

# Home Health Care Service Standard

**Health Resources & Services Administration (HRSA) Description:** Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g., intravenous, and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostic testing administered in the home
- Other medical therapies

**Program Guidance:** The provision of Home Health Care is limited to clients that are homebound.

**Limitations:** Home Health Care cannot be provided in nursing facilities or inpatient mental health/substance abuse treatment facilities. Personal care and non-licensed in-home care providers are not allowable services.

**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 care services must be prescribed by a licensed medical provider and can be performed by licensed medical professionals such as physicians, mid-level providers, nurses, and certified medical assistants.

## Service Standard and Measure

The following Standards and Measures are guides to improving healthcare outcomes for people living with HIV throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Measure
<p><b>Physician Orders:</b> The primary care provider has deemed Home Health Care services necessary. The referring physician must:</p> <ul style="list-style-type: none"> <li>• Provide signed orders in writing to the agency prior to the initiation of care Act as that client's primary care physician</li> <li>• Maintain a consistent plan</li> <li>• Communicate changes from the initial plan directly to the agency.</li> </ul> <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 client to the care of an accepting medical care provider that meets program licensure and other educational requirements.</p>	<p>Percentage of clients with documented evidence in the client's primary record of the ordering physician's signed orders for home health care services.</p> <p>Percentage of clients with documented evidence in the client's primary record of the physician's home health care plan as provided to the agency.</p>
<p><b>Agency Refusal of referral:</b> The home health agency may refuse a referral for the following reasons only:</p> <ul style="list-style-type: none"> <li>• 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 setting.</li> <li>• The agency must document the situation in writing and immediately contact the client's primary medical care provider.</li> <li>• The agency has attempted to complete an initial assessment and the referred client has been away from home on three occasions.</li> <li>• The agency must document the situation in writing and immediately contact the referring primary medical care provider.</li> <li>• 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.</li> </ul>	<p>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 health agency.</p>
<p><b>Initial Assessment:</b> A preliminary needs assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care.</p> <p>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.</p>	<p>Percentage of clients with documented evidence of needs assessment completed in the client's primary record.</p> <p>Percentage of clients with documented evidence of a comprehensive evaluation completed by the home health care agency provider in the client's primary record.</p>

<p><b>Initial Assessment (continued):</b> A comprehensive evaluation of the client’s health, psychosocial status, functional status, and home environment should be completed to include:</p> <ul style="list-style-type: none"> <li>• Assessment of client’s access to primary care</li> <li>• Adherence to therapies</li> <li>• Disease progression</li> <li>• Symptom management and prevention, and</li> <li>• Need for nursing services.</li> </ul>	
<p><b>Implementation of Care Plan</b>  A care plan will be completed based on primary medical care provider's order and include:</p> <ul style="list-style-type: none"> <li>• Current assessment and needs of the client including medication, dietary, treatment, and activities orders;</li> <li>• Need for home health services;</li> <li>• Types, quantity, and length of time services are to be provided</li> <li>• All planned services are allowable within this service category</li> <li>• Care plan is signed by clinical health care professional.</li> </ul> <p>Care Providers will update the plan of treatment at least every sixty (60) calendar days.</p> <p>Professional staff will:</p> <ul style="list-style-type: none"> <li>• Provide nursing and rehabilitation therapy care under the supervision and orders of the client’s primary medical care provider.</li> <li>• 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.</li> <li>• Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services).</li> <li>• Monitor changes in client’s physical and mental health, and level of functionality.</li> <li>• Work closely with client’s other health care providers and to effectively communicate and address client service-related needs, challenges, and barriers.</li> </ul>	<p>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.</p> <p>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.</p>

<p><b>Provision of Services:</b> 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 primary client's record and must be written the day service rendered and incorporated into the client record within 14 working days.</p> <p><a href="https://texreg.sos.state.tx.us/public/readtac\$ext.TacPage?sl=R&amp;app=9&amp;p_dir=&amp;p_rloc=&amp;p_tloc=&amp;p_ploc=&amp;pg=1&amp;p_tac=&amp;ti=1&amp;pt=15&amp;ch=354&amp;rl=1039">https://texreg.sos.state.tx.us/public/readtac\$ext.TacPage?sl=R&amp;app=9&amp;p_dir=&amp;p_rloc=&amp;p_tloc=&amp;p_ploc=&amp;pg=1&amp;p_tac=&amp;ti=1&amp;pt=15&amp;ch=354&amp;rl=1039</a></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 client's primary record progress notes throughout the course of the treatment, the client is not in need of acute care.</p>	<p>Percentage of clients with documented evidence of completed progress notes within 14 working days of the service rendered in the client's primary record.</p> <p>Percentage of clients with documented evidence of ongoing communication with the primary medical care provider as indicated in the client's primary record.</p>
<p><b>Transfer/Discharge:</b> Transfer and discharge of clients from home health care services should result from a planned and progressive process that takes into account the needs and desires of the client and his/her caregivers, family, and support network.</p> <p>A transfer plan should be developed when one or more of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Agency no longer meets the level of care required by the client.</li> <li>• Client transfers services to another service program.</li> <li>• The client is not stable enough to be cared for outside of the acute care setting as determined by the agency and the client's primary medical care provider.</li> <li>• The client no longer has a stable home environment appropriate for the provision of home health services as determined by the agency.</li> <li>• Client is unable or unwilling to adhere to agency policies.</li> <li>• 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.</li> </ul>	<p>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.</p> <p>Percentage of clients with documented evidence of a discharge plan developed with client, as applicable, as indicated in the client's primary record.</p>

**Transfer/Discharge (continued):**

Per TAC, agency intending to transfer or discharge a client must:

- Provide written notification to the client or the client’s parent, family, spouse, significant other or legal representative; AND
- Notify the client’s attending physician or practitioner if he/she is involved in the agency’s care of the client.
- Written notification must be delivered no later than five (5) days before the date on which the client will be transferred or discharged.

[https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p\\_dir=&p\\_rloc=&p\\_tloc=&p\\_ploc=&pg=1&p\\_tac=&ti=1&pt=15&ch=354&rl=1039](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=354&rl=1039)

Client may be discharged if:

- The client no longer medically requires home health care as determined by the agency or the primary medical care provider.
- Client moves out of the area.
- Client wishes to discontinue services (with or against medical advice).

## References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p.13-14. Accessed on October 12, 2020 at: <https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf>

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 13-14. Accessed October 12, 2020 at: <https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf>

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

Texas Administrative Code, Title 1 Administration, Part 15 Texas Health and Human Services Commission, Chapter 354 Medicaid Health Services, Subchapter A Purchased Health Services, Division 3 Medicaid Home Health Services, Rule §354.1039 Home Health Services Benefits and Limitations,  
[https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p\\_dir=&p\\_rloc=&p\\_tloc=&p\\_ploc=&pg=1&p\\_tac=&ti=1&pt=15&ch=354&rl=1039](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=354&rl=1039)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), [https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN\\_16-02Final.pdf](https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf)