff Training

Staff Qualification	Expected Practice
Agency Qualifications The agency shall be licensed and certified by the State of Texas to provide home health services.	License and /or certification is posted in a conspicuous place at the agency's main office.
Agency System of Care The agency shall provide access to its system of care for HIV/AIDS patients twenty-four (24) hours/day, and must provide mechanisms for urgent and/or emergency care.	Documented policy on operation and procedures to contact agency after hours for urgent and/or emergency care.

<p>Agency Policies and Procedures</p>	<p>The agency shall have policies/procedures for the following:</p> <ul style="list-style-type: none"> -Patient rights and responsibilities, including confidentiality guidelines -Patient grievance policies and procedures -Patient eligibility and admission requirements -Referral resources and procedures that ensure access to a continuum of services -All appropriate consent forms (e.g., consent to share information, shared patient data/registration system (ARIES), HIPAA requirements) -Data collection procedures and forms, including data reporting -Quality assurance/quality improvement -Guidelines for language accessibility
<p>Staff Experience Agency shall employ clinical staff who are experienced regarding their area of clinical practice as well as knowledgeable in the area of HIV/AIDS clinical practice.</p>	<p>Personnel records/resumes/applications for employment will reflect requisite experience/education. Provider will document training received according to professional licensure requirements.</p>
<p>Staff Credentials Professional staff (nurses, physical therapists, and social workers) should have appropriate licenses and/or credentials set forth by the State of Texas per the HRSA National Monitoring Standards.</p>	<p>All agency professional staff, contractors, and consultants who provide direct-care services, and who require licensure, shall be properly licensed by the State of Texas, or documented to be pursuing Texas licensure while performing tasks that are legal within the provisions of the Texas Medical Practice Act (or in the case of a nurse, the Nursing Practice Act), including satisfactory arrangements for malpractice insurance, with evidence of such in the personnel file.</p>
<p>Education The agency shall keep abreast of current treatment methodologies as outlined in the most recent version of the Public Health Service guidelines for persons living with HIV/AIDS.</p>	<p>Provider will document provision of in-service education to staff regarding current treatment methodologies and promising practices.</p>
<p>Billing Requirements Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third party payers.</p>	<p>Provider will provide evidence of third-party billing.</p>

Standards of Care

Standard	Measure
<p>Intake and Service Eligibility According to the HRSA HIV National Monitoring Standards, eligibility for services must be determined.</p>	<p>The primary care provider has deemed home and community-based home health care services necessary.</p> <p>-The referring physician must:</p> <ul style="list-style-type: none"> • Provide signed orders in writing to the agency prior to the initiation of care • Act as that patient's primary care physician • Maintain a consistent plan • Communicate changes from the initial plan directly to the agency. <p>In the event that the referring provider is unable to continue the provision of primary health care services, the provider must be willing to transfer the patient to the care of a willing medical care provider.</p> <p>Eligibility information will be obtain from the primary care provider/case manager that includes</p> <ul style="list-style-type: none"> - Contact and identifying information (name, address, phone, birth date, etc.) -Language(s) spoken -Literacy level (patient self-report) -Demographics -Emergency contact -Household members -All current health care and social service providers, including case management providers - Pertinent releases of information -Documentation of insurance status -Documentation of income (including a “zero income” statement) -Documentation of state residency -Documentation of proof of HIV positivity -Photo ID or two other forms of identification -Acknowledgement of patient's rights <p>Consent for treatment and signed release for sharing information with other providers will be obtained to ensure coordination of services.</p> <p>The patient’s eligibility must be recertified for the program every six (6) months.</p>
<p>Refusal of referral</p>	<p>The home health agency may refuse a referral for the following reasons only:</p>

	<p>-Based on the agency's perception of the patient's condition, the patient requires a higher level of care than would be considered reasonable in a home setting.</p> <ul style="list-style-type: none"> • The agency must document the situation in writing and immediately contact the patient's primary medical care provider. <p>-The agency has attempted to complete an initial assessment and the referred patient has been away from home on three occasions.</p> <ul style="list-style-type: none"> • The agency must document the situation in writing and immediately contact the referring primary medical care provider. <p>-The patient's home or current residence must be determined physically safe (if not residing in a community facility) before services can be offered or continued.</p>
<p>Initial Assessment A preliminary needs assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care.</p>	<p>Patient will be contacted within twenty-four (24) hours of the referral, and services should be initiated at the time specified by the primary medical care provider, or within forty-eight (48) hours, whichever is earlier.</p> <p>A comprehensive evaluation of the patient's health, psychosocial status, functional status, and home environment should be completed to include: -Assessment of patient's access to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for nursing services.</p>
<p>Implementation of Care Plan According to the HRSA National Monitoring Standards, all services are provided based on a written care plan signed by a health care provider.</p>	<p>A care plan will be completed based on primary medical care provider's order and include: -Current assessment and needs of the patient. -Need for home health services -Types, quantity and length of time services are to be provided</p> <ul style="list-style-type: none"> • All planned services are allowable within this service category • Care plan is signed by clinical health care professional. <p>Professional staff will: -Provide nursing and rehabilitation therapy care under the supervision and orders of the patient's primary medical care provider. -Monitor the progress of the care plan by reviewing it regularly with the patient and revising it as necessary based on any changes in the patient's</p>

	<p>situation.</p> <ul style="list-style-type: none"> -Advocate for the patient when necessary (e.g., advocating for the patient with a service agency to assist the patient in receiving necessary services). -Monitor changes in patient’s physical and mental health, and level of functionality. -Work closely with patient’s other health care providers and to effectively communicate and address patient service related needs, challenges and barriers.
<p>Provision of Services Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home health services.</p>	<p>Progress notes will be kept in the agency's patient's record.</p> <p>Care Providers will update the plan of treatment at least every sixty (60) days.</p> <p>The agency will maintain ongoing communication with the primary medical care provider in compliance with Texas Medicaid and Medicare Guidelines.</p> <p>The Home Health provider will document in the patient's agency progress notes throughout the course of the treatment, the patient is not in need of acute care.</p>
<p>Transfer/Discharge Transfer and discharge of patients from home and community-based home health care services should result from a planned and progressive process that takes into account the needs and desires of the patient and his/her caregivers, family, and support network.</p>	<p>A transfer plan should be developed when one or more of the following criterion are met:</p> <ul style="list-style-type: none"> -Agency no longer meets the level of care required by the patient. -Patient transfers services to another service program. -The patient is not stable enough to be cared for outside of the acute care setting as determined by the agency and the patient's primary medical care provider. -The patient no longer has a stable home environment appropriate for the provision of home health services as determined by the agency. -Patient is unable or unwilling to adhere to agency policies. -An employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a patient's home, in the company of an escort or not. The agency may discontinue services or refuse the patient for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within 24 hours and followed by a written report. A copy of the police report is sufficient, if applicable.

	<p>All services discontinued under above the circumstances must be accompanied by a referral to an appropriate service provider agency.</p> <p>Patient may be discharged if:</p> <ul style="list-style-type: none"> -The patient no longer medically requires home health care as determined by the agency or the primary medical care provider. -Patient moves out of the area. -Patient wishes to discontinue services (with or against medical advice).
<p>Documentation in Patients Chart</p>	<p>The following will be documented in the agency's patients record:</p> <ul style="list-style-type: none"> -Documentation of proof of HIV positivity -Proof of residency -Verification of financial eligibility, if appropriate -Patient demographics -Intake and assessment information -The types, dates, and location of services provided - Documentation that services provided were consistent with the treatment plan -Signature of the professional who provided the service at each visit -Documentation that primary medical care provider was updated periodically regarding patient's progress -Documentation of reason for transfer/discharge.

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
April 2013, p.13-14.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B
April, 2013, p. 13-14.

Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS
Standards of Care for HIV/AIDS Services 2009.

San Francisco EMA Home-Based Home Health Care Standards of Care February 2004.

Texas Administrative Code, Title 40, Part 1, Chapter 979, Subchapter B, Rule 97.211