Making the Connection:

Standards of Care for
Client-Centered Services

Residential Home Health Care

San Francisco EMA
Includes San Francisco City and County,
San Mateo County and Marin County

All of the existing HHS standards of care were reviewed and evaluated by the HIV Health Services Planning Council over FY-2014-15, finalized in May of 2015 without any revisions required.

Prepared for

San Francisco Department of Public Health,
HIV Health Services, and the
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Dedication

The Residential Home Health Care Standards of Care are dedicated to the clients of the HIV Health Services system, to home health care providers who devote themselves to providing services to others, and to individuals who are both client and provider in the San Francisco EMA.

Acknowledgments

Sincere gratitude goes out to all who contributed to the process of developing the Residential Home Health Care Standards of Care. Special thanks go to the Home Health Care Working Group members who contributed their knowledge and experience to make these standards practical and worthwhile.

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RESIDENTIAL
HOME HEALTH CARE
Standards of Care

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I. Introduction

The Ryan White HIV/AIDS Program, Part A, provides emergency assistance to Eligible Metropolitan Areas (EMAs) most severely affected by the HIV/AIDS epidemic. As it applies to San Francisco, the CARE Act stipulates that Title I funds should be used to provide access to integrated health services for persons living with HIV/AIDS (PLWHA) who:

- Reside within the San Francisco EMA; **and**
- Have no third party payment source (uninsured);
- Have limited third party coverage (underinsured); **or**
- Have been denied coverage by a third party payer (uninsured or underinsured).

In addition, enrollment priorities are as follows:

- First priority: Residents of the San Francisco EMA who have low or no income and are uninsured
- Second priority: Residents of the San Francisco EMA who have low or no income and are underinsured

Finally, Part A funds will be used only for services that are not reimbursed by any other source of revenue.

In addition to these federal guidelines, the San Francisco EMA has developed standards of care for all Part A-funded HIV health services in the San Francisco EMA. These standards, outlined here, are designed to define the minimally acceptable levels of service delivery and provide suggested measures to determine whether service standards are being met.

II. Overview

Residential Home Health Care Setting Standards of Care are designed to ensure consistency among the Title I home health care services provided as part of the San Francisco EMA's continuum of care plan for PLWHA. These minimally acceptable standards for service delivery are not intended to promote a formula approach to the care of PLWHA but rather to provide guidance so that programs are best equipped to:

- Provide nursing care to effectively meet the needs of PLWHA who have a need for supervised or assisted living.
- Reach out to PLWHA in need of agency services.
- Meet the specific and varied needs of HIV-positive residents using a multidisciplinary team approach and as appropriate, conduct HIV risk reduction specifically for HIV-positive individuals (prevention for positives).
- Provide comfort to residents and respite for family systems and other caregivers.
- Support residents' access to and ongoing follow-up with primary and other supportive services.
- ~~Assist in implementing~~ Participate in coordinated, client-centered, and effective service delivery networks.
- Identify and address barriers to services.
- Appropriately address issues of consent, confidentiality, and other client rights, for residents enrolled in services.
- Address clients' needs using a multidisciplinary team approach.

III. Description of Service

PLWHA who are no longer able to live independently in the community and in need of supervised or assisted living may be eligible to live in a licensed residential setting that helps maintain their level of functioning through assistance with daily needs. Therapeutic, nursing, and supportive health services, including services to maintain activities of daily living, are provided in a licensed residential care facility by a licensed or certified home health provider. Services are provided to PLWHAs in accordance with an individualized care plan established by the multidisciplinary care team. Home health care providers work closely with the multidisciplinary care team that includes the patient's case manager, primary care provider, and other appropriate health care professionals.

Home Health Care service categories provided by a licensed or certified home health provider, in a licensed residential setting include:

Paraprofessional Care – (e.g., attendant care) **–** Supportive services and assistance with activities of daily living provided in the home to allow a client to continue living independently. These services include non-medical and non-nursing assistance such as housecleaning, preparing meals, escort to medical appointments, and assistance with personal care and other activities of daily living.

Professional Care – Provision of services by licensed healthcare workers (e.g., nurses, LVN, medical social workers, physical therapists, occupational therapists). Services include assisted care, physical assessment, medication administration and teaching, rehabilitation therapy, and/or mental health services.

IV. Unit of Service

A Paraprofessional Care or Professional Care Unit of Service is one patient day which is equal to 8 hours of care.

V. Standards of Care

A. Administration

Administrative standards ensure all ~~professionals~~ staff providing home health care services are properly trained and credentialed, have an understanding of the scope of their job responsibilities, and that all programs funded are adequately staffed. As part of their administrative hiring procedures, programs are encouraged to recruit and hire individuals who reflect the diversity of the client target population.

Standard 1: Experience/education.

Paraprofessional residential home care providers should have:

- Experience providing home health attendant services
- Appropriate certification, if required by State regulations (Certified Nurse Assistant Certification by the state of CA)
- Strong communication, reading, and writing skills
- Skill and comfort working with men who have sex with men, women, transgender, people of color, substance users, homeless and/or individuals with mental illness
- Preferred: Multilingual~~Training in peer counseling preferable.~~
- Preferred: Experience working and/or volunteering in direct client services within the HIV community or related social service experience ~~San Francisco Bay Area counties~~

Professional residential home care providers should:

- Maintain appropriate licenses and/or credentials.
- Have experience in HIV/AIDS.

Measure: **Completed paperwork on file for all staff.**

Standard 2: **Staffing levels.**

Contracted agencies will ensure appropriate staffing levels are reached and maintained to provide contracted services.

Measure: **Full and part-time positions funded under contract are filled; OR appropriate actions being taken to fill positions.**

Standard 3: **Job descriptions.**

Staff members will have a clear understanding of their job definition and responsibilities.

Measure: **Written job description on file signed by the staff/staff supervisor.**

Standard 4: **Policies and procedures.**

Each funded agency will have a written policies and procedures manual that contains both personnel and program policies and procedures for the following areas:

Personnel Policies and Procedures

- Annual performance reviews
- Staff training and other personnel policies (e.g., behavioral standards)

Program Policies and Procedures

- Client/patient rights and responsibilities, including confidentiality guidelines (with particular discussion of confidentiality issues for PLWHA)
- Client grievance policies and procedures
- Client eligibility and admission requirements
- Nondiscrimination policies for clients with children
- Referral resources and procedures that ensure access to a continuum of services

- All appropriate consent forms (e.g., consent to share information, treatment consent, shared client data/registration system[1] consent form for San Francisco only, HIPAA requirements)
- Data collection procedures and forms, including data reporting
- Quality assurance/quality improvement
- Guidelines for language accessibility
- Plans for accommodating people with disabilities (plans should adhere to Americans with Disabilities Act (ADA) standards to the extent possible)

Measure: **Written policies and procedures manual.**

Standard 5: Staff training.

Every effort should be made for required trainings to be completed within the first year of employment. In addition, regardless of credentials, all providers must receive ongoing HIV/AIDS training as appropriate for employee job function. Both paraprofessional and professional providers should have the following trainings:

- Harm reduction training as required by San Francisco DPH of all staff providing direct services
- CPR and First Aid certification preferred within the first year of employment and kept current thereafter for all professional staff
- As necessary, training on Prevention for Positives principles
- For licensed staff, any additional training in compliance with their license
- Any additional training that provides the development of skills ~~which~~ and knowledge to support the implementation of the Residential Home Health Care Standards of Care

Measure: **Documentation of all completed trainings on file.**

B. Facility Standards

Facility standards are intended to ensure program safety and accessibility for both clients and staff.

Standard 6: Standard safety requirements.

[1]The shared client data/registration system is maintained by the San Francisco Department of Public Health HIV Health Services and is currently referred to as REGGIE.

The program is located in a physical facility that:

- Meets fire safety requirements
- Meets criteria for ADA compliance
- Is clean and comfortable
- Complies with Occupational Safety and Health Administration (OSHA) infection control practices
- Has emergency protocols for health- and safety-related incidents posted
- Is equipped for safe, legal, and appropriate storage of pharmaceuticals

Measure: **Compliance with all appropriate regulatory agencies, including ADA compliance; written policy describing plan for accommodating individuals with disabilities.**

Standard 7: Residential facility licensure.

Residential facilities must be licensed by the appropriate agencies (e.g., California State Department of Social Services Community Care Licensing).

Measure: **Compliance with appropriate licensing agencies.**

C. Service Delivery (for Professional Care)

Standards related to service delivery define the minimum set of activities to be performed and under what parameters. The service standards that follow describe activities that are normally the responsibility of professional health care providers (e.g., nurses, RN case managers, medical social workers) working with clients in a licensed residential setting and are conducted in coordination with the multidisciplinary care team.

Standard 8: Eligibility screening.

- In order to determine program eligibility, obtain client information including demographic information, verification of HIV status, disease state, and prognosis.
- If appropriate, conduct a site visit or evaluation of the client in their current living situation to confirm that the client meets eligibility criteria for admission into residential facility (e.g., unable to live independently in the home and needs assisted living care).

- Conduct a preliminary needs assessment, which includes services needed, perceived barriers to accessing services and/or medical care.

Measure: **Detailed documentation of eligibility screening process in client charts.**

Standard 9: Intake and assessment.

- Review client rights and program services with resident.
- Obtain resident consent for treatment and signed release for sharing information with other providers to ensure coordination of services.
- Assign admitted residents a nurse case manager and/or social work case manager responsible for assessment of client's needs and for coordinating with the multidisciplinary care team in developing a care plan.~~Conduct a needs assessment as part of outreach efforts and at each face-to-face or telephone encounter with clients to determine their primary, secondary and tertiary needs.~~
- Conduct a comprehensive assessment of the client's health including assessment of client's access to primary care, adherence to therapies, disease progression, symptom management and prevention.
- ~~Combine primary, secondary data and~~Determine client's ability to perform activities of daily living and the level of assistance required.
- In coordination with the multidisciplinary care team that includes the client's primary care providers and case manager, develop a care plan based on current assessment and needs of the client.

Measure: **Detailed documentation in client charts.**

Standard 10: Implementation of the care plan.

- Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation.
- Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services).
- Monitor changes in client's physical and mental health.
- Provide nursing care, including medication administration, under the supervision and orders of the client's primary care provider.
- Administer medication according to Residential Care Facility for the Chronically Ill (RCFI) regulations.

- Notify the resident's primary care provider if resident refuses to comply with prescribed medication regimens.
- Work closely with members of the care team to effectively address client needs.
- Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate.

Measure: **Detailed documentation in client charts.**

Standard 11: Coordination of referrals.

- Provide clients with accurate information on available resources.
- ~~Provide referrals to program and services that can successfully meet the client's needs, taking into consideration their preferential choices.~~Consult with case managers/care coordinators in order to facilitate appropriate referrals to programs and services that can successfully meet the client's needs.
- Assist clients in making informed decisions on choices of available service providers and resources.
- Address client's spectrum of needs in a comprehensive way while minimizing duplication of services.

~~**Sources to access referral information include Case Manager/Care Coordinator, written resource manual, and the Internet.**~~

Measure: **Frequently updated inventories of services provided in-house and through referrals.**

Standard 12: Transfer and discharge.

Transfer and discharge of clients from residential care facilities should result from a planned and progressive process that takes into account the needs and desires of the client and his/her caregivers, family, and support network. A transfer or discharge plan is developed when one or more of the following criterion are met:

- Agency no longer meets the level of care required by the client;
- Client is noncompliant with facility licensing policies;
- Client wishes to discontinue services (with or against medical advice); or
- Client transfers services to another service program.

~~when appropriate.~~

Measure: **Documentation of discharge planning and discharge of client in care plan and client charts.**

Standard 13: Coordination with a multidisciplinary team.

- Work closely with client's other health care providers and other members of the care team in order to effectively communicate and address client service related needs, challenges and barriers.
- Participate in the development of individualized care plan with members of the care team.
- Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate.

Measure: **Detailed documentation in client charts.**

D. Service Delivery (for Paraprofessional Care)

The service standard that follows describes activities of paraprofessional home health care providers in a residential setting, conducted in coordination with the multidisciplinary care team and under the supervision of a registered nurse.

Standard 14: Practical support.

- Consult with case managers working with the client in order to clarify roles and responsibilities to successfully meet client's needs and avoid duplication of services.
- Provide attendant care services which include taking vital signs and assisting clients with activities of daily living (e.g., bathing and personal hygiene care, prescribed exercises).
- Under supervision of RN, assist client's self-administration of medication.
- Promptly report to supervising RN any problems or questions regarding the client's adherence to medication.
- Report any changes in the client's condition and needs.
- Complete appropriate client records as required by supervising RN.

Measure: **Documentation of practical support provided to clients in their client charts.**

E. Cultural sensitivity and competency

Standard 15: Cultural sensitivity and competency.

- Agency~~/clinic~~ must have a nondiscrimination policy in place regarding hiring and client treatment that addresses issues of race/ethnicity, gender identity, sexual orientation, disability, and other relevant issues.
- Agency~~/clinic~~ must show experience with the target population(s) or have a plan for developing staff sensitivity to the target population(s).
- Staff should be ethnically, culturally, and linguistically diverse or reflect the diversity of the population they serve.
- Services are provided using language and methods sensitive to the communities served.
- Services provide opportunities for clients to assist in identifying issues related to culture that may affect how they respond to services (e.g., primary language, spirituality needs, sexual orientation, community identification, immigration status, family needs, and customs).
- Service providers should have referral relationships that can address gaps in culturally competent services (e.g., if agency does not have Spanish-speaking staff, Spanish-speaking clients can be referred).
- Agency must have a cultural competency plan on file with the San Francisco Department of Public Health (for agencies in San Francisco).

Measure: **Adherence to the San Francisco DPH cultural competency requirements for agencies and services in San Francisco; adherence to relevant local county/city cultural competency plan for agencies and services in San Mateo or Marin County.**

F. Coordination and Referral

The objectives of coordination and referral are to address the client's spectrum of needs in a comprehensive way, while minimizing duplication of services. Home health care providers in residential settings are a core component of the multidisciplinary team.

Standard 16: Coordination and referral.

- Coordination and referrals include identification of other service providers or staff members with whom the client may be working.

The agency will:

- ~~Ensure~~ Make sure that services for clients will be provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and encouraging client access to integrated health care.

- Consistently report referral and coordination updates to the multidisciplinary team.

Measure: **Documentation in client's record of referrals made; up-to-date treatment plan in client's chart documenting necessity of specialty referral, follow-up required and desired outcome.**

G. Quality Assurance and Service Maintenance

The objectives of quality assurance and service maintenance are related to periodic evaluations of client treatment plans, service delivery, and client satisfaction with service provision, the results of which lead to service improvement.

Standard 17: Client satisfaction survey.

Providers will conduct client satisfaction surveys (or other client satisfaction activity) at least ~~bi-~~annually.

Measure: **Annual written summary and analysis of the program's client satisfaction activity.**

Standard 18: Quality assurance.

The agency must have an active Continuous Quality Improvement (CQI) program to monitor care provided and identify means of improving care and services.

Measure: **Written policies on CQI in place, including how data will be used to improve programs; one report per contract period on improvements made through CQI.**

TABLE 1: Summary of Standards of Care Measures

Standard	Measure
1. Experience and education.	1. Completed paperwork on file for all staff.
2. Staffing levels.	2. Full and part-time position funded under contract are filled; OR appropriate actions being taken to fill positions.
3. Job descriptions.	3. Written job description on file signed by the staff/staff supervisor.
4. Policies and procedures.	4. Written policies and procedures manual.
5. Staff training.	5. Documentation of all completed trainings on file.
6. Standard safety requirements.	6. Compliance with all appropriate regulatory agencies, including ADA compliance; written policy describing plan for accommodating individuals with disabilities.
7. Residential facility licensure.	7. Compliance with appropriate licensing agencies.
8. Eligibility screening.	8. Detailed documentation of eligibility

	screening process in client charts.
9. Intake and assessment.	9. Detailed documentation in client charts.
10. Implementation of the care plan.	10. Detailed documentation in client charts.
11. Coordination of referrals.	11. Frequently updated inventories of services provided in-house and through referrals.
12. Transfer and discharge.	12. Documentation of discharge planning and discharge of client in care plan and client charts.
13. Coordination with a multidisciplinary team.	13. Detailed documentation in client charts.
14. Practical support.	14. Documentation of practical support provided to clients in client charts.
15. Cultural sensitivity and competency.	15. Adherence to the San Francisco DPH cultural competency requirements for agencies and services in San Francisco; adherence to relevant local county/city cultural competency plan for agencies and services in San Mateo or Marin County.
16. Coordination and referral.	16. Documentation in client's record of referrals made; up-to-date treatment plan in client's chart documenting necessity of specialty referral, follow-up required, and desired outcome.
17. Client satisfaction survey.	17. Annual written summary and analysis of the program's client satisfaction activity.
18. Quality assurance.	18. Written policies on CQI in place, including how data will be used to improve programs; one report per contract period on improvements made through CQI.