HRSA Definition: Home and Community-Based Health Services are provided to a 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. Services include:

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

Limitations: Services cannot be provided in the following facilities: inpatient hospital facilities, nursing homes, and other long term care facilities.

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.

Services: Home and Community-Based Health Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a licensed/certified home or community-based setting (e.g. adult daycare center) in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following:

- **Para-professional care** is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help clients remain in their homes.
- **Professional care** is the provision of services in the home by licensed providers for mental health, development health care, and/or rehabilitation services.

Home and Community-Based Health Providers work closely with the multidisciplinary care team that includes the client's case manager, primary care provider, and other appropriate health care professionals.
Service Standard and Performance Measure
The following Standards and Performance Measures are guides to improving health outcomes for PLWH throughout the State of Texas within the Ryan White Part B and State Services Program.

<table>
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<tr>
<th>Standard</th>
<th>Performance Measure</th>
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<tr>
<td><strong>Refusal of referral:</strong> The home or community-based health agency may refuse a referral for the following reasons only:</td>
<td>Percentage of clients with documented evidence of agency refusal of services with detail on refusal in the client’s primary record AND if applicable, documented evidence that a referral is provided for another home or community-based health agency.</td>
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| • Based on the agency’s perception of the client's condition, the client requires a higher level of care than would be considered reasonable in a home/community setting.  
  a. The agency must document the situation in writing and immediately contact the client's primary medical care provider. |                                                                                                                                                      |
| • The agency has attempted to complete an initial assessment and the referred client has been away from home on three occasions.  
  a. The agency must document the situation in writing and contact the referring primary medical care provider. |                                                                                                                                                      |
| The client's home or current residence is determined to not be physically safe (if not residing in a community facility) before services can be offered or continued. |                                                                                                                                                      |
### 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 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.

### 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.
**Provision of Services:** Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community-based health services.

Progress notes will be kept in the client's primary record and must be written the day services are rendered.

Progress notes will then be entered into the client record within 14 working days.

The agency will maintain ongoing communication with the multidisciplinary medical care team in compliance with Texas Medicaid and Medicare Guidelines.

The Home and Community-Based Provider will document in the client’s primary record progress notes throughout the course of the treatment, including evidence that the client is not in need of acute care.

**Coordination of Services and Referrals:** If referrals are appropriate or deemed necessary, the agency will:
- Ensure that service for clients will be provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and encouraging client access to integrated health care.
- Consistently report referral and coordination updates to the multidisciplinary medical care team.
- Assist clients in making informed decisions on choices of available service providers and resources.

| Percentage of clients with documented evidence of completed progress notes in the client’s primary record. |
| Percentage of clients with documented evidence of ongoing communication with the primary medical care provider and care coordination team as indicated in the client’s primary record. |
| Percentage of clients accessing home and community-based health services with documented evidence of referrals, as applicable, to other services as indicated in the client’s primary record. |
| Percentage of clients accessing home and community-based health services have follow up documentation to the referral offered in the client’s primary record. |
**Transfer/Discharge**: A transfer or discharge plan shall be developed when one or more of the following criterion 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.

<table>
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<tr>
<th>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.</th>
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<tr>
<td>Percentage of clients with documented evidence of a discharge plan developed with client, as applicable, as indicated in the client’s primary record.</td>
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References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 14-16


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 97, Subchapter B, Rule 97.211