Home Health Care Service Standard

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

Subcategories	Service Units
Home Health Care	Per visit
Home Health Specialized Care	Per visit

Health Resources & Services Administration (HRSA) Description:

Home Health Care is the provision of services in the home, by licensed professionals, that are appropriate to an eligible client's needs.

Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g., intravenous medication, aerosolized treatments, or parenteral feeding)
- Preventive and specialty care
- Wound care
- Physical therapy
- Occupational therapy
- Speech-language pathology services
- Routine diagnostic testing administered in the home
- Other medical therapies

Program Guidance:

Home Health Care is limited to homebound clients. Agencies may fund non-licensed personal care services under the Home and Community-based Health Services service category.

Limitations:

Providers cannot conduct Home Health Care in nursing facilities or inpatient mental health or substance abuse treatment facilities. Service providers must have licensure. Agencies may not provide personal care services under the Home Health Care category.

Universal Standards:

Services providers for Home Health Care must follow HRSA and DSHS Universal Standards 1-63 and 99-100.

Service Standards and Measures:

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
Initiation of Care Orders: The home health agency must receive written orders from the client's primary HIV medical provider before initiating care. The referring provider may be a physician, nurse practitioner, clinical nurse specialist, or physician assistant. A licensed practitioner must provide care to include the following: • Doctor of Medicine (MD) • Doctor of Osteopathy (DO) • Nurse Practitioner (APRN) • Clinical Nurse Specialist (CNS) • Physician Assistant (PA)	1. Percentage of clients with documentation of signed orders for home health care services by a qualified licensed practitioner before initiation of care by the home health agency.
Homebound Status: The ordering provider must certify the client is homebound or confined to home as defined by one or more of the following criteria: • The client needs the aid of supportive devices, such as crutches, canes, wheelchairs, or walkers, to leave the house. • The client has a condition where leaving the home is medically contraindicated. • Leaving the home would require a considerable and taxing effort. Note: If the client does leave the home, the client may still meet the definition of homebound if the absences from the home are infrequent or for periods of relatively short duration	2. Percentage of clients with documentation that a licensed health care practitioner certified the client's homebound status.

or are attributable to the need to receive health care treatment.	
Timely Initiation of Care: Staff must contact the client within one business day of the referral and initiate services at the time specified by the primary medical care provider or within two business days.	3. Percentage of clients with documentation that the agency initiated care either within two business days of receipt of a referral or on the date specified by the provider.
Initial Assessment: Agencies must complete a comprehensive assessment of the client's past medical history and psychosocial, functional, and current health status. The assessment must include, as applicable to the client's needs: • Assessment of access to medical care • Ability to adhere to therapies • Disease stage • Symptom management and prevention • Need for nursing and support services • Family and or another support system • Safety of living environment • Level of risk for falls • Medications • Treatments • Head-to-toe nursing assessment of body systems • Ability to perform activities of daily living	4. Percentage of clients with documentation of a completed comprehensive assessment on initiation of care.
Implementation of Care Plan: Staff will complete a care plan based on the primary medical care provider's order that includes: • Current assessment and needs of the client • Need for home health services • Types and quantity of services and length of time the agency will provide services	5. Percentage of clients with documentation of a care plan completed in accordance with the primary medical care provider's order(s). 6. Percentage of clients with care plans reviewed or updated as necessary based on changes in the client's situation at least every 60 calendar days.

• Signature of a licensed healthcare professional Care providers will update the care plan at least every 60 calendar days.	
Provision of Services: Professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the client's primary medical care provider. • Monitor changes in the client's physical and mental health, and level of functionality. • Work closely with the client's other healthcare providers and effectively communicate and address client service-related needs, challenges, and barriers. • Assure that the services are in accordance with allowable modalities and locations under the definition of home health services. • Write progress notes on the day staff rendered service and incorporate progress notes into the client record within 14 working days. • Maintain ongoing communication with the client's primary medical care provider.	7. Percentage of clients with documentation of completed progress notes within 14 working days of the service rendered in the client's primary record. 8. Percentage of clients with documentation of ongoing communication and care coordination with the primary medical care provider.
Transfer and Discharge: The agency must develop a planned and progressive process for transferring and discharging clients from home health care services. The discharge and transfer processes must consider the needs and desires of the client, caregiver(s), family, and support network. Agencies must develop a transfer or discharge plan when one or more of the following occur: • The agency no longer meets the level of care required by the client. • The client transfers services to another service program.	9. Percentage of clients with documentation of a discharge or transfer plan developed in coordination with the client, caregiver(s), and multidisciplinary team, as applicable.

• The client is not stable enough to receive services outside of the acute care setting, as determined by the agency and the client's primary medical care provider. • The client no longer has a stable home environment appropriate for the provision of home health services as determined by the agency. • The client is unable or unwilling to adhere to agency policies. An employee of the agency has experienced a real or perceived threat to 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.	
Notification of Transfer or Discharge: When an agency transfers or discharges a client from services, they must: • Provide written notification to the client or the client's parent, family, spouse, significant other, or legal representative. • Provide written notification to the client's attending physician or practitioner. Agencies must deliver the written notification no later than five days before the date on which the agency will transfer or discharge the client.	10. Percentage of clients with documentation of notification of transfer or discharge within five days before the date of transfer or discharge as applicable to the following parties: 10a: The client or legal representative 10b: The client's attending practitioner, as applicable.

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 22, 2018.

42 USC 1395n and 42 USC 1395x(m): Social Security Act

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*