Making the Connection:

Standards of Care for Client-Centered Services

Home-Based Home Health Care

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

February 2004

Prepared for

San Francisco Department of Public Health,
HIV Health Services, and the
HIV Health Services Planning Council

Prepared by

Harder+Company Community Research
San Francisco, CA

Dedication

The Home-Based 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 Home-Based 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.

Home Health Care Working Group Members

Sherilyn Adams, LCSW
Diane Jones, RN
Rodney Murphy
Tim Patriarca, MA
David Powell

Project Staff

Joseph Cecere, HIV Health Services Program Manager
Hilda Jones, HIV Health Services Program Manager

Project Consultants

Aimee F. Crisostomo, Research Assistant
Michelle Magee, Vice President

HOME-BASED
HOME HEALTH CARE
Standards of Care

February 2004

I. Introduction

The Ryan White CARE Act, Title I, 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, CARE 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 Title I-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

Home-Based Home Health Care Standards of Care are designed to ensure consistency among the Title I home health care services provided as part of the San Francisco EMAs 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 assistance in performing activities of daily living to allow patients to continue living independently in their home.
- Promote patients' independence and self-sufficiency.
- Reach out to PLWHA in need of agency services.
- Meet the specific and varied needs of HIV-positive clients using a multidisciplinary team approach and as appropriate, conduct HIV risk reduction specifically for HIV-positive individuals (prevention for positives).
- Provide comfort to patients and respite for family systems and other caregivers.
- Support patients' access to and ongoing follow-up with primary and other supportive services.
- Participate in coordinated, patient-centered, and effective service delivery networks.
- Identify and address barriers to services.
- Appropriately address issues of consent, confidentiality, and other patient rights, for patients enrolled in services.
- Address patients' needs using a multidisciplinary team approach.

III. Description of Service

Home health care services help maintain PLWHAs in their homes and support their level of functioning through assistance with daily needs and/or through the provision of routine or skilled nursing. Therapeutic, nursing, and supportive health services, including services to maintain activities of daily living, are provided by a licensed or certified home health provider in a home setting and 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 in the patient's home include:

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

Specialized Professional Care – Provision of services by licensed health care workers (e.g., nurses, LVN, social workers, physical therapists, occupational therapists). Services may include routine and skilled nursing interventions including blood draws, specimen collection, physical assessment and medication administration and teaching, rehabilitation, therapy, mental health services, and supervision of paraprofessionals.

IV. Unit of Service

A Paraprofessional Care or Professional Unit of Service is defined as one patient visit or a contact between a patient and a provider that is two hours in duration.

V. Standards of Care

A. Administration

Administrative standards ensure all 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 patient target population.

Standard 1: Experience/education.

Paraprofessional home health care providers should have:

- Experience providing homemaker services (for in-home supportive service providers)
- Experience providing home health attendant services (for home health aides)
- Appropriate certification, if required by State regulations (e.g., Home Health Aide Certification issued 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
- Preferred: Experience working and/or volunteering in direct patient services within the HIV community or related social service experience

Professional home health 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

- Patient rights and responsibilities, including confidentiality guidelines (with particular discussion of confidentiality issues for PLWHA)
- Patient grievance policies and procedures
- Patient eligibility and admission requirements
- Nondiscrimination policies for patients 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

[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.

- 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. Home health care providers (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
- As necessary, training on Prevention for Positives principles
- Any additional training that provides the development of skills and knowledge to support the implementation of the Home Health Care Standards of Care

Measure: Documentation of all completed trainings on file.

B. Facility Standards

Home-based home health care services are delivered in the patient's home. The following facility standards are intended to ensure safety for staff delivering services in the patient's home as well as to ensure program safety and accessibility for staff in the program's facility.

Standard 6: Safety assessment of patient's home.

The patient's home or current residence must be determined physically safe before service can be offered or continued.

Measure: Detailed documentation of safety assessment in patient charts.

Standard 7: Standard safety requirements for program site.

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

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

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 home health care providers (e.g., nurses, RN case managers, medical social workers) and are conducted, in coordination with the multidisciplinary care team, in the patient's home or current residence.

Standard 8: Intake and service eligibility criteria.

- Obtain patient information including eligibility and demographic information, verification of HIV status, disease state, and prognosis.
- Conduct a preliminary needs assessment, which includes services needed, perceived barriers to accessing services and/or medical care.
- Conduct ongoing assessment of service eligibility such as in-home supportive services (IHSS) and eligibility for benefits (e.g., Medi-Cal, Medicare)
- Obtain patient consent for treatment and signed release for sharing information with other providers to ensure coordination of services.

Measure: Detailed documentation in patient charts.

Standard 9: Assessment.

- Conduct a comprehensive evaluation of the patient's health, including a comprehensive physical exam (as applicable to individual agencies), psychosocial status, functional status, and home environment.
- Assess patient's access to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for skilled nursing or rehabilitation services.
- Gather information to determine patient's ability to perform activities of daily living and the level of attendant care assistance the patient needs to maintain living independently.
- In coordination with the multidisciplinary care team that includes the patient's primary care providers and case manager, develop a care plan based on current assessment and needs of the patient.

Measure: Detailed documentation in patient charts.

Standard 10: Implementation of the care plan.

- Provide nursing and rehabilitation therapy care under the supervision and orders of the patient's primary care provider.
- Monitor the progress of the care plan by reviewing it regularly with

the patient and revising it as necessary based on any changes in the patient's situation.
- Advocate for the patient when necessary (e.g., advocating for the patient with a service agency to assist the patient in receiving necessary services).
- Monitor changes in patient's physical and mental health, and level of functionality.

Measure: Detailed documentation in patient charts.

Standard 11: Coordination of referrals.

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

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

Standard 12: Transfer and discharge plan.

When appropriate or possible, transfer and discharge of patients from home health care services should result from a planned and progressive process that takes into account the needs and desires of the patient 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 patient;
- Patient moves out of the area;
- Patient wishes to discontinue services (with or against medical advice);
- Patient transfers services to another service program;
- Patient is no longer safe living in the home, but refuses higher level of care; or
- Patient is unable or unwilling to adhere to agency policies.

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

Standard 13: Coordination with a multidisciplinary team.

- Work closely with patient's other health care providers and other members of the care team in order to effectively communicate and address patient 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 patient charts.

D. Service Delivery (for Paraprofessional Care)

The service standard that follows describes activities of paraprofessional home health care providers (e.g., home health aides, attendant, homemakers) in coordination with the multidisciplinary care team and under the supervision of a registered nurse or rehabilitation therapist (OT/PT) case manager.

Standard 14: Practical support.

- Provide homemaking services including meal preparation, grocery shopping, house cleaning, laundry, running errands, accompanying patients to scheduled medical or related appointments, and other household tasks and services.
- Provide attendant care services which include taking vital signs and assisting patients with activities of daily living (e.g, bathing and personal hygiene care, prescribed exercises).
- Under guidance and supervision of case manager, assist patient's self-administration of medication.
- Promptly report to case manager any problems or questions regarding the patient's adherence to medication.
- Report any changes in the patient's condition and needs.
- Complete appropriate patient records as required by supervising case manager.

Measure: Documentation of practical support provided to patients in patient charts.

E. Cultural sensitivity and competency

Standard 15: Cultural sensitivity and competency.

- Agency must have a non-discrimination policy in place regarding hiring and patient treatment that addresses issues of race/ethnicity, gender identity, sexual orientation, disability, and other relevant issues.
- Agency 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 patients 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 patients 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 patient's spectrum of needs in a comprehensive way, while minimizing duplication of services. Home health care providers 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 patient may be working.

The agency will:

- Make sure that services for patients 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 patient access to integrated health care.
- Consistently report referral and coordination updates to the multidisciplinary team.

Measure: Documentation in patient's record of referrals made; up-to-date treatment plan in patient'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 patient treatment plans, service delivery, and patient satisfaction with service provision, the results of which lead to service improvement.

Standard 17: Patient satisfaction survey.

Providers will conduct patient satisfaction surveys (or other patient satisfaction activity) at least annually.

Measure: Annual written summary and analysis of the program's patient 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.

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. Safety assessment of patient's home.	6. Detailed documentation of safety assessment in patient charts.
7. Standard safety requirements for program site.	7. Compliance with all appropriate regulatory agencies, including ADA compliance; written policy describing plan for accommodating individuals with disabilities.
8. Intake and service eligibility criteria.	8. Detailed documentation in patient charts.
9. Assessment.	9. Detailed documentation in patient charts.
10. Implementation of the care plan.	10. Detailed documentation in patient charts.
11. Coordination of referrals.	11. Frequently updated inventories of services provided in-house and through referrals.
12. Transfer and discharge plan.	12. Documentation of discharge planning and discharge of patient in care plan and patient charts.
13. Coordination with Multidisciplinary Team.	13. Detailed documentation in patient charts.

14. Practical support (for paraprofessional care).	14. Documentation of practical support provided to patients in patient 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 patient's record of referrals made; up-to-date treatment plan in patient's chart documenting necessity of specialty referral, follow-up required, and desired outcome.
17. Patient satisfaction survey.	17. Annual written summary and analysis of the program's patient 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.