Virginia Department of Health
Division of Disease Prevention
HIV Care Services
Service: Standards

Home Health and Community-based Health Services 2009-2010

Definition of Service:
Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home-health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that included appropriate healthcare professionals. Component services include:

- Durable Medical Equipment
- Homemaker or Home-Health Aide services and personal care services
- Day treatment or other partial hospitalization services
- Intravenous and aerosolized drug therapy, (including prescription drugs administered as part of therapy)
- Routine diagnostic testing administered in the home of the individual
- Appropriate mental health, developmental, and rehabilitation services.

Inpatient hospitals services, nursing home and other long term care facilities are NOT included. (HRSA definition)

HOME HEALTH: Professional Care:
The provision of services in the home by licensed healthcare workers, such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing and other medical therapies. (HRSA definition)

HOME HEALTH: Paraprofessional Care:
The provision of services in the home by a homemaker, home health aide, personal caregiver, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to HIV/AIDS disabled clients remaining in their homes. Home Health Paraprofessionals are supervised by a Home Health Professional

Objectives for Service:

- To provide and coordinate quality home care for clients with HIV infection, utilizing current established clinical practice standards.
- To assess the physical, psychosocial, cognitive, and therapeutic needs of clients and provide appropriate interventions.
- With client consent and in support of the client’s well-being, appropriately involve the client’s caregivers, through outreach, provision of information, and inclusion in care planning.
- To comply with recommended infectious disease protocols for outpatient care.
- To coordinate care with other service providers/service systems to ensure optimal client care.
- To provide referrals as needed for assessment and treatment.

STANDARD	MEASURE
Universal Standards:	
Medical record reflects compliance with current United States Public Health Services (USPHS) medical standards of care and VDH standards for HIV infected persons.	Documented patient care complies with (USPHS) and VDH standards.
A signature log with name and credential, initials, signature will be maintained by the provider agency.	The signature log is available for review.
The provider should conduct periodic, random chart reviews for oversight.	Documentation of periodic chart reviews is available for review.
Service Standards:	
The client's eligibility for Ryan White Part B services is determined or is in process of determination before services are initiated.	Documentation of the client's eligibility or that eligibility process has begun is present in the client's record.
A referral by a Ryan White Part B provider is made for initiation of home health/community-based services.	Documentation of the referral or form is present in the client's record, signed and dated.
Assessment:	
A complete initial medical history and assessment which includes drug allergies, current medications and drug/substance abuse as part of this assessment and physical assessment is conducted **within 30 days** of initial contact with the client.	Documentation of a completed medical history is present in the client's record, signed and dated **within 30 days** of initial patient contact with provider.
A psychosocial/mental health history is part of the initial medical assessment.	Documentation of a completed psychosocial/mental health history is present in the client's record, signed and dated.
A nutritional assessment is part of the initial medical assessment.	Documentation a completed nutritional assessment is present in the client's record, signed and dated.
Treatment Plan:	
Physicians' orders must be in writing and present on the client's record.	Documentation of all physicians' orders is present in the client's records, signed and dated.
All actions taken and outcomes related to physicians' orders are documented in the client's record.	Documentation of action taken and outcomes related to the physicians' orders is present in the client's record, signed and dated.

A medical care plan is developed in collaboration with the client and/or client's care giver. The client will receive a copy of the medical treatment plan.	Documentation must of a completed medical care plan developed in collaboration with the client is present on the client's record, signed and dated by the provider and the client and/or client's care giver. Documentation that the client received a copy of the plan or documentation if client declined is present on the client record signed and dated.
Continued Services:	
Medication and treatment records are current and complete; they verify all current treatments and medications, with names of drugs, doses, timing, and methods of administration signed and dated within last 6 months (for HAART therapy) or last 12 months (for OI treatment).	Documentation of all medications and treatment is current and present in the client's record, signed and dated.
Laboratory reports are current and complete; laboratory results will be dated and initialed to verify review of results of labs.	Documentation of laboratory reports current and present in the client's record signed/initialed and dated.
Evidence of age appropriate health prevention/maintenance (HIV and other disease risk-reduction) measures is present on the client's record, e.g. mammograms, PSA/rectal exams, nutrition counseling.	Documentation of health prevention/maintenance measures and status of vaccinations is present on the client's record, signed and dated.
All referrals and follow-up for outcomes are documented.	Documentation of all referrals and follow up is present in the client's record, signed and dated.
An HIV prevention message is provided at each visit.	Documentation that an HIV prevention message is provided at each visit is present in the client's record, signed and dated.
All clients' records are current, with legible signatures, dates, and progress notes.	Documentation present in the client's record, signed and dated is current.
Reassessment:	
Medical care plan will be reassessed **every 6 months** in collaboration with the client or when conditions or client needs arise that must be addressed.	Documentation of a reassessed medical care plan must be present on the client's record, signed and dated by the provider and the client.
Discharge:	
The discharge process is implemented when a client no longer requires home health services.	Documentation of the discharge plan is present in the client's record, signed and dated, including reason for discharge.

Third Party Payer:	
When the agency is a third-party provider, the subcontractor maintains a client record to provide adequate documentation on the record for accountability of primary medical care provided by payee.	At a minimum, payer's record must contain a statement(s) of: 1. Medical history, physical examination, laboratory reports, medications, and treatments, plan of care. 2. Interim progress notes, laboratory reports. 3. Referrals and follow-ups 4. All reports must be signed and dated.
Home Health Paraprofessional Care:	
Home health paraprofessionals will work in accordance with a written, Individualized Service Plan established by a Health Care Professional and the client.	Documentation of an Individualized Service Plan written by a Health Care Professional and the client is present in the client's record, signed and dated.
Home health paraprofessionals will provide non-medical services in the home. Therapeutic, nursing, supportive, and/or compensatory health services may be provided by licensed/certified home health aids that are supervised by Home Health Professionals. There is documentation on the client's record at least monthly by the Home Health Professional of supervision provided for the services rendered by the Home Health Paraprofessional.	Documentation of the supervision of the home health paraprofessional by the home health professional is present in the client's record, signed and dated.
Qualifications:	
All home health professionals and paraprofessionals will hold current licensure and/or certification in the Commonwealth of Virginia.	Documentation of current licensure and/or certification must be present in the staff's personnel file and available for review.
Annual Training Requirements:	
All home health professionals must complete 2 hours of continuing education in HIV/AIDS annually.	Documentation of completion of the continuing education must be kept in the home health professional's personnel file.