HOME HEALTH
STANDARDS OF CARE

FOR

RYAN WHITE ACT-FUNDED SERVICES IN ORANGE COUNTY

Effective 10/12/2016

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SECTION 1: INTRODUCTION

People living with HIV are able to live long and healthy lives due to access to care and treatment. Some individuals require services at home in order to aid in their health and well-being. Home health services are for eligible clients who are unable to meet their personal care needs without assistance.

GOALS OF THE STANDARDS

These standards of care are provided to ensure that Orange County's Ryan White-funded home health services:

- Are accessible to all persons infected with HIV who meet eligibility requirements
- Are provided by licensed or credentialed individuals
- Provide assistance in performing activities of daily living to allow clients to continue living independently in their homes
- Promote a client's independence and self-sufficiency
- Participate in a coordinated, client-centered, and effective service delivery networks while using a multidisciplinary team approach
- Appropriately address issues of consent and confidentiality for a client enrolled in services

SECTION 2: DEFINITION OF HOME HEALTH SERVICES

Home Health Care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include: 1) Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding); 2) Preventative and specialty care; 3) Wound care; 4) Routine diagnostics testing administered in the home; 5) Other medical therapies.

Home and Community-Based Health is the provision of services 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: 1) Durable medical equipment (DME); or 2) Home health aide services and personal care services in the home.

Home Health Services includes an individualized plan for clients, with health care providers working closely with clients and the multidisciplinary care teams that include the client's care manager, primary care provider, and other appropriate health care professionals.

SECTION 3: STAFFING REQUIREMENTS AND QUALIFICATIONS

Quality home health services starts with well-prepared and qualified staff. To ensure this, Ryan White providers must meet all of the following requirements and qualifications:

- **HIV Knowledge.** Providers should have training and experience with HIV related issues and concerns. At a minimum, providers providing home health services to people with HIV should possess knowledge about the following:
  - HIV disease process and current medical treatments
  - Psychosocial issues related to HIV
  - Cultural issues related to communities affected by HIV
  - Adherence to medication regimens
  - Diagnosis and assessment of HIV-related health issues
  - Prevention issues and strategies specific to HIV-positive individuals ("prevention with positives")
  - Harm reduction strategies

- **Licensure.** All staff must hold the appropriate degrees, certifications, licenses, permits, or other appropriate qualifying documentation as required by Federal, State, County or municipal authorities.
  - Home Health Care:
    - Licensed health care workers such as registered nurses and licensed vocational nurses will maintain appropriate licenses and/or credentials as required by Orange County and the state of California.
  - Home and Community-Based Health Services:
    - Paraprofessionals employees such as certified nursing assistants and homemakers/home health aides will maintain appropriate licenses and/or credentials as required by Orange County and the state of California (such as Home Health Aide Certification issued by the state of California).

- **Legal and Ethical Obligations.** Service Providers must be aware of and able to practice under the legal and ethical obligations as set forth by California state law and their respective professional organizations. Obligations include the following:
  - **Duty to treat**: Service Providers have an ethical obligation not to refuse treatment because of fear or lack of knowledge about HIV.

- **Confidentiality:** Maintenance of confidentiality is a primary legal and ethical responsibility of the service provider. Limits of confidentiality include danger to self or others, grave disability, child/elder/dependent adult abuse. Domestic Violence must be reported based on the requirements of the service provider's professional standards.
- **Duty to warn:** Serious threats of violence (including terrorist threats) against a reasonably identifiable victim must be reported. However, at present, in California, a person living with HIV engaging in behaviors that may put others at risk for HIV infection is not a circumstance that warrants breaking of confidentiality.
- Staff are advised to seek legal advice when they are unsure about particular issues and the legal/ethical ramifications of their actions.

Standard	Measure
Staff agree to maintain standards set forth in Code of Conduct	Documentation of staff signature on file
Staff will have a clear understanding of job responsibilities	Written job description on file
Staff receive initial trainings within 60 days of hire and annual education regarding HIV related issues/concerns	Training/education documentation on file including: • Date, time, and location of education • Education type • Name of staff receiving education • Certificate of training completion or education outline, meeting agenda and/or minutes
Service provider shall ensure that staff will have appropriate degrees, certifications, licenses, permits, or other appropriate qualifying documentation, for the functions they perform	Documentation of degrees, certifications, licenses, permits, or other documentation on file

SECTION 4: CULTURAL AND LINGUISTIC AWARENESS

Providers must participate in a process of training and education that increases cultural and linguistic competence and improves their ability to provide culturally and linguistically appropriate services to all persons living with HIV. Although an individual's ethnicity is generally central to their identity, it is not the only factor. Other relevant factors include gender, gender identity, language, religious beliefs, disability, sexual orientation, beliefs, and institutions. In providing culturally and linguistically competent services, it is important to acknowledge one's personal limits and treat one's client as the expert on their culture and relation to it. If a service provider determines that they are not able to provide culturally or linguistically appropriate services, they must be willing to refer the client to another service provider that can meet the client's needs.

Culturally and linguistically appropriate services:

- Respect, relate, and respond to a client's culture in a non-judgmental, respectful manner
- Match the needs and reflect the culture and language of the clients being served, including providing written materials in a language accessible to clients
- Recognize the significant power differential between provider and client and work toward developing a more collaborative interaction
- Consider each client as an individual, not making assumptions based on perceived membership in any group or class
- Translation services as appropriate
- Non-judgmental environment concerning sexual practices

Standard	Measure
Service Provider will recruit a diverse staff that reflects the culture (including gender, sexual identity, and disability) of the community served	Service provider have a written strategy on file
All staff (including administrative staff) will receive initial trainings within 60 days of hire and annual trainings to build cultural and linguistic awareness	Training/education documentation on file including: • Date, time, location, and provider of education • Education type • Name of staff receiving education • Certificate of training completion or education outline, meeting agenda, and/or minutes
Service provider shall have posted and written materials in appropriate languages for the clients served	Site visit will ensure
Service provider will maintain a physical environment that is welcoming to the populations served	Site visit will ensure
Service provider complies with American Disabilities Act (ADA) criteria	Completed form/certification on file
Services are accessible to community served	Site visit to review hours of operation, location, accessibility with public transportation

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SECTION 5: CLIENT REGISTRATION

Client registration is required for all clients who request or are referred to home health services. Registration is a time to gather information and provide basic information about home health and other HIV services, as appropriate. It is also a pivotal moment for establishment of trust and confidence in the care system. Service provider shall provide an appropriate level of information that is helpful and responsive to client need.

If a client is receiving multiple Ryan White services with the same service provider, registration is only required to be conducted one time. *With the exception of Releases of Information specific to home health services information* and *Home Health Services Consent for Treatment,* file if registration information was completed as part of another service; documentation in the client file is sufficient.

If a client has been referred by another Ryan White provider to receive services, it is acceptable to note that eligibility and registration information discussed in this section were verified and exist at the referring Ryan White provider. Registration information may be sent from the referring provider to the provider receiving the referral so that the provider receiving the referral may enter information for the Ryan White Services Report. Provision of information regarding *Client Rights and Responsibilities* and *Client Grievance Process* may be conducted one-time at the referring service provider. To document the provision of this information, the referring service provider may send the service provider receiving the referral a signed document indicating that they have provided this information to the client.

- **Timeframe.** Registration shall take place as soon as possible, at maximum within five business days of referral or initial client contact. If there is an indication that the client may be facing imminent loss of medication or is facing other forms of medical crisis, the registration process will be expedited and appropriate interventions may take place.

- **Eligibility and Qualification Determination.** The service provider shall obtain the necessary information to establish the client's eligibility via the Eligibility Verification Form (EVF). (See Requirements to be Eligible and Qualify for Services: http://ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=31965)

- **Demographic Information.** The service provider shall obtain the appropriate and necessary demographic information to complete registration; this includes basic information about the client's HIV medical history, living situation, employment and financial status, service linkages, and emergency contact information.

- **Provision of Information.** The service provider shall explain what home health services entail and provide information to the client. The provider shall also provide the client with information about resources, care, and treatment (this may include the county-wide HIV Client Handbook) available in Orange County.

- **Required Documentation.** The provider shall develop the following forms in accordance with state and local guidelines. The following forms shall be signed and dated by each client.
    - **ARIES Consent:** Clients shall be informed of the AIDS Regional Information and Evaluation System (ARIES). The ARIES consent must be signed at intake prior to entry into the ARIES database and annually thereafter. The signed consent form shall indicate (1) whether the client agree to the use of ARIES in recording and tracking their demographic, eligibility and service information and (2) whether the client agrees to share select information contained in ARIES with other agencies in the Ryan White system of care.
    - **Confidentiality and Release of Information:** When discussing client confidentiality, it is important *not* to assume that the client's family or partner knows the HIV-positive status of the client. Part of the discussion about client confidentiality should include inquiry about how the client wants to be contacted (at home, at work, by mail, by phone, etc). If there is a need to disclose information about a client to a third party, including family members, clients shall be asked to sign a Release of Information form, authorizing such disclosure. A Release of Information form describes the situations under which a client's information can be released and includes the name of the agency and/or person with whom information will be shared, the specific information to be shared, duration of the release consent, and the client's signature. This form may be signed at intake prior to the actual need for disclosure. Releases of information may be cancelled or modified by the client at any time. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the Release of Information must be a HIPAA-compliant disclosure.
    - **Consent for Treatment:** Signed by the client, agreeing to receive services/treatment.

The following forms shall be signed and dated by each client receiving Home Health Services and posted in a location that is accessible to clients. For documents available in the HIV Client Handbook, completed forms may indicate that the client has received the HIV Client Handbook.

- **Notice of Privacy Practices (NPP):** Clients shall be informed of the provider's policy regarding privacy rights based on the provider's confidentiality policy. For agencies and information covered by HIPAA, providers shall comply with HIPAA guidelines and regulations for confidentiality.
- **Client Rights and Responsibilities:** Clients shall be informed of their rights and responsibilities (included in the HIV Client Handbook).
- **Client Grievance Process:** Clients shall be informed of the grievance process. The HCA's Grievance Process is included in the HIV Client Handbook.

Standard	Measure
Registration process began within five business days of referral or initial contact with client	Registration information is completed and in client file
Eligibility for services is determined	Client's file includes proof of eligibility and qualification

Standard	Measure
Registration information is obtained	Client's file includes data required for Ryan White Services Report
ARIES Consent signed and completed prior to entry into ARIES	Signed and dated by client and in client file
Release of Information is discussed and completed as needed	Signed and dated by client and in client file as needed
Consent for Treatment completed	Signed and dated by client and in client file
Client is informed of Notice of Privacy Practices	Signed and dated by client and in client file
Client is informed of Rights and Responsibilities	Signed and dated by client and in client file
Client is informed of Grievance Procedures	Signed and dated by client and in client file
Service provider collects and documents health history information for each client prior to providing care. This information should include, but not be limited to, the following: • A baseline current (within the last 6 months) CBC laboratory test results for all new clients, and an annual update thereafter, and when clinically indicated • Current (within the last 6 months) Viral Load laboratory test results, when clinically indicated • Client's chief complaint, where applicable • Medication names • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis • Involuntary weight loss or weight gain	Documentation of health history information in the client record.

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SECTION 6: IMPLEMENTATION AND EVALUATION

The following shall be provided under Home Health Services:

- Provide a safety assessment of a client's home before services are offered in order to ensure the safety of both the client and service provider (detailed assessment)
- Provide nursing care under the supervision of the registered nurse or licensed vocational nurse
- Monitor the progress of the care plan and also changes in a client's physical and mental health, and level of functionality, by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation
- Development and revisions of the care plan can only be done by the registered nurse.
- Advocate for the client when necessary
- Provider will periodically visit and contact selected clients and ask them about the quality of care they are receiving in order to ensure optimal care for clients

Standard	Measure
Provide a safety assessment of a client's home before services are offered and at minimum	Detailed assessment in client file
Monitor and review progress of the care plan and also changes in a client's health monthly in order to revise the care plan as necessary	Detailed assessment in client file
Provider will periodically visit and contact selected clients and ask them about the quality of care they are receiving in order to ensure optimal care for clients.	Documentation on file
Home health care workers will work with clients and families in order to administer the best care for the client	Assessment in client updates

SECTION 7: COORDINATION OF CARE

It is recommended that the home health provider consult with the client's primary care physician and/or case manager when additional information or coordination is needed to assist in providing safe and appropriate care. Home health providers should obtain and document HIV primary care physician contact information for each client and should consult with client's medical care providers when indicated. By working closely with other health care providers and other members of the health team a client's needs, challenges and barriers can be effectively addressed. Members of the team should coordinate to create an individualized care plan.

- The home health provider should also play a role in reminding clients of the need for regular primary medical care (viral load tests at least every six months, depending on health) and encouraging client to adhere to their medication regimens
- Consult with case managers in order to facilitate appropriate referrals to programs and services that can successfully meet the clients need
- Address the client's spectrum of needs in a comprehensive way while minimizing duplication of services
- Assist client in making informed decisions on choices of available resources and service providers

Standard	Measure
Home health provider should obtain and document HIV primary contact information from client	Documentation in client file
Consultation with medical providers is required when: • More complete medical information is needed • A client's symptoms have changed and it is necessary to determine if treatment modifications are indicated • Opportunistic infections are present	Signed and dated progress note to detail consultations
The home health provider should remind clients of the need for regular primary medical care	Signed and dated progress note to detail consultations
Consult with case managers in order to facilitate appropriate referrals to programs and services	Documentation in client file
Assist client in making informed decisions on choices of available resources and service providers	Signed and dated progress note to detail consultations

SECTION 8: HOME HEALTH SERVICE CLOSURE

Receiving home health services can be critical to a client's health. Discharge from home health services may negatively affect the client's overall health. As such, discharge or termination of home health services must be carefully considered and reasonable steps must be taken to assure clients who need home health services are maintained in services.

A client may be suspended or terminated from home health services due to the following conditions:

- The client has successfully attained health goals
- The client has died
- The client has become ineligible for services (e.g., due to relocation outside Orange County or other eligibility requirements)
- The client chooses to terminate services
- The client's needs would be better served by another agency
- The client demonstrates pervasive unacceptable behavior that violates client rights and responsibilities
- The client cannot be located after documented multiple and extensive attempts

The following describe components of discharge planning:

- **Efforts to Find Client.** The provider shall periodically query data systems to identify clients who appear to be lost to follow-up. If the client is receiving case management, the home health services provider may work with the case manager to locate the client. It is recommended, but not mandatory, that at least three attempts to contact the client are made over a period of three months. Efforts shall be made to locate and contact a client who has not shown up for appointments or responded to provider's phone calls. These efforts shall include contacting last known medical provider and other providers for which releases have previously been obtained. Clients who cannot be located after extensive attempts may be referred to available outreach services so that they may be linked back into the care system. Emergency contacts may be used to reach a client and may be done based on agency policy.

- **Closure Due to Unacceptable Behavior.** If closure is due to pervasive unacceptable behavior that violates client rights and responsibilities including excessive missed appointments, the provider shall notify the client that his/her services are being terminated and the reason for termination. Within the limits of client's authorization to receive mail, notification of closure shall be mailed to the client. A copy of the notification shall be placed in the client's chart. If the client has no known address or the provider is not authorized to send mail to the client, the provider shall document other types of notification of closure (e.g. phone calls, visit) or attempts to notify the client of closure. If the client does not agree with the reason for closure, he/she shall be informed of the provider's grievance procedure.

- **Home Health Service Closure Summary.** A service closure summary shall be documented in the client's record. The service closure summary shall include the following:

- **Data Collection Closeout.** The provider shall close out the client in the data collection system (ARIES) as soon as possible, but no later than thirty (30) days after service closure unless the client is receiving other services at the agency. A progress note should clearly indicate why the client was not closed out in ARIES.

Standard	Measure
Follow-up will be provided to clients who have dropped out of treatment without notice	Signed and dated note to document attempt to contact in client file
Notify client regarding closure if due to pervasive unacceptable behavior violating client rights and responsibilities	Copy of notification in client file. If client has no known address or is unable to receive mail, documentation of other types of notification or attempt at notification in client file.
A service closure summary shall be completed for each client who has terminated treatment and shall include: • Circumstances and reasons for closure • Summary of service provided • Referrals and linkages provided at closure	Client file will include signed and dated service closure summary to include
Closeout of data collection shall be completed for each client who has been closed from all Ryan White services at that provider agency	Data collection system (ARIES) will indicate client's closure no later than thirty (30) days of service closure