

**COUNTY OF SAN DIEGO  
HEALTH AND HUMAN SERVICES AGENCY  
HIV PLANNING GROUP**

**HOME AND COMMUNITY-BASED HEALTH  
SERVICES  
SERVICE STANDARDS  
FOR RYAN WHITE CARE AND TREATMENT**



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# Home and Community-Based Health Services

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## Service Category Definition

Home and community-based health services (HCHS) are provided to a client living with HIV in an integrated setting 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.

## Purpose and Goals

The goal of home and community-based health services is to provide services in the home and prevent the need for hospitalization or entry into a skilled nursing facility while improving the quality of health for functionally impaired individuals with HIV/AIDS. Services are available for persons with HIV-related disabilities who might otherwise require institutional services.

## Intake

The following inclusion criteria must be met to receive home and community based health services:

- Client has a health condition consistent with in-home services
- Client has a home environment that is safe for both the client and the service provider
- Client has a score of 70 or less on the Cognitive and Functional Ability (Karnofsky) Scale

Individuals eligible for or receiving services from the AIDS Medi-Cal Waiver Program which offers a similar high acuity medical case management are not eligible for HCHS services. HCHS staff will refer all Medi-Cal AIDS Waiver-eligible to an AIDS Medi-Cal Waiver Program if applicable.

## Exclusions

- Emergency room services
- In-patient hospital services
- Nursing homes
- Other long-term care facilities

## Key Service Components and Activities

The follow components are provided as part of the service:

- Eligibility Screening/Intake
- Comprehensive Assessment or Reassessment
- Comprehensive Service Plan
- Follow-up and Comprehensive Service Plan Implementation
- Case Closure/Discharge
- Benefits Counseling
- Screening/Application to AIDS Drug Assistance Program
- Screening/Application for Health Insurance, Income
- Benefits, Support Services and Housing
- Screening/Provision of Medical Transportation Services
- Representative Payee Services

Standard	Measure
Staff ensures clients' eligibility and needs	Documentation of interviews and assessments all potential clients utilizing a standard client eligibility screening tool
Staff maintains records of eligibility, intake and assessments	Documentation of eligibility, intake, comprehensive assessments, individual care plans, and progress of clients on a standard home and community-based health services form
	Maintain a single record for each client
Staff ensures clients are connected to the appropriate services when needed	Documentation of all services provided/offered to clients
	Completion of the Client Transition Plan for deemed ineligible for home and community-based health services or deemed ready to be transitioned out of these services

**Personnel Qualifications**

The core case management team consists of the nurse case manager and the social work case manager.

The nurse case manager is a registered nurse (RN) licensed by the State of California with two years of experience as an RN and at least one year in community nursing. It is desirable, but not mandatory, that the RN Case Manager has obtained a Bachelor of Science degree in Nursing (BSN), and a Public Health Nurse certificate (PHN).

The social worker case manager is licensed by the State of California as an LCSW, MFT, or Psychologist; have a Master's Degree in Social Work, Counseling, or Psychology; or similar qualifications approved by the HSHB. This position also serves as a member of the core case management team and provides case management services.

Both the nurse case manager and social work case manager are required to maintain copies of current valid California licenses.

Standard	Measure
Staff will meet minimum qualifications	Documentation of appropriate licensure and/or degrees
Staff will have clear understanding of job responsibilities	Documentation of current job descriptions on file that are signed by staff and appropriate supervisors
Staff are competent	Documentation of a training plan that includes specific topics, identification of the trainer, and a timeline for all newly employed staff
Provider maintains copies of current valid California licenses in the respective professional disciplines for all licensed staff	Document of licensure is maintained on file

**Service Requirements**

Allowable services within the Home and Community-based Health Services are specified in the Health Resources and Services Administration's Program Monitoring Standards – Part A at <http://hab.hrsa.gov/manageyourgrant/files/programmonitoringparta.pdf>, and includes the provision of:

- Durable medical equipment
- Home health aide and personal care services

- Day treatment or other partial hospitalization services
- Home intravenous and aerosolized drug therapy, including prescription drugs administered as part of such therapy
- Routine diagnostic testing
- Mental health and rehabilitation services

Allowable services are provided in the home of a client with HIV/AIDS.

Standard	Measure
Staff will routinely assess and document client’s access needs	Documentation of: <ul style="list-style-type: none"> <li>• Informed Consent/Agreement to Participate</li> <li>• Certificate of Eligibility- Physician or Primary Care Practitioner</li> <li>• Authorization to Exchange Confidential Information</li> <li>• Client Rights in Case Management</li> <li>• Home Environment Assessment/Reassessment</li> <li>• Initial Comprehensive Client Assessment</li> <li>• Ongoing Client Reassessment</li> <li>• Comprehensive Service Plan- updated every 90 days</li> <li>• Cost Avoidance Record</li> </ul>
Staff will monitor client needs	Documentation of coordination and follow up

**Assessment and Service Plan**

Key activities for Home and community-based health services include conducting comprehensive assessments with clients conducted by the nurse case manager, social work case manager or other home and community-based health services staff. These include assessing factors that affect access to and retention in medical care; to include, but not be limited to the following:

- Overall functional status
- Health status
- Medical care and providers
- Activities of daily living
- Mental health status
- Substance abuse assessment/screening
- Financial-income, benefits, and health insurance status
- Family/social support system
- Living situation/environment
- Partner services needs and options
- Other factors affecting ability of client to access health and social services

The nurse case manager, social work case manager or other home and community-based health services staff who completed the assessment will develop and document a Comprehensive Service Plan (CSP) for each client based on the results of the comprehensive assessment. Each CSP will consist of the following elements:

- Clear definition or description of priority areas for needed services
- Measurable objectives and specific action steps to be taken by the client with timelines
- Expected outcomes and goals

The CSP will be reassessed and updated every 90 days, or more frequently as needed.

Standard	Measure
Staff will develop and document a Comprehensive Service Plan (CSP) for each client based on the results of the comprehensive assessment	Maintenance of progress notes in the client record that includes a chronological record of all phone, face-to-face, or ancillary contacts with the client, service providers, and significant others for the purpose of monitoring the CSP
	Assurance that all progress notes are up-to-date and signed Documentation of the: <ul style="list-style-type: none"> <li>• Types of services provided</li> <li>• Number of the services provided</li> <li>• Duration of the services</li> <li>• Dates and locations of the service</li> <li>• Assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community based health services</li> </ul>
The CSP will be reassessed and updated a minimum of every 90 days	Documentation of reassessment and updates

**Case Closure and Discharge**

Services will cease when:

- The individual’s case has been resolved
- The Client has died
- The Client requests that his or her case be closed
- The Client cannot be located within 120 days after repeated efforts including written, oral and personal contact.
- Client relocates outside of San Diego County
- Client demonstrates repeated non-compliance or inappropriate behavior in violation of specific written policies of the provider especially with regard to violation of confidentiality of other client information.
- The Client’s needs cannot be adequately addressed by the service

Standard	Measure
Staff will document reasons for disenrollment in the client record	Documentation of reason for disenrollment
Staff will determine client eligibility for other programs and re-instatement in Ryan White home health care	Documentation of “inactive status” and maintenance of records and contact information to facilitate rapid re-enrollment, as appropriate

### Complaint Process

All providers will have written policies and procedures for an internal complaint process. The policy will identify staff responsible, an appeal process, tracking system, follow-up procedures, and a timeline.

The complaint process will be posted in a prominent location. In addition to the internal complaint process, information on how clients may contact the County of San Diego’s HIV, STD and Hepatitis Branch (HSHB) will be provided.

Standard	Measure
Clients' rights are protected and clients have access to a complaint resolution process and are made aware of such a process and the outcome	Documentation of a complaint policy
Clients have the ability to file a complaint	Verification of visible goldenrod (English and Spanish) placement in client sites

### Client Rights and Responsibilities

Clients will be informed of their rights and responsibilities.

Standard	Measure
Clients will be informed of their rights and responsibilities.	Documentation of Client’s rights and responsibilities during intake

### Cultural and Linguistic Competency

Cultural competency as defined by the HIV Planning Group is: “Recognizing the differences in physical and emotional life challenges, including disabilities of all kinds, culture and ethnicity, religion and spirituality, and in histories, traditions and languages. More specifically, all providers must have the ability to provide appropriate and acceptable services to all potential and current clients, including people of color, gay men, men who have sex with men (MSM), men or women at risk for HIV, bisexual men and women, transsexuals, transgender individuals, gender non-binary individuals, persons who use substances, persons with mental health concerns, persons of differing abilities, and others. Providers who serve any of these groups will make reasonable accommodations in service provisions.”

All providers must include a requirement in their policies that all staff, board members and volunteers possess knowledge of the Ryan White Part A program and the Americans with Disabilities Act. Program policies and procedures regarding cultural competency will address cultural sensitivity, diversity, and inclusiveness. Policies on cultural competency are given to clients at intake. Provider’s intake procedures will assess client access issues, including cultural needs, physical accessibility, and service location.

Providers must assess and ensure the training and competency of individuals who deliver language services to assure accurate and effective communication between clients, staff and volunteers to transcend language barriers and avoid misunderstanding and omission of vital information. Staff working directly with clients must receive a minimum of four hours of cultural sensitivity training each year.

Providers will also identify staff and volunteers who can provide bilingual/bicultural services to individuals who need or prefer to communicate in other languages. If there are no staff members or volunteers who can perform this function, the provider will develop alternate methods to ensure language appropriate services are available. Providers will employ proactive strategies such as partnering with other local organizations to develop a diverse workforce.

Standard	Measure
Agency policies will address cultural and linguistic competency	Documentation on policies on cultural competency
Staff will receive annual training on cultural competency	Documentation of all staff trainings on cultural competency
	Copies of the curriculum and handouts etc. kept on file (If training is provided by the provider)
Staff and volunteers are bilingual and can address the language needs of the populations they serve. If there are no appropriate bilingual people on staff, a plan is in place to ensure language needs are met	Copy of written plan to address
Provider will have written materials in the appropriate languages for the communities being served that are available to clients	Materials will be available.

**Privacy and Confidentiality**

All providers must develop written policies and procedures that address security, confidentiality and access and operations.

- All physical case files and electronic files are secured at all times.
- All activities that relate to client data will have appropriate safeguards and controls in place to ensure information security.
- All employees and volunteers working under this agreement have signed a confidentiality agreement.
- All staff orientation materials include client confidentiality policies and procedures and indicate how they are communicated to staff and volunteers.

Policies regarding confidentiality are presented to and signed by clients and maintained in clients' case files. A release of Information form will also be signed by clients as needed. Prior to releasing any client information, signed by clients, providers must obtain written consent which includes:

- The name of the program or person permitted to make the disclosure;
- The name of the client;
- The purpose and content (kind of information to be disclosed) of the disclosure;
- Client's signature or legal representative's signature.
- Policies regarding confidentiality are presented to and signed by clients and maintained in case files

Make available a private, confidential environment for clients to discuss their cases.

Standard	Measure
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Standard	Measure
Staff will develop written policies and procedures that address security, confidentiality, access and operations	Copies of policies and procedures
All files are secured	Inspected and noted during routine site visits
Staff and volunteers will receive training on privacy and confidentiality	Documentation of all staff/volunteer trainings on privacy and confidentiality
	Copies of the curriculum and handouts etc. kept on file (If training is provided by the provider)

