

Home and Community-Based Health Services (HCBHS)

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimally acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards, to be used as grant/contract guidance, are essential in defining program expectations and ensuring consistency in quality management.

Subrecipient Organizations must adhere to all federal, state and local legislative and programmatic requirements and expectations and shall abide by any professional best practices of the service category/health care industry. Guidance shall be issued as updates are officially developed.

I. SERVICE CATEGORY DEFINITION

Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that 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 in the home.

II. INTAKE, ELIGIBILITY, & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, income, and HIV status. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate eligibility for Ryan White Services.

A. INITIAL CUSTOMER ELIGIBILITY DETERMINATION

1. **Proof of HIV-positive status:** Written documentation from a medical provider or laboratory indicating that the customer meets the HIV serostatus criterion.
2. **Residency:** The following are acceptable methods of proof for residency in the EMA:
 - Current District of Columbia or State (Maryland or Virginia) driver's license.
 - Current District of Columbia or State (Maryland or Virginia) identification card.
 - Current voter registration card.
 - Current lease or mortgage statement.
 - Deed settlement agreement.
 - Active (unexpired) homeowner's or renter's insurance policy.
 - Property tax bill or statement (past 60 days).
 - Rental lease or receipt (within the past 90 days).
 - Fuel/utility bill (within the past 90 days).
 - Pay stubs or bank statement with the name and address of the customer
 - Letter from another local, state or federal government agency addressed to the customer.
 - Proof of DC Residency form from DC Healthcare Alliance.
 - If homeless, a written statement from a HCBHS agency to vouch for the address of the customer. _____
 - If homeless, a written statement from a(n) emergency shelter/transitional housing program to vouch for the homelessness of the customer.

- If homeless, a current notice of decision from Medicaid, *DC.gov Eligibility Inquiry Result*, as proxy proof of customer eligibility, pending determination or denial through DC.gov of the Department of Health Care Finance or DHCF. Such documentation could also serve as proxy proof of income since DHCF uses the financial methodology of the tax code, known as the Modified Adjusted Gross Income or MAGI, to determine client income. More information available at: <https://dhcf.dc.gov/node/892092>
3. **Income:** Client income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the customer and any household members for whom applicants have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is customer's or a household member's income.

The following are acceptable forms of proof of income:

- Pay stubs for the past 30 days. The pay stub must show the earnings, hours worked, all deductions, and the dates covered by the paystub.
- A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return.
- Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the applicant projecting current annual income must be included.
- Copy of the tenant's lease showing client as the landlord and a copy of their most recent income tax return.
- Letters from the SSA indicating income, such as Social Security Disability Income (SSDI)/Supplemental Security Income (SSI) award letters.
- Unemployment statements.
- Documentation of pension benefits, etc. from the past 30 days.
- Zero income self-attestation form and/or a letter from a supportive family member or friend attesting to customer support.

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (Customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of "no change" when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

ASSESSMENT/SERVICE PLAN/PROVISION OF SERVICES	
Standard	Measure
All customers must be assessed prior to provision of services	Documentation of assessment in customer's record signed and dated by licensed professional
Within 30 days of initial assessment, a HCBHS plan is developed for each eligible customer and signed by the licensed professional. The plan should include:	HCBHS plan, documented in customer record, signed, and dated by the customer and licensed professional

<ul style="list-style-type: none"> ● Goals ● Expected outcomes ● Actions taken to achieve each goal ● Person responsible for completing each action ● Target date for completion of each action 	
The HCBHS plan shall be reassessed every 90 days to assess customer progress and identify emerging needs.	Documentation of review and update of HCBHS plan as appropriate signed and dated by customer and licensed professional.
Refer customer to other services as appropriate, e.g. mental health, treatment for substance use disorder, patient navigation services, etc.	Documentation of referral(s) in customer's record Documentation of customer receiving referred service(s)
Providing mental health, substance abuse, rehabilitation, or developmental services if available.	Documentation of plan of care for the services provided
Durable Medical Equipment (DME)	Document purchase of DME Document distribution or usage of DME Document insurance denial for DME
Day treatment or other partial hospitalization services	Documentation of service plan Documentation of services provided
Provision of Home Health Aide services and personal care in the home	Documentation of services provided
TRANSITION & DISCHARGE	
Standard	Measure
<p>Customer discharged when HCBHS services are no longer needed, goals have been met, upon death or due to safety issues.</p> <p><u>Prior to discharge</u>: Reasons for discharge and options for other service provision should be discussed with the customer. Whenever possible, discussion should be occurring face-to-face. If not possible, the provider should attempt to talk with the customer via phone. If verbal contact is not possible, a certified letter must be sent to the customer's last known address. If the customer is not present to sign for the letter, it must be returned to the provider.</p> <p><u>Transfer</u>: If customer transfers to another location, agency or service provider, the transferring agency will provide a discharge summary and other requested records within 5 business days of the request. If customer moves to another area,</p>	<p>Current memoranda of agreement (MOAs) with discharge planning teams at community inpatient facilities are on file at the agency.</p> <p>Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable.</p> <p><u>Documentation</u>: Customer's record must include:</p> <ul style="list-style-type: none"> ● Date services began ● Special customer needs ● Services needed/actions taken, if applicable ● Date of discharge/transfer/withdrawal ● Reason(s) for discharge/transfer/withdrawal ● Referrals made at time, if applicable

transferring agency will make referral for needed services in the new location.

Unable to Locate:

If the customer cannot be located, the agency will make and document a minimum of three follow-up attempts on three separate dates (by telephone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made.

Withdrawal from Service:

The customer has right to withdraw from receiving service:

The customer reports that services are no longer needed or decides to withdraw from receiving services. The provider should follow the process of discharge and document action as appropriate

Administrative Discharge:

Customers who engage in behavior that violates the safety and/or confidentiality of others may be discharged. Prior to discharging a customer for such a reason, the case must be reviewed by the leadership according to agency policies. Customers who are discharged for administrative reasons must be provided written notification of, and reason for, the discharge and must be notified of alternative resources. A certified letter that notes the reason(s) for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's file.

CASE CLOSURE	
Standard	Measure
<p>The case will be closed if the customer:</p> <ul style="list-style-type: none"> ● Has met the service goals ● Decides to transfer to another agency ● The Customer reports that needs are more appropriately addressed in other programs ● Moves out of the EMA ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services ● Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact customer ● Can no longer be located ● Withdraws from or refuses funded services. ● Reports that services are no longer needed. ● No longer participates in the individual service plan. ● Exhibits pattern of abuse as defined by agency's policy ● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program ● Is deceased 	<p>Documentation of case closure in customer's record with clear rationale for closure</p>

IV. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and sign a written job description with specific minimum requirements for each position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. Agencies are also responsible for maintaining documentation of the appropriate education, qualifications, training, and experience in personnel files. Sixteen hours of continuing training/education in HIV/AIDS is required annually. Annual training on changes to benefit programs and customer eligibility, such as Medicare, Medicaid, SSDI and SSI entitlements as well as Ryan White benefits, etc. is also required.

A. Home Health Nurse

1. Registered Nurse licensure in the jurisdiction of service delivery.
2. A minimum of two years of experience working with persons living with HIV or persons at risk of contracting HIV.
3. Ongoing education/training ~~in~~ relating to HIV-related subjects.
4. The Agency will provide new hires with training regarding confidentiality, customer rights and responsibilities and the grievance procedures.

B. Certified Nursing Assistants (CNA)

Any staff with a CNA license must be registered in the jurisdiction that care is being provided to customer. In addition to being licensed, must possess the following skill necessary to perform their duties adequately:

1. Excellent verbal and written communication
2. Knowledge of community resources.
3. Compassion when caring for persons living with HIV.
4. Culturally and linguistically appropriate competence required as applicable.
5. Continuing education/training in HIV-related subjects.

C. Non-Clinical Service Assistant

1. Licensed or otherwise credentialed agency or staff person with a high school diploma or GED preferred and two years of experience working with persons living with HIV and/or health care training, such as certified medical assistants and medical clerks.
2. Ability to read, write, understand, and carry out instructions.
3. Knowledge of community resources.
4. Compassion when caring for persons living with HIV.
5. Culturally and linguistically appropriate competence required as applicable.
6. Continuing education/training in HIV-related subjects.

NOTE:

All Home Health Nurses, Certified Nursing Assistants and Non-Clinical Service Assistants must complete a minimum training regimen within one year of the hire date that includes:

1. Home and Community-Based Health Service Standards
2. National Standards for Culturally and Linguistically Appropriate Services (CLAS)
3. Ryan White customer eligibility criteria

If newly hired, Health Home Nurses, Certified Nursing Assistants and Non-Clinical Service Assistants have previously obtained all of the required training, they do not need to repeat it. Documentation of completion of required trainings must be kept in personnel files.

V. CLINICAL QUALITY MANAGEMENT

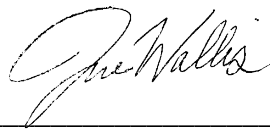
Include at least one performance measure in the Clinical Quality Management Program for the service. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

VI. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on January 2, 2024. The next annual review is July 31, 2025.



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