HIV Home Care Program (HHCP)

New Jersey Department of Health and Senior Services
Division of HIV, STD and TB Services
Background

- Funded since 1990 by HRSA with Ryan White Part B dollars
  - Medicaid Model
- Alternative care setting to hospital, nursing home, institution
- Medical care in the home of individuals with HIV/AIDS
- Eligibility
  - NJ Resident
  - Income
  - Proof of insurance/lack of insurance
  - Physician documented HIV/AIDS
  - Physician certified diagnosis/surgery related to HIV/AIDS requiring home care services
  - Require direct, hands-on nursing care or the supervision by a registered nurse or hands-on care provided by a home health aide or personal care assistant for chronic or medical dependencies
Purpose

- Provide home care service for individuals with no or limited insurance
- Fills the gap in medical care services from hospital discharge until long term insurance is applied for & enrollment confirmed
- Provide wrap-around services if third party or private insurance is inadequate
- Provide service if denied long term insurance or ineligible for insurance
- Must be used as payer of last resort
Administration

- Statewide network of certified home health care agency providers
- Annual application for Letter of Agreement (LOA)
- LOA includes:
  - Eligibility Requirements, Service Categories and Rates, Reporting Requirements
- Agencies receive referrals from hospitals, physicians, clinics, social service agencies, family
Provide skilled health services in the home for a medical diagnosis/surgery related to HIV/AIDS
- Skilled nursing (SKN) need
- Nursing home level of care
- Require assistance w/Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) in neuro/cognitive deficiencies (neuropathy, dementia)

Based on a written Physician Certification and Plan of Care prepared by a case management team including health care professionals
- Case manager prepares Physician Certification and Plan of Care based on assessment
- Includes service type, quantity, duration of services
- Treating physician certifies diagnosis and care every 60 days
- Ongoing communication/coordination of services among team

Provided services are documented in a record keeping system
- Service, date, location (home) & provider signature
Program & Fiscal Standards
HRSA - April 2011, 2012

- Services are provided by professionals with appropriate licensure/certification as required by law
- Ryan Whites funds are payer of last resort; maximize 3rd party funds
  - Assess insurance status
  - Assist and document steps taken to enroll eligible uninsured clients into Medicare, Medicaid, private insurance, SSI, SSD
  - Coordinate benefits; obtain approval/denial of 3rd party sources
- Compliance with HRSA standards is assessed
  - Biannual site visits by program Coordinator
  - Ongoing communication with providers to ensure compliance
**Additional HRSA Requirements**

- Assess, Track and Monitor......
  - Clients are in care and stay in care
    - Routine care visits
  - Clients receive appropriate laboratory tests
    - CD4, Viral Load, etc.
  - Clients receive appropriate Antiretroviral Therapy
    - Assess compliance
  - Monitor client data
  - Track outcomes
## Application and Monitoring Process

<table>
<thead>
<tr>
<th>Form</th>
<th>Frequency</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Application/Renewal</td>
<td>Admission &amp; Every 6 months</td>
<td>Determines eligibility; income, insurance</td>
</tr>
<tr>
<td>Client Assessment</td>
<td></td>
<td>Documents health/mental health, social, physical environment, met/unmet needs</td>
</tr>
<tr>
<td>Case Management Client Care Plan</td>
<td></td>
<td>Documents services provided by all sources</td>
</tr>
<tr>
<td>Medical Certification by Physician</td>
<td>Admission</td>
<td>Certifies HIV &amp; HIV-related medical/surgical condition requiring care; Baseline CD4/Viral Load/ART/Linkage</td>
</tr>
<tr>
<td>Physician Certification &amp; Care Plan</td>
<td>Admission &amp; Every 60 days</td>
<td>Certifies HIV-related condition &amp; care every 60 days; Ongoing CD4/Viral Load/ART/Linkage</td>
</tr>
<tr>
<td>Client Intake Form submitted to HHCP</td>
<td>Admission</td>
<td>Summarizes data to determine eligibility</td>
</tr>
<tr>
<td>Client Monitoring Record &amp; Progress Notes</td>
<td>Monthly</td>
<td>Documents monthly visits, communication with client &amp; health team</td>
</tr>
<tr>
<td>Client Quarterly Status Report</td>
<td>Quarterly</td>
<td>Documents ongoing medical and insurance status</td>
</tr>
</tbody>
</table>
HHCP Client

- Hospital medical/surgical discharge requiring continued care at home
- Newly diagnosed HIV+ with an OI
- HIV+ and on medications for many years with:
  - Multisystem Failure
  - Chronic Condition: Liver/Kidney/Pulmonary/Cardiac
  - Neuro-cognitive process; dementia, neuropathy
  - Reflects NJ aging HIV/AIDS population
### Clients Served 4/1/11-3/31/12 by County/Provider Agency

<table>
<thead>
<tr>
<th>County</th>
<th>Clients Served</th>
<th>New Admits</th>
<th>Discharge*</th>
<th>Clients 03/31/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burlington</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Essex</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Middlesex</td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Somerset</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Monmouth</td>
<td>12</td>
<td>5</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Hunterdon</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hudson</td>
<td>20</td>
<td>10</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Bergen</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Mercer</td>
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<td>1</td>
</tr>
<tr>
<td>Passaic</td>
<td>26</td>
<td>5</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>Union</td>
<td>8</td>
<td>2</td>
<td>3,</td>
<td>5</td>
</tr>
<tr>
<td>Sussex</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ocean</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Warren</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>91</td>
<td>31</td>
<td>38</td>
<td>48</td>
</tr>
</tbody>
</table>

*Reason for Discharge*

- 17 Improved
- 11 Medicaid/Waiver
- 6 Expired/Hospice
- 4 Unable to Locate/Other

- Enrollment changes monthly due to constant movement of new admits/discharges
- 4 new clients in April
Clients Served 4/1/12-6/15/12 by County/Provider Agency

<table>
<thead>
<tr>
<th>County</th>
<th>Clients Served</th>
<th>New Admits</th>
<th>Discharge</th>
<th>Clients 06/15/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burlington</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Essex</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Middlesex/</td>
<td>10</td>
<td>2</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Somerset</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Monmouth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hunterdon</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hudson/Bergen</td>
<td>18</td>
<td>1</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Mercer</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Passaic</td>
<td>16</td>
<td>5</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Union</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Atlantic</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ocean</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Warren</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>64</td>
<td>11</td>
<td>11</td>
<td>53</td>
</tr>
</tbody>
</table>

*Reason for Discharge*
- 3 Improved
- 5 Medicaid/Waiver
- 1 Expired/Hospice
- 2 MICA

* Enrollment changes monthly due to constant movement of new admits/discharges.
## Client Demographics

<table>
<thead>
<tr>
<th></th>
<th>04/01/10-03/31/11</th>
<th>04/01/11-03/31/12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clients Served</strong></td>
<td>N = 84</td>
<td>N = 91</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>35%</td>
<td>38%</td>
</tr>
<tr>
<td>Male</td>
<td>65%</td>
<td>62%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-24 Yrs</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>25-44</td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td>45-64</td>
<td>73%</td>
<td>74%</td>
</tr>
<tr>
<td>65+</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>20.5%</td>
<td>21%</td>
</tr>
<tr>
<td>Black</td>
<td>57%</td>
<td>53%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>19%</td>
<td>22%</td>
</tr>
<tr>
<td>Asian/PI</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>2.5%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Services

- **Monthly Case Management**
  - All clients receive monthly case management home visit

- **Skilled Nursing (SKN)**
  - SKN Visit (hands-on care, or behavioral, IV, respiratory, diagnostic service by a registered nurse); and/or
  - Home Health Aide/Personal Care Assistant with SKN; and/or supervision; and or
  - Medical Day Care

- **Clients may also be eligible for:**
  - Professional Therapy (Occupational, Physical, Speech, Behavioral)
  - Nutritional Counseling/Supplements
  - Respiratory Therapy
  - Durable Medical Equipment
  - Escort Service
  - Diagnostic Testing
Accomplishments

- Re-establish health status after hospital discharge
- Gain functioning health level; perform ADLs and IADLs
- Care while awaiting approval of services by third party payers
- Prevent hospital/institutional care; maintain dignity at home
- Ensure linkage to care, laboratory testing, medication adherence
- Ensure Ryan White Funds are payer of last resort by linking to long term/third party sources when possible; coordinate services appropriately
- Quality care by the statewide network of HHCP Providers
Accomplishments

- Ensure appropriate & adequate services to eligible individuals
  - Physician certified home care services
  - Annual Quality Assurance Review
  - Biannual site visit/chart review
  - Ongoing communication with home care provider agencies

- What the HIV Home Care Program is not:
  - Source of lifetime services
  - Housekeeping service
  - Companion service
  - Source of DMEs
Challenges

- Securing home care agencies throughout the state
  - Sussex, Morris, Camden, Gloucester, Cape May, Cumberland, Salem, Warren
  - Must be private non-profit agency

- Predicting client numbers
  - Medicaid HMOs
  - Expansion of NJ Medicaid
  - Increases clients transitioned to Medicaid to ensure payer of last resort requirement

- Predicting an operating budget
  - No way to predict who will get sick and at what cost
2013 Income Guidelines

(Based on U.S. Department of Health and Human Services Poverty Guidelines)

- Household is a domestic establishment which includes members of a family and/or others living under the same roof.
- The number of persons in a household includes:
  - 1) those persons whose living situation is supported primarily by the individual making application to the program;
  - 2) the parent or guardian in the case of an adolescent; and
  - 3) other persons contributing to the primary support of the applicant.
- Provide proof of income and 2 proofs of residency in client record.
- If client filed Income Taxes, provide copies in client record.

<table>
<thead>
<tr>
<th># Persons in Household</th>
<th>Maximum Monthly Income Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$4,788</td>
</tr>
<tr>
<td>2</td>
<td>$6,463</td>
</tr>
<tr>
<td>3</td>
<td>$8,138</td>
</tr>
<tr>
<td>4</td>
<td>$9,813</td>
</tr>
<tr>
<td>5</td>
<td>$11,488</td>
</tr>
</tbody>
</table>

For households w/more than 5 persons, add $1675 for each additional person.
Statewide Provider Network

- Atlantic – AtlantiCare – Ellen Wolownik: 609-484-7300
- Bergen/Hudson – Visiting Homemaker Service of Hudson County – Darlene Smith: 201-656-6001
- Burlington – Virtua Home Care Community Nursing – Diane Veit: 856-581-7306
- Essex – VNA Health Group – Cindy Reich: 732-502-5122
- Hunterdon – Hunterdon Medical Center Home Health Service – Maria Bartholomew: 908-788-6138
- Mercer – VNA Home Care of Mercer County – Malvina Williams: 609-815-3762
- Middlesex/Somerset – VNA Health Group – Cindy Reich: 732-502-5122
- Monmouth – VNA Health Group – Cindy Reich: 732-502-5122
- Ocean – Ocean County Health Department – Anne McBride: 732-341-9700
- Passaic – St. Joseph’s Regional Medical Center Comprehensive Care Center – Linda Smith: 973-754-4233
- Union – Visiting Nurse and Health Services, Inc., Holy Redeemer Home Care – NJ – Ludovina Archeval: 908-659-4222
- Camden, Gloucester, Cape May, Cumberland, Morris, Sussex, Salem, Warren – Open
Contact

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Fax: 609-984-6495
Email: Sally.D’Errico@doh.state.nj.us
Thank You!