Home and Community-Based Health Services Service Standard

Texas Department of State Health Services, HIV Care Services Group – HIV/STD Program

Subcategories	Service Units
Durable Medical Equipment	Per item
Home and Community-Based Health Services	Per visit
Para-Professional Care	Per visit
Professional Care	Per visit

Health Resources and Services Administration (HRSA) Description:

Home and Community-Based Health Services (HCBHS) are services provided to an eligible client 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
- Home health aide services and personal care services

Limitations:

Agencies cannot fund services provided in inpatient hospital facilities, nursing homes, and other long-term care facilities.

Services:

Home and Community-Based Health Services are therapeutic, nursing, supportive, or health services provided by a licensed and certified home health agency in a licensed and 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:

- **Paraprofessional care:** services provided by a home health aide, personal caretaker, or attendant. This also includes assistance with cooking and cleaning activities to help clients remain in their homes.
- **Professional care**: services in the home by licensed providers for mental health, developmental health care, 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 healthcare professionals as appropriate.

Universal Standards:

Service providers for Home and Community-Based Health Services must follow HRSA and DSHS Universal Standards 1-63 and 101-104.

Service Standards and Measures:

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

Standard	Measure
Referral by Licensed Medical Provider: A medical provider must provide a referral for clients receiving Home and Community-Based Health Services.	1. Percentage of clients with documentation of a referral for services from a licensed medical provider prior to initiation of services.
Initiation of Services and Assessment: Agencies must contact the client within one business day of the agency's receipt of a referral from a licensed medical provider. Agencies must initiate services within two business days of receipt of the referral or when specified by the referring provider. Service initiation must include a comprehensive assessment of the client's physical, psychosocial, and home safety status. Assessments may include, as relevant to the client's needs and planned services: • Past medical history • Acute or chronic health conditions • Current system of support to meet basic needs and activities of daily living • Fall risk and home and environmental safety • Cognition and level of consciousness • Access to food and emergency assistance • Access to primary and specialty medical care • Ability to self-manage prescribed therapies	2. Percentage of clients with documentation that a comprehensive assessment was completed within two business days of receipt of the referral or at the time specified by the ordering provider.

• Nursing assessment (for skilled nursing services), including a head-to-toe assessment • Current regimen and response to prescribed symptom management and prevention • Current medication list • Emergency contact(s)	

Care Plan: Agency staff must complete a care plan based on the client's needs that includes:
• Need for Home and Community-Based Health Services, including, as applicable:
  • Assistance with activities of daily living (e.g., personal hygiene, dressing, eating) or basic cooking and cleaning assistance
  • Day treatment or adult daycare services
  • Durable medical equipment
• Types and quantity of services, and length of time the agency will provide services
 	
Staff must update the care plan at least every 60 days.
	3. Percentage of clients with documentation of a client-centered care plan.
	4. Percentage of clients with documentation of review and update to their care plan every 60 days at a minimum.

Provision of Services: Staff must provide services in accordance with the client's care plan and document all services in the client's record. Documentation must include: • The type of service provided • The date of service • The location of services (e.g., the client's home or an outside facility) • The signature of the professional who provided services. If staff identify a client need outside the agency's scope, the agency must refer the client to an outside provider. Agencies shall assist clients and caregivers in making informed decisions on referral services. Staff must document all referrals in the client record.	5. Percentage of client charts with documentation of services provided, in accordance with the care plan, including: (Pilot Measure 2025-2026) 5a. Type of service provided 5b. Date of service 5c. Location of service 5d. Signature of the professional providing services
Transfer and Discharge: Agencies will develop a transfer or discharge plan in coordination with the client or client's caregiver for any of the following circumstances: • The agency is not able to meet the level of care required by the client. • The client transfers services to another service program. • The client discontinues services. • The client relocates out of the service delivery area. • The agency determines that the client's home or current residence is not physically safe or appropriate for the provision of Home and Community-Based Health Services. When agencies transfer services, they must document a referral to an appropriate service provider.	6. Percentage of clients transferred or discharged from services with documentation of a transfer or discharge plan developed in coordination with the client or client's caregiver to facilitate a safe transfer, handoff, or discharge from services.

References:

Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients.* Health Resources and Services Administration, March 2025.

Division of State HIV/AIDS Programs, HIV/AIDS Bureau (HAB). *Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients*. Health Resources and Services Administration, March 2025.

Ryan White HIV/AIDS Program. *Policy Notice 16-02: Eligible Individuals & Allowable Uses of Funds*. Health Resources & Services Administration, October 2018.

Centers for Medicare and Medicaid Services (CMS), Home and Community-Based Services. *Home-and Community-Based Services | CMS*. Centers for Medicare & Medicaid, January 2023.