HOME HEALTH CARE STANDARDS

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I. DEFINITION OF SERVICES

Health Resources and Services Administration/Transitional Grant Area (TGA) Definition

*Home and Community-based Health Services* includes skilled health services furnished to the individual in the individual’s home, based on a written plan of care, established by a case management team that includes appropriate health care professionals (registered nurse, licensed vocational nurse, home health aide). Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; appropriate mental health, developmental and rehabilitation services. In patient hospitals services, nursing home and other long term care facilities are NOT included.

II. PURPOSE OF SERVICE

The purpose is to provide home based services to eligible clients so they can safely remain in their homes and reduce hospitalizations.

III. GOALS OF SERVICE

To improve the quality of health for HIV/AIDS clients while they are home-bound.

IV. CLIENT CHARACTERISTICS

Individuals living with HIV/AIDS can live longer, healthier lives because of advances in treatment of HIV care; however some clients continue to need services at home to prevent future hospitalizations. Home care services are for clients who are unable to meet their personal care needs without assistance and who have no additional resources to pay for home health services.
Clients are eligible for home care services based on: Proof of HIV+ Serostatus; established residence within the TGA; and Medi-cal eligibility. Referrals are from medical case managers or primary care providers. CARE funds will be used only for services that are not reimbursed by any other source of revenue.

V. PROVIDER QUALIFICATIONS

The agency must have a state of CA home care license and the ability to bill Medi-Cal or have a system in place to refer Medi-Cal eligible clients.

**Skilled Nurse** is a registered nurse (RN) that provides appropriate skilled nursing care to clients in their place of residence in accordance with state/federal regulations. The nurse teaches the client/family disease process and self-care needs and assists clients to return to their highest level of functioning; monitors the physiological state to determine an appropriate level of safety and comfort to promote rehabilitation; provides services requiring nursing skills in accordance with the treatment plan of care; develops and coordinates the treatment plan of care; performs duties consistent with the nursing practice act that include the standards of competent performance including Title 16 chapter 14 section 1443.5 of the California Code of Regulations

**Licensed vocation nurse (LVN)** – is a health professional that works under the supervision of a doctor (MD) or RN. Basic bedside care services performed by the LVN include taking vital signs such as temperature, blood pressure, pulse, and respiration; treat bedsores; prepare and give injections and enemas; apply dressings and monitor catheters; observe patients and report adverse reactions to medications or treatments; collect samples for testing; perform routine laboratory tests; feed patients and record food and fluid intake and output; assist patients with bathing, dressing, and personal hygiene; keep patients comfortable; care for client’s emotional needs

**Home Health Aide (HHA)** is a paraprofessional involved in a range of services that extend from basic housekeeping to assistance with activities of daily living. Services that are performed by the HHA typically include ensuring a clean, healthy home environment, shopping and meal preparation, grooming, bathing and other personal care services for the client. All agencies must have a plan in place to determine the competency of all HHA’s. Supervision of the HHA’s in the home is the responsibility of the home care provider agency. A nurse must provide supervision with the HHA’s every two weeks, (monthly for Ryan White program). The home care provider visits the clients’ home either when the HHA is present to observe the aide providing care or when the HHA is absent to assess the relationship between the HHA and the client (HIM-11, Section 206.2)

**Attendant**

State Office of AIDS/Community Based Care Section (OA/CBC) requires that only individuals who possess either a current California Certified Nursing Assistant (CNA) or Certified Home Health Aids (CHHA) certificate can provide Attendant Care. Program staff shall monitor
subcontractors to ensure that only individuals who possess current California CNN or CHHA certificates are used to provide attendant services to Ryan White clients.

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<td>1.1 Staff meets the minimum qualifications detailed in the job description</td>
<td>1.1 Resume, license, certifications (as applicable); CEU’s and written job descriptions</td>
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<td>1.2 Each agency will ensure that appropriate staffing levels are reached and maintained to provide contracted services.</td>
<td>1.2 Full and part-time positions funded under contract are filled; or appropriate actions are taken to fill positions.</td>
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<tr>
<td>1.3 Each agency will have a CA home care license and meet state standards</td>
<td>1.3 Licensures, list of staff trainings, consents, HIPPA regulations, policies and procedures</td>
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VI. UNITS OF SERVICE/ACUITY

Client caseload is determined by level of acuity, service activity and funding amount. A home health care unit of service is 1 hour of service. Services are reimbursed by a fee for service contract.

Acuity levels measure cognitive and functional ability and should be assessed every 30-60 days using the attached tool. Areas of assessment include nutrition, hygiene, excretion, activity, treatment/medication, teaching, support systems, mental status and behavior. Clients requiring home care services need moderate to considerable assistance. Totally dependent clients should be referred to a hospice program or nursing home.

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<td>1.1 Units of Service and fees must be reflected in the outpatient medical care contract.</td>
<td>1.1 Documentation of Units of Service and Fee Schedule in service contract or CAREWare or other database</td>
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<tr>
<td>1.2 Acuity levels are assessed every 30-60 days</td>
<td>1.2 Cognitive and Functional Ability Scale Tool is in the client’s chart.</td>
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The following are services that are reimbursed:

- **Attendant/home health aide services**: bathing, meal preparation, including therapeutic diets, and assisting with eating, light housekeeping,
- **personal care services in the home**, i.e., skin, mouth,
- **skilled nursing**: assessment, education,
- **pain management**, treatment adherence and infection control, IV therapy, supervision, dressing changes
hair care and bathing
- assisting in and out of bed and with ambulation
- provide reminders about medications that are ordinarily self-administered, the home health aide shall not administer medications of any kind;
- reporting changes in the individual’s condition and needs to the supervising nurse or physician,
- completing record regarding services performed
- routine allowable diagnostics testing administered in the home
- durable medical equipment
- performing other activities taught by a health professional for a specific individual, these may include services such as changing colostomy bags, changing of non-sterile dressing, taking of vital signs, and non-sterile bowel and bladder hygiene care

VII. HOME AND COMMUNITY–BASED HEALTH SERVICES ACTIVITIES

1. INITIAL ASSESSMENT OF SERVICE NEEDS /SCREENING/ INTAKE

A registered nurse provides the initial nursing assessment prior to the provision of care, conducts a comprehensive initial evaluation which includes a review of the physician’s order every 30 days.

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<td>1.1  Staff must screen clients for Medi-cal eligibility or other payer sources.</td>
<td>1.1 Documentation of a primary care provider referral, HIV+ status, residence, identification and Medi-cal eligibility status in the client record within 30 days of initiation of service.</td>
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<td>1.2  Initial and comprehensive assessments should be conducted by a registered nurse as needed, including a skin assessment.</td>
<td>1.2 Documentation in the client record.</td>
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<td>1.3  All home care orders are from an M.D. or nurse case manager</td>
<td>1.3 Documentation in client record</td>
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<td>1.4  Agency staff immediately report changes in the ADL function of the client to the appropriate supervisor</td>
<td>1.4 Reassessment tools completed in the client record</td>
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2. ACCESS TO CARE

Services are offered in a way that overcomes barriers to access and uses resources to support positive health outcomes. An on-call staff member must be available by phone 24 hours/day, 7/days/week, 365 days/year
2.1 Home care services will be initiated within 24 hours of determination of need
2.2 Providers must have a protocol for clients on a wait list

2.1. Documentation in client record and/or client satisfaction survey.
2.2. Agency’s wait list protocol

3. CARE PLAN

The purpose of the care plan is to guide the provider in delivering high quality care corresponding to the client’s level of need, including the determination of home bound and other referrals as indicated.

3.1 Home health providers will document any changes in the client’s condition and reassess needs every 30 days, and sends report to M.D. and nurse case manager

3.1. Documentation in the client record, including goals, objectives and a medication list

4. HOME CARE EDUCATION

Home Health Care Education should be provided to the client at least monthly, by a registered nurse and include the following components as applicable:

- How to not transmit HIV
- Interpretation of lab results
- Treatment information
- General information regarding potential side effect of treatment
- Access to medication and adherence
- Insurance information
- Smoking cessation
- Prevention for positives activities/Harm Reduction/PCRS
- Nutrition
- Oral health
- Support services and support groups available to the client
- Symptom management
- Skin care
- Emotional health
5. COORDINATION AND REFERRAL OF SERVICES

Home care staff should maintain appropriate referral relationships with key points of entry within and outside of the HIV system to ensure referral into home care of eligible clients. Key points of entry include medical providers, hospital discharge planners and nurse case managers etc. Staff cannot transport clients in their personal vehicles.

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<td>4.1 Home care staff must provide health education to all clients that is</td>
<td>4.1. Documentation in the client record includes copies of brochures,</td>
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<td>provided in a language and at a literacy level appropriate for the client.</td>
<td>fact sheets and other health education materials.</td>
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<td>4.2 Conduct monthly case conference with physician/nurse</td>
<td>4.2 Maintain case conference notes or log in record</td>
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5.1 Maintain appropriate referral relationships with key points of access.

5.1 Agency staff must have knowledge of emergency procedures and safety in the home.

5.2 Agency emergency and safety protocols.

VIII. QUALITY IMPROVEMENT

1. CLIENT LEVEL OUTCOMES

Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in treatment. Outcomes can be client-level or system-level. An Indicator is a measure used to determine, over time, an organization’s performance of a particular element of care. The indicator may measure a particular function, process or outcome. An indicator can measure: accessibility, continuity, effectiveness, efficacy, efficiency, and client satisfaction. Data collected should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized. The following indicators are TGA-wide indicators suggested for Home and Community Based Services.
• % of clients with HIV infection who have a medical visit with an HIV specialist at least every 6 months
• % of clients assessed every 60 days for need in the following home health areas: durable medical equipment, physical and occupational therapy, medical nutrition therapy, home health aide services, medical social worker
• % of clients who received HIV-related education monthly on at least one of the following topics: HIV disease and its progression to AIDS, HIV transmission and infection control, HIV disclosure and confidentiality
• % of clients with HIV infection who received a complete health history assessment including a physical exam, prior medical history, laboratory data, current and past substance abuse, mental status, psychological assessment, and a monthly nutrition assessment

2. PATIENT SATISFACTION
Clients should be assessed for satisfaction with service provision for the purposes of improvement to the care delivery system at least once annually.

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<td>2.1 Assessment of client satisfaction with the services provided will be conducted through a survey distribution (or other method) by the grantee and/or by the agency</td>
<td>2.1 Annual written summary and analysis of the will be documented and reported by the grantee and/or the agency (if applicable)</td>
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• See Administrative Standards for additional requirements of all Ryan White Program service providers.
• The Standards of Care will be reviewed every two years by the Oakland TGA Grantee Quality Management Staff to address changes in the scope of practice.