DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

# Home Health Care Services

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 minimal 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 are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

## I. SERVICE CATEGORY DEFINITION

Home Health Care is the provision of services in the home that are appropriate to an eligible customer's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the customer'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 diagnostics testing administered in the home
- Other medical therapies

## II. INTAKE AND ELIGIBILITY

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually, with recertification every six months. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

### A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

   - Current lease or mortgage statement
   - Deed settlement agreement
   - Current driver's license
   - Current voter registration card
   - Current notice of decision from Medicaid
   - Fuel/utility bill (past 90 days)

- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the customer (past 30 days)
- Letter from another government agency addressed to customer
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility or a letter from landlord that customer is a resident

1. **Income:** Customer 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 customers have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is the customer's income or a household member's from each source.

   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year-to-date 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 customer projecting current annual income must be included
   - Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the customer

### B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic 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 | |
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| **Standard** | **Measure** |
| Home Health Care providers must:<br>• Conduct an initial customer intake and assessment for every new admission<br>• Certify upon intake, and throughout the course of the treatment plan, that the customer is not in need of acute care<br>• Initiate Home Health Care services within 24 hours, or at the nearest possible timeline, of receipt of the medical provider's referral, unless otherwise specified<br>• Maintain ongoing communication with the customer's medical provider and case manager | Documentation of:<br>• A medical referral for Home Health Care services<br>• Intake and assessment (in the customer's record)<br>• Dates and topics of communication with the customer's medical provider and case manager |
| Home Health Care providers must administer prescribed therapeutics such as intravenous and aerosolized treatment, and parenteral feeding when needed | Documentation of the therapeutics provided including dosages and frequency in customer's medical record |
| Home Health Care providers must provide preventive and specialty care | Documentation of the preventive and specialty care provided in customer's medical record |
| Home Health Care providers must provide wound care | Documentation in customer's medical record |
| Home Health Care providers must administer routine diagnostic testing in the customer's home | Documentation of diagnostics testing performed in customers medical records |
| Home Health Care providers must provide other medical therapies | Documentation of medical therapies in customer's medical records |
| Home Health Care services must be provided:<br>• To individuals who are homebound<br>• By a licensed medical professional whose goal is to provide medical treatment to the patient in their home so they may remain in the community and avoid unnecessary hospitalizations, opportunistic infections, and general decline in health status.<br>• Must include a linkage to medical care<br>• According to an individualized care plan, which must<br>a. Be developed for each customer accepted into this program<br>b. Include an assigned case manager<br>c. Be updated every 60 days<br><br>***Note: Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.*** | Documentation of:<br>• A medical referral stating the need for Home Health Care services and the expected duration<br>• An individualized nursing plan (in the customer's record), indicating:<br>d. Home Health Care goals and services to be provided<br>e. The roles and responsibilities of the Home Health Care staff<br>f. Activities conducted and the dates<br>g. Signature of the professional who provided each service<br>• At least one medical visit, viral load or CD4 test reported in the measurement year |
| Home Health Care providers must be appropriately licensed/certified by the jurisdiction in which they operate | Documentation of agency licensure |

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| able to bill Medicare, Medicaid, private insurance, and/or other third-party payers. | |
| **RE-ASSESSMENT OF HOME HEALTH CARE NEEDS** | |
| **Standard** | **Measure** |
| Home Health Care providers must re-assess customers every 60 days and/or according to the provisions in their respective jurisdictions and per Medicare, Medicaid, private insurance, and other third-party payers' regulations. | Documentation of reassessment in customer's record |
| **TRANSITION & DISCHARGE** | |
| **Standard** | **Measure** |
| Customers may be discharged when Home Health Care services goals have been met, upon death or due to safety issues. Customers may also be discharged when:<br>• The customer is not stable enough to be cared for outside of the acute care setting as determined by the agency and the customer's medical provider<br>• The customer no longer has a stable home environment appropriate for the provision of home health services as determined by the agency and the case manage<br>• The customer no longer desires home healthcare<br>• The customer no longer medically requires home healthcare as determined by the agency or the customer's referring medical provider<br><br>Prior to discharge: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not present to sign for the letter, it must be returned to the provider.<br><br>Transfer: If customer transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location.<br><br>Withdrawal from Service: If customer reports that services are no longer needed or decides to discontinue participation in the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies. | 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.<br><br>Documentation in the customer's record must include:<br>• Date services began<br>• Special customer needs<br>• Services needed/actions taken, if applicable<br>• Date of discharge<br>• Reason(s) for discharge<br>• Referrals made at time of discharge, if applicable |

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| Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason 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 chart. | |
| **CASE CLOSURE** | |
| **Standard** | **Measure** |
| Case will be closed if customer:<br>● Has met the service goals<br>● Decides to transfer to another agency<br>● Needs are more appropriately addressed in other programs<br>● Moves out of the EMA<br>● Fails to provide updated documentation of eligibility status thus, no longer eligible for services<br>● Fails to maintain contact with the insurance assistance staff for a period of three months despite three documented attempts to contact customer<br>● Can no longer be located<br>● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan<br>● Exhibits pattern of abuse as defined by agency's policy<br>● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program<br>● Is deceased | Documentation of case closure in customer's record with clear rationale for closure |

## 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 will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

At minimum, Home Health Care staff will be able to provide linguistically and culturally appropriate care for people living with HIV and complete documentation as required by their positions. Home Health Care staff will complete an agency-based orientation before providing services.

Home Health Care services will be provided by trained and licensed personnel such as certified health worker, nurse's aide, or nurse. Home Health Care staff must be supervised by a licensed physician or registered professional

nurse. Depending on the scope of practice, staff must meet the appropriate licensure and/or certification requirements set forth by the relevant jurisdiction. Staff must have at least two years of experience working with PLWH.

Newly hired Home Health Care staff must complete the following training within 180 calendar days of hire:

- HIV 101
- Home health Care policies and procedures
- Infection control/bloodborne pathogens
- Patient confidentiality & HIPAA
- Cultural and linguistic competency
- Referral and linkage processes

All Home Health Care staff must also complete 6 hours of continuing education on HIV/AIDS annually.

## 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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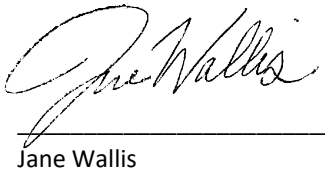

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