H. Homecare Services and Supplies

Service Definition

Homecare Services and Supplies aim to support people living with HIV (PLWH) by providing a range of services that promote living independently, safely, and comfortably. Homecare Services and Supplies are provided in an integrated setting appropriate to the client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider.

Key service components and activities include:

- Appropriate mental health, developmental, and rehabilitation services.
- Day treatment or other partial hospitalization services.
- Durable medical equipment.
- Home health aide services and personal care services in the home.

Note: Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing homecare services and supplies.

Recipients providing Homecare Services and Supplies are expected to comply with the Life Care and Early Intervention Services (LCEIS) Universal Standards, as well as these additional standards:

Standard 1: Homecare Services and Supplies must be delivered in accordance with the Wisconsin LCEIS Eligibility and Recertification Policy and Procedures.

Providers are responsible for determining eligibility at enrollment and for confirming eligibility annually.

Documentation

Client records must document that the client is living with HIV and resides in Wisconsin at initial enrollment in accordance with the Wisconsin LCEIS Eligibility Policy.

Standard 2: During initial contact, key information about the client must be collected or verified in a data system.

Providers must attempt to collect and confirm the following client information:

- Contact and identifying information
- Emergency contact, if available
- Insurance status
- Documentation of residing in Wisconsin
- Demographic information
- Contact information for other service providers and corresponding release(s) of information (ROI)
- Proof of HIV diagnosis

Documentation

Documentation of all elements outlined above must be completed within 30 days of first medical visit, initial referral, or contact. Documentation must show any corresponding ROIs as needed and applicable.

Standard 3: Intake may be performed by providers, non-service provider staff, or interns.

Intake may be performed by recipient staff or interns who are not providers given that they meet all the following criteria:

- Are an employee or intern of the recipients.
- Received proper onsite training and signed the agency confidentiality agreement.
- Completed the HIV Basics Online Course offered through the University of Wisconsin HIV Outreach Project Training System.

Documentation

The client record must indicate who performed the intake. If the client record shows that intake is performed by someone who is not a provider, the required criteria must be documented in their personnel file.

Standard 4: Homecare Services and Supplies are provided based on a written care plan to meet the individualized needs of each client.

Care plans should meet the individualized needs of each client and include:

- Client's need(s) for services.
- Client goal(s).
- Action steps (to be taken towards goal[s]).
- Individual responsible for the action step.
- Anticipated timeframe for each action step, when known.
- Client signature and date, or documentation of verbal approval.
- Supervisor's signature and date indicating review and approval, when applicable.

Documentation

Documentation of plan(s), signed and dated, must be present in the client record.

Standard 5: Referrals to other services are made as needed and monitored for client follow-up.

The provider must initiate referrals that were agreed upon by the client and the provider and include:

- Referral to a named agency.
- The name of a contact person at the referral agency (if available).
- An exact address.
- Identifying referral agency eligibility requirements.

Documentation

Effective referral relationships must be available for the full range of services, as evidenced by memorandum of understanding, letters of agreement, or subcontracts.

All referrals and outcomes of such referrals must be documented in the client record.

Standard 6: Each instance of Durable Medical Equipment (DME) provided is documented.

The recipient must maintain documentation of each instance of DME provided to each client and have a way to link the documentation to the client's records.

The log and the client record must document the following:

- Unique identifier of client receiving assistance.
- Name of staff member arranging service.
- Date of purchase of DME.
- Date of distribution to client or usage of DME.
- Dollar value of DME provided.
- Insurance denial for DME (if applicable).

Documentation

The provider must be able to demonstrate that each instance of DME was appropriately documented, including all required elements. If the recipient keeps a physical or electronic DME log that is separate from the client record, the log must be linked back to the client file without compromising the client's Personal Health Information (PHI) as defined by HIPAA. The log must be available for review by the Wisconsin HIV Care Unit upon request.

Standard 7: Use of Homecare Services and Supplies funds must be monitored to ensure funding is exclusively used for allowable purposes, as a payer of last resort.

LCEIS funds must be the provider of last resort. If a client is eligible for Homecare Services and Supplies through Medicaid, Medicare, or private insurance, the recipient or client must try to use services through their insurance first. If the client has a copay for Homecare Services and Supplies through their insurance, LCEIS funds can be used to cover the expense.

Documentation

The reason for the use of LCEIS funds must be documented in the client record using a brief narrative.

Standard 8: Upon termination of Homecare Services and Supplies, the client is discharged.

Criteria for client discharge are:

- Client is no longer eligible for services.
- Client is lost to follow-up or does not engage in service*.
- Client is incarcerated for longer than six months.
- Client relocates outside of service area.
- Agency initiates termination due to behavioral violations. This should be a last resort*.
- Client chooses to terminate service.
- Client death*.

*See Universal Standards for guidance.

Documentation

The client record must document which discharge criteria were met. Documentation must show notification of the client and other care team members as outlined in the Universal Standards.

A brief discharge narrative must be included in the client record.