دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

DOH STANDARD FOR HOME HEALTHCARE SERVICES IN THE EMIRATE OF ABU DHABI

August 2021

PUBLIC عـــام

Contents

دائـــــرة الـــصـــحـــة
DEPARTMENT OF HEALTH

Document Title:	DOH Standard for Home Health Care Services in Emirate of Abu Dhabi		
Document Ref. Number:	DOH/AHHS/SD /1.6	Version:	1.6
Approval Date:	24/08/2021	Effective Date:	25/08/ 2021
Document Owner:	Healthcare Facilities Sector		
Applies to:	Healthcare Facilities seeking to Provide Health Care Services in The Home in the Emirate of Abu Dhabi		
Classification:	Public		

This Standard should be read in conjunction with related UAE laws, DOH Standards, Policies and Manuals, including but not limited to:

- Federal Law No. (5) Of 2019 on the Subject of Regulating the Practice of the Profession of Human Medicine,
- Federal Decree No. (4) Of 2016 on the Subject of Medical Liability,
- Ministerial Decree No. 14 for 2021 on Charter of Patient's Rights and Responsibilities,
- DOH Regulator Manual,
- DOH Policy on Emergency & Disaster Management,
- DOH Consent Guideline,
- DOH Standard for Adverse Events Management & Reporting,
- DOH Standard for Infection Control,
- Ministerial Resolution 1448 of 2017 concerning the Code of Ethics and Professional Conduct for Health Professionals.

For more information, kindly visit: http://www.mohap.gov.ae and www.doh.gov.ae

1. Purpose

This standard aims to:

1.1. Ensure the continuity of care for patients discharged from an in-patient setting to the home setting and for whom Home Health Care is deemed necessary by their health condition and supported by evidence;

1.2. Ensure high quality, safe and accessible Home Health Care services in the Emirate of Abu Dhabi through setting out the following:

1.2.1. The duties of Home Health Care Providers, Home Health Care Referring Facilities, Payers and Third-Party Administrators;

1.2.2. Service requirements for Home Health Care providers;

1.2.3. Licensing requirements for facilities and health professionals seeking to provide Home Health Care services in Emirate of Abu Dhabi;

1.2.4. Scope of healthcare services to be provided in the Home Health Care setting;

1.2.5. Patients' eligibility requirements.

2. Scope

This standard applies to:

2.1. Healthcare facilities licensed by DOH to provide Home Health Care Services in the in the Emirate of Abu Dhabi;

2.2. DOH licensed healthcare professionals employed by a DOH licensed Home Health Care Facility;

2.3. DOH licensed healthcare providers and professionals who refer patients to Home Health Care Services;

2.4. Eligible patients for Home Health Care services in the Emirate of Abu Dhabi, including adults and pediatrics.

3. Definitions and Abbreviations

The following definitions apply in the interpretation and enforcement of this Standard:

3.1. **Homebound:** A status where the patient is medically confined to his/her home and require skilled health care services as certified by the Referring Physician due to:

3.1.1. An illness or injury resulting in the patient's inability to leave the patient's place of residence without assistance of another individual or the aid of a supportive device; or

3.1.2. Having a condition such that leaving the place of residence requires a taxing effort or is medically contraindicated; and

3.1.3. May only leave his/her residence or for absences that relate to seeking medical care, and concern attending religious service, family event or memorial service infrequent and for short duration only.

3.2. **Home Health Care Physician:** A DOH licensed physician employed by a Home Health Care provider ensuring the delivery of Home Health Care services, as per duties in Section 4.

3.3. **Patient:** A person who is served by, or uses the services of a DOH licensed Home Health Care provider.

3.4. **Non-Health Services and Unskilled Services**: Services not covered under Home Health Care, including but not limited to Activities of Daily Living (ADL). (Appendix 2).

3.5. **Home Health Care Service Provider:** A healthcare facility or provider that is licensed by DOH to provide Home Health Care services.

3.6. **Home Health Care Services:** Healthcare services I service which by its nature requires a physician-supervised health plan and that are skilled healthcare services. Refer to Appendix 2 for further details on Home Health Care Services Scope.

3.7. **Supportive Services:** Skilled health services that are delivered by healthcare professionals other than the nurse that includes PT, OT, ST, RT and dietician services to improve, maintain or prevent the further deterioration of the patient health status and functional performance, control, or relieve complications, provide necessary education and training.

3.8. **Specialized Services and Consultation Home Visits:** Skilled health services other than the skilled nursing services and the supportive services that are delivered by DOH licensed professionals in order to obtain a specified therapeutic outcome, and provided safely to the patient. Refer to Appendix 2 for further details on Home Health Care Services Scope.

3.9. **Patient Care Plan:** An individualized plan of care devised through an interdisciplinary team with supporting documentation for each patient as per Appendix 5. The Care Plan includes skilled nursing activities and therapy treatments determined by the Referring Physician following consultation with qualified registered nurses and therapists and specifies the duration and expected patient outcome.

3.10. **Referring Healthcare Provider:** A DOH licensed Healthcare Facility that refers patients for Home Health Care Services in the Emirate of Abu Dhabi according to this Standard.

3.11. **Treating Physician:** A DOH licensed Specialist or Consultant who has an established history of providing treatment to a patient for a specific condition within his/her area of expertise. He/ She furnishes a consultation and/or treats a patient for a specific medical problem, and uses the results of a diagnostic test in the management of the patient's specific medical problem. A treating physician, by definition, is not simply a doctor who has seen a patient once or twice. The treating physician will refer a patient to an additional source of medical expertise for assistance, examination, information, treatment or therapy and will generate the patient's medical report.

3.12. **Referring Physician:** Specialist / Consultant located at the Referring Healthcare Provider, that will review the follow-up healthcare plan initiated by the Treating Physician and that will fill the face-to-face form in line with the patient's medical condition and the nursing / supportive / specialized services needed for this patient, and specifying the type of service, the timeframe

and frequency of the service. The Referring Physician orders Home Health Care services and the Referring Healthcare Provider gives the patient / family the updated lists of Home Health Care providers. Note that the Treating Physician can be the Referring Physician.

3.13. **Other Specialized Services:** Any new services that can be delivered safely and effectively at the patient's home. These services will be subjected to DOH pre-approval to be added and billed under the (Specialized Therapy) domain.

3.14. **Interdisciplinary Team (IDT):** Consists of various licensed medical specialties. Members collaborate to ensure that the treatment plan is appropriately applied according to the recommendations of the Referring Physician

3.15. **Registered Nurse (RN):** Licensed healthcare professional as Registered Nurse.

3.16. **Assistant Nurse (AN):** Licensed healthcare professional by DOH as Assistant Nurse.

3.17. **Physiotherapist (PT):** Licensed healthcare professional by DOH as Physiotherapist.

3.18. **Respiratory Therapist (RT):** Licensed healthcare professional as by DOH Respiratory Therapist.

3.19. **Speech Therapy (ST):** Licensed healthcare professional by DOH as Speech Therapist.

3.20. **Occupational Therapy (OT):** Licensed Healthcare professional by DOH as Occupational Therapist.

4. Duties for Healthcare Facilities, Providers and Professionals

4.1. Duties for Referring Healthcare Providers:

All Healthcare Facilities and Professionals licensed by DOH and referring patients to Home Health Care services must:

4.1.1. Ensure that all appendices related to referral of this standard are utilized to achieve eligible referral;

4.1.2. Ensure that inter-disciplinary teams engage in the assessment and provision of Home Health Care services and comprise healthcare professionals with the necessary qualifications and skills mix to provide quality and safe healthcare to patients in home setting;

4.1.3. Coordinate the referral and follow up process with the Home Health Care providers by ensuring that:

4.1.3.1. Patient review and assessment at the end of the Patient Care Plan is undertaken by the Referring Physician through face-to-face (FTF) consultation to assess progress and the need for any ongoing Home Health Care service; and

4.1.3.2. Receiving services under a Care Plan for Home Health Care patients are periodically reviewed by the Referring Physician within a range from 30 to 90 days depending on patient needs. This could be done face-to-face or through a tele-consultation session with the Referring Physician, as per the DOH standard for Teleconsultation Services.

4.1.4. Ensure that Referring Physicians:

4.1.4.1. Are aware of the eligibility criteria of Home Health Care patients as per Article 7;

4.1.4.2. Develop a Patient's Care Plan that is devised by an interdisciplinary team to meet the patient's needs including equipment and requisite medical supplies/consumables; visit protocol, duration, treatments and safety and assessment timeframe;

4.1.4.3. Are responsible for the input from the IDT and that the Patient's Care Plan is delivered and appropriate to meet the patient's needs;

4.1.4.4. Are able to communicate the eligibility criteria to the patients/ patient's family;

4.1.4.5. Review documentation of services provided, one week prior to established discharge date from Home Health Care services;

4.1.4.6. Do not to have conflict of interests including but not limited to:

4.1.4.6.1. The Referring Physician must not be from a specific Home Health Care provider;

4.1.4.6.2. The provider in which the Referring Physician works should refer to DOH for the updated list of home healthcare providers; and

4.1.4.6.3. The Referring Physician may not generally refer to a Home Health Care provider with which they or an immediate family member have an ownership or compensation relationship.

4.1.4.7. Ensure that the length of time of Home Health Care services to be covered is generally determined by the patients' needs and should be documented by the IDT as an estimated length of stay at time of admission and shared with family and patient;

4.1.4.8. Ensure clear documentation of the medical necessity, this includes the progress in the medical condition and functional status.

4.2. Duties Home Health Care Providers:

All Healthcare Facilities and Professionals licensed by DOH to provide Home Health Care services must:

4.2.1. Ensure that all Appendices of this standard are utilized to document service activity;

4.2.2. Ensure risk assessments are undertaken in the home including staff security and safety; and the presence of documented plans to mitigate identified risks;

4.2.3. Comply with the healthcare service process for provision of healthcare services home as set out in this Standard and illustrated in Appendix 3.

4.3. Duties for Home Health Care Physicians:

4.3.1. Ensure the adequacy of the implementation of the Patients' Care Plans;

4.3.2. Provide education to the clinical staff of the Home Health Care provider;

4.3.3. Develop ongoing relationships with Referring Physicians and raise any observed concerns to the Referring Physician;

4.3.4. Engage in performance improvement activities as needed;

4.3.5. Participate in program development and modification in collaboration with the Referring Physician;

4.3.6. Respond to emergent medical issues and decide course of action needed. In an emergency situation, the Home Health Care physician would make the decision on whether he/ she would visit or notify a specialty physician or notify appropriate emergency personnel; and

4.3.7. Support preventive practices for general health and wellness through identification of any further needs for skilled nursing care, need of supportive care or specialized therapy at home, and notify the Referring Physician.

5. Home Health Care Service Specifications

DOH licensed Home Health Care Providers and Healthcare facilities must:

5.1. Ensure that all healthcare professionals employed by the facility are licensed by DOH to provide skilled health services at home;

5.2. Accept referrals from a DOH licensed Specialist / Consultant in the Emirate of Abu Dhabi and within the scope of his/her specialty;

5.3. Assess the referred patients within 3 days from receiving a referral;

5.4. Ensure that the assessment and evaluation:

5.4.1. Is done in accordance with the specifications of this Standard;

5.4.2. Takes into account the patient's condition, expected duration of healthcare services, the eligibility criteria for Home Health Care, the type of service to be provided and the range of clinical services to be provided;

5.4.3. Is relevant to the actual needs of the patient and addresses all their health-related issues.

5.5. Be able to demonstrate to DOH the adequate training of health staff to maintain identified competencies;

5.6. Healthcare professionals involved in the provision of Healthcare services in the patient's home must restrict their practice to what is permitted by their job description and privileges granted by the employing facility in accordance with the DOH Clinical Privileging Framework and healthcare professional scope of his/her practice, and allowed by their respective DOH license and scope of this standard as mentioned in appendix 2;

5.7. Designate healthcare staff duties to achieve the care plan objectives undertaken by the Home Health Care Physician;

5.8. Establish quality management and training systems for the facility(s) scope of practice and ensure that such systems are consistent with internationally recognized evidence-based practices and review, and document the quality and safety of patient care regularly, adjusting own procedures as necessary. Evidence must be documented and maintained

to demonstrate performance in patient safety and high-quality clinical outcomes as per DOH's JAWDA indicators;

5.9. Healthcare professionals involved in the provision of Home Health Care services must monitor and evaluate patient care plans as per patient's assessment outcomes and healthcare needs;

5.10. Ensure that Home Health Care services are offered in a manner that is clear and understandable to the patient as per the patient needs (e.g. practitioner and patient / the patient's family can communicate in the same language);

5.11. Healthcare professionals involved in the provision of Home Health Care services must record and maintain patient care plans in patient files and ensure that members of the treating team involved in the care for the patient are provided appropriate handover and access to patients' care plans and assessment outcomes;

5.12. Healthcare professionals involved in the provision of Home Health Care services providing peritoneal dialysis services or administering narcotics/controlled substances for pain management at the home must satisfy the requirements of certified training and special authorization;

5.13. If the Home Health Care provider is providing controlled medications the below procedures should be undertaken:

5.13.1. Provision of the controlled medications as per the healthcare plan initiated by the Treating physician;

5.13.2. Compliance with medication storage policies and procedures;

5.13.3. Ensure emergency preparedness requirements are met for as per DOH Standards.

5.14. No service provider is permitted to have the medical staff housed at the patient's place of residence unless the need for a 24 hours service has been identified by the Referring Physician.

6. Licensure and Authorization Rules

6.1. Healthcare facilities may seek to provide healthcare services in the home through one of the following:

6.1.1. A new facility under "New DOH license application"; or

6.1.2. An existing DOH licensed facility under "Add service".

6.2. Application for New License or Add service under existing license to provide healthcare services in the home is only available for the following healthcare facility license types:

6.2.1. Hospital (all subtypes);

6.2.2. Clinic (Medical / Dental);

6.2.3. Centre (Day Care Center / PHC / Medical / Dental / Dialysis Center / Rehabilitation);

6.2.4. Provision of Health (incl. Home Health Care Services).

6.3. All Home Health Care providers under the license category of provision of healthcare services must add the service under their facility trade license;

6.4. All Home Health Care providers must satisfy the following requirements for licensure:

6.4.1. Meet a minimum requirement of one (1) Physician and twenty-five (25) Registered Nurses and an appropriate skill mix of staff including physiotherapist, occupational therapist, speech therapist and respiratory therapist;

6.4.2. Assistant Nurses can be employed by the Home Health Care provider to provide services under DOH recommended scope of practice for Assistant Nurses and under the supervision of registered nurses;

6.4.3. Obtain and maintain an internationally recognized Home Health Care accreditation;

6.4.4. The provider must have a risk management plan that identifies potential financial loss exposures and potential ways to mitigate the risk for both business and clinical risks. Assessment and outcome tools should be appropriate to the populations served;

6.4.5. Submit quality and safety performance metrics as determined by DOH JAWDA Indicators for Home Health Care Providers (https://www.doh.gov.ae/resources/muashir/jawda-indicators-submission-guidelines);

6.4.6. Adhere to any other authorization requirements set out by DOH.

6.5. Home Health Care service authorization, referral and treatment process are set out at Appendix 3.

7. Home Health Care Admission/ Eligibility Criteria

To be eligible for the Home Health Care benefit, the patient should meet the following requirements:

7.1. Is diagnosed by the Referring Physician as Homebound patient as defined by this Standard;

7.2. The care needed is medically necessary and reasonable and in need of skilled nursing care and/ or therapy including PT, OT, ST, and/ or RT;

7.3. Is under the care of a Referring Physician whose specialty is related to patient's diagnosis;

7.4. Has a detailed report that:

7.4.1. Is signed by two specialists/consultants:

7.4.1.1. One of the specialists/consultants should be considered as Referring Physician as defined by this standard;

7.4.1.2. The second specialist/consultant could be a licensed specialist/consultant with expertise in the patient's condition by being either a Referring Physician of the patient from a different specialty than the first specialist/consultant or any licensed specialist/consultant with the same specialty as the first specialist/consultant.

7.4.2. Justifies eligibility for Home Health Care supported by evidence, clinical guidelines, or X-ray that is specific with treatment needed, frequency and intensity; and

7.4.3. Is filled and prepared based on a face-to-face (FTF) appointment with the Referring Physician. The FTF encounter must be related to the primary reason for the Home Health Care admission. The Referring Physician writes the Home Health Care orders using the DOH mandated referral form as per Appendix 4. In case of renewals, the Home Health Care physician must make a recommendation to the Referring Physician for a reassessment of the patient.

8. Home Health Care Discharge Criteria

Home Health Care Providers should ensure discharge of patients who meet the following:

8.1. Their established goals and objectives for care have been met;

8.2. The patient/patient's family refuses services or no longer desires services (patient self-determination);

8.3. The patient no longer meets admission criteria;

8.4. The patient's condition has changed and/or the provider's resources are such that the required care or services are beyond the scope, type, or quantity that can be provided by the provider;

8.5. The patient has left the provider's service area;

8.6. The patient/patient's family is no longer able or willing to cooperate with the established Care Plan;

8.7. The patient's Referring Physician will not initiate or renew orders authorizing Home Health Care services; and/or

8.8. The patient's home environment will not support the provision of services.

9. Duties for Payers and Third-Party Administrators (TPAs)

All Payers and TPAs must:

9.1. Comply with the provisions and specifications of this Standard in respect of healthcare services specified in this Standard as covered under the health insurance scheme;

9.2. Accept referrals from Specialists in remote areas, and in the absence of consultant may be accepted following submission of evidence of privileges being granted as per DOH Clinical Privileging Framework and in compliance with the requirements set out in this Standard;

9.3. Ensure that referrals for Home Health Care services have the appropriate documentation to evidence the need for Home Health Care services and authorization by the Referring Physicians as per Article 7;

9.4. Billing and reimbursement of the Home Health Care shall be in accordance with Standard Provider Contract, DOH Mandatory Tariff and associated Claims and Adjudication Rules, and the Claims and Adjudication Standard;

9.5. Authorization must be obtained following initial and subsequent face to face patient assessment by the Referring Physician (see Appendix 4);

9.6. Referrals for Home Health Care should fulfill the criteria outlined under Home Health Care Admission/ Eligibility Criteria;

9.7. Ensure that all received Home Health Care referral do not to have a conflict of interest including but not limited to:

9.7.1. The referral must not be to a specific Home Health Care provider, the Referring Physician should refer to DOH for an updated list of providers in the area of the patient's medical needs;

9.7.2. The Referring Physicians (or their immediate family members) should not own a Home Health Care provider, the Referring Physician may not generally refer to a Home Health Care provider with which they or an immediate family member have an ownership or compensation relationship.

10. Enforcement and Sanctions

10.1. Home Health Care service providers must comply with the terms and requirements of this Standard, the DOH Standard Provider Contract and the DOH Data Standards and Procedures.

10.2. DOH may impose sanctions in relation to any breach of requirements under this Standard in accordance with the Complaints, Investigations, Regulatory Action and Sanctions Chapter, Healthcare Regulator Manual Version;

10.3. Where a healthcare provider is in breach of a duty under this Standard, as indicated by DOH auditors, DOH may take the appropriate disciplinary action and/or financial penalties provided for under the applicable laws & regulations; and

10.4. Monitor and review the referral reports and physicians attempting to frequently circumvent eligibility standards should be reported to DoH.

11. Appendix 1. General Requirements

A. Dimension	B. Element	C. Requirement
General Considerations	1. Governance	i. <u>Governance and management</u> a. Governance and management protocols defining clinical/medical, quality/safety and clinical performance roles and responsibilities, including job descriptions for staff; development plan for competencies and performance evaluations; b. Quality and performance oversight, monitoring, documentation and management, identification of KPIs, measurement procedures, management of information and performance improvement plans developed and implemented.
	2. Facility Specific Policies and Standard Operating Procedures *All Such Policies and Procedures to Comply with UAE and Abu Dhabi Laws and DOH Policies and Standards*	i. <u>Patient Access</u> a. Provision of information to patients and their families on the healthcare services, the frequency and type of healthcare services to be provided to the patient, and the expected results of healthcare services provided; admission, transition and discharge criteria; b. Provision of healthcare services in a language and manner understandable by the patient and his/her family and that is culturally appropriate; c. Provision and management of patient referrals, and where required, transfers. ii. <u>Patient Assessment:</u> a. Have in place an assessment process to evaluate, monitor and document patient healthcare service needs, including, care planning, care outcomes and estimated length of stay. All assessments must be undertaken within 3 days of referral and reassessments by the Referring Physician must be undertaken in accordance to the patients care plan through face to face consultation; b. Have in place a process to re-assess patients at appropriate intervals to determine the patients' response to care and plan for any needs for continued/changed care requirements, and keep records of this on patient files. A facility policy will determine when the reassessment of patients will happen. This is based on need and could range from daily if there is an emergent change in status being dealt with to weekly, every other week, or once a month. A reassessment should automatically be triggered at 30 days if no previous re-assessment has been done;

		c. Have in place a process to refer patients for any additional assessment or treatment needs, when identified as necessary; d. Have in place policies, procedures and arrangements to provide clinical laboratory services and diagnostic imaging services and emergency management where required, and a process to facilitate patients' access to these services; e. Have policies, procedures and appropriate forms for patient informed consent or refusal or expression of choice; f. Have procedures to tailor patient care plans to the individual needs of patients, to monitor and review progress/changed care needs and to document these on patients' records; g. Have in place policies and procedures in support of patient medication management and education, including for the preparation, dispensing, actions to be taken in case of emergencies, identification of why each medication is prescribed, implications of management of multiple medications and implications of abrupt discontinuations; side effects storage administration and monitoring as well as reporting of adverse drugs reactions or medication errors.
	3. Policies and Standard Operating Procedures (SOPs) for Patient Identification and Data Management – *All Such Policies and Procedures to Comply with UAE and Abu Dhabi Laws and DOH Policies and Standards*	iii. <u>Standard Operation Procedures</u> a. Appropriate SOPs for patient identification and identity authentication in the home setting; b. Appropriate SOPs to secure and protect patient data and medical files when in the home setting; c. Risk management and data/file recovery protocols; d. Observations that highlight patient, family member, care giver or wider public risk shall be reported to the competent authority.
Service Operation Considerations	1. Infrastructure Equipment and support services	iv. <u>Equipment and Supplies</u> a. Have in place the requisite equipment and supplies in support of the range of clinical and healthcare services (refer to Section 6 of this Standard) to be provided to patients in the home setting; b. Environmental and occupational health and safety policies and procedures tailored to the provision of service in the home of the patient and compliant with DOH requirements (Healthcare Providers Manual, and the DOH Standards for Health Sector EHSMS Requirements); including for infection prevention and control, management and safety of the environment,

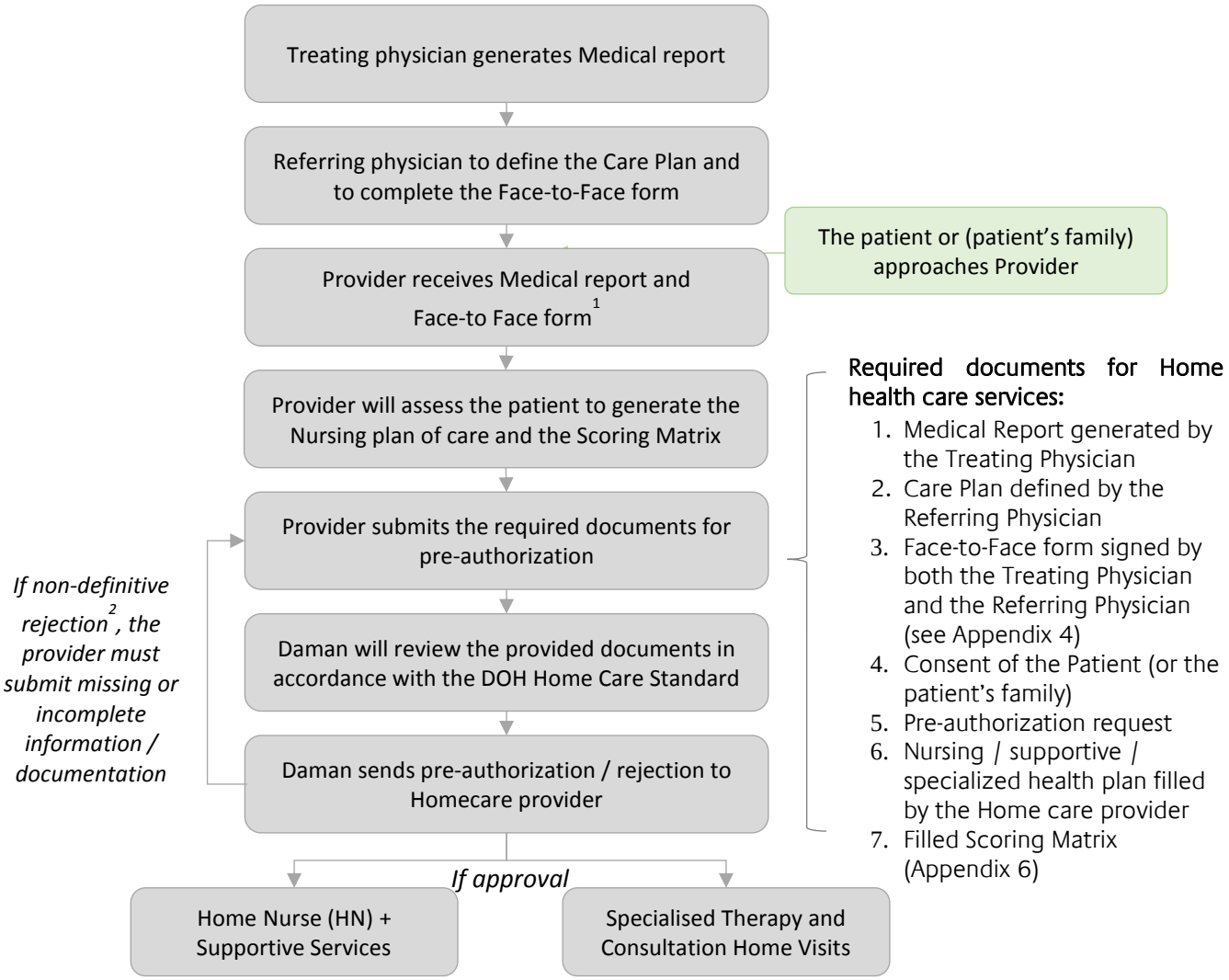
		and staff education with demonstration of safety competencies; c. Technologies to support case management, communication with the patient and referrals, where required including in cases of emergency.

	2. Quality assurance and measurement	v. Treatment Protocols and Training a. Standardized treatment protocols using evidence-based guidelines for each of the clinical services they intend to provide, and evidence that these are implemented and updated in accordance with evidence; b. Training and certification of professionals and staff, including special authorization for healthcare professionals engaged in providing peritoneal dialysis services and/or pain and symptom management using narcotics and controlled drugs. Facilities seeking to provide: vi. Peritoneal dialysis a. Peritoneal dialysis services at home, must satisfy the following requirements: • Submit special request seeking pre-authorization to provide peritoneal dialysis in the home; and • Provide evidence that the DOH licensed healthcare professionals providing this service have successfully completed certified training and received certification/accreditation and that they work within their scope of practice and the scope of service of the facility. vii. Pain management a. Provide pain management using narcotics and/or controlled drugs must satisfy the following requirements: • Submit special request seeking authorization to provide narcotics and/or controlled drugs in the home (DOH Narcotics and Psychotropic Drugs Standard); and • Provide evidence of a system in place for referral to 24-hour emergency provision in the event of need for advice, support and/or intervention for acute symptom management and/or admission to an appropriate inpatient setting. viii. Jawda reporting a. Establish metrics and indicators and measurement protocols to plan and measure quality improvement and patient safety, which must include indicators to assess clinical and service delivery aspects b. Comply with Jawda reporting and performance requirements https://www.doh.gov.ae/resources/muashir/jawda-indicators-submission-guidelines;

12. Appendix 2: Scope of Home Health Care Services

A. Home Health Care Services	B. Scope of Services
Skilled Nursing Services	1) Skilled nursing services that are necessary to maintain or improve the patients' current condition or prevent or reduce further deterioration; 2) Services can be provided by either Registered Nurses and/ or Assistant Nurses; 3) Services to be provided are as per DOH's Scope of Practice for Nurses and Midwives.
Supportive Therapy	1) Rehabilitation services that can delivered by Home DOH licensed health care professional at the patient home, and should be expected to result in a significant improvement or maintenance of the patient health condition and functional capabilities within a reasonable and defined period of time, or requires a skilled therapist to safely and effectively establish a maintenance therapy program. These services include ST, OT, PT, and RT 2) Supportive services also include Tele-monitoring Services (see DOH standard for Teleconsultation Services) if performed with a specific intent, and not just for observation, for example: (1) To monitor patient pulse, blood pressure, blood glucose levels daily through a wearable device; (2) To follow up on therapy/exercise program with the patient remotely.
Specialized Services and Consultation Home Visits	1) Are skilled Health Services delivered by DOH licensed professional or technical medical personnel in order to obtain the specified medical outcome, and provided safely to the patient. The conditions for this include: a) The patient is expected to improve at the end of their treatment plan or prevent or reduce further deterioration; b) Ordered and monitored by the Referring Physician; c) The service may include the following health services subject to DOH approval: i) Specialty Physician Home Consultation; ii) Emergency Home Visit by General Practitioner Physician (follow-up or routine physician visits are excluded and will be billed (bundled) within the Pattern of Care fees); iii) Home Psychotherapy; iv) Home Hemodialysis; v) Investigational and Screening Services (Including Point of Care Testing, Radiology exam); and vi) Provision of other services are subject to DOH approval. 2) Dependent upon the individual needs of the patient, specialized services that require specific equipment and supplies must be part of the Home Health Care provider inventory; and personnel who will be performing the specialized service must demonstrate competency and training to provide the specialized service and be pre-approved by DOH.

13. Appendix 3: The Process



1) FTF form should be no older than 72 hours.
2) Definitive rejections are when eligibility is not established for Home Health Care services, as per the DOH Home Health Care Standard.

14. Appendix 4: DOH Home Health Care Referral Form

Home Health Care Referral Form

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DEPARTMENT OF HEALTH

Date:

1	Referring Facility Details		
1.1	Facility Name:		
1.2	License No:		
2	Administrative Items	3	Pre-referral Status
2.1	**Personal Information**	**3.1**	**Patient is referred for Home Health Care from**
2.1.1	Patient Name:	3.1.1	Acute in-patient setting (hospital) (Please specify the diagnosis ———— ————)
2.1.2	Date of Birth	3.1.2	Outpatient setting
2.1.3	Emirates ID Number:	3.1.3	Long Term Facility
2.1.4	Patient Language/s:	3.1.4	Rehabilitation Hospital
2.1.5	Gender:	3.1.5	Other: Please Specify
2.2	**Insurance:**	**3.2**	**In the past two months, patient was admitted to which of the following setting other than the one mentioned in previous point**
2.2.1	Type:	3.2.1	Acute in-patient setting (hospital) (Please specify the diagnosis ———— ————)
2.2.2	Card Number:	3.2.2	Home Health Care Services
2.3	Residence:	3.2.3	Long Term Facility
2.3.1	Alone	3.2.4	Rehabilitation Hospital
2.3.2	With Family	3.2.5	Other: Please Specify

4	Face-to-face encounter confirmation
A physician must order Home Health Care services and must certify a patient's eligibility for the benefit. * The face-to-face requirement ensures that the orders and certification for Home Health Care services are based on a physician's current knowledge of the patient's clinical condition. * Prior to certifying a patient's eligibility for the Home Health Care benefit, the referring physician must document that he or she has had a face-to-face encounter with the patient. * Documentation regarding these face-to-face encounters must be presented on certifications for patients within 30 days prior to the start of Home Health Care, or within the 60 days after the start of care . * As part of the certification form itself, or as an addendum to it, the physician must document when the physician saw the patient, and document how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.	
Medical Information	
The clinical reason for the encounter was... *[brief statement on the main reason why patient was admitted]* The patient's clinical condition, as observed, during the encounter supports the patient's homebound status as follows... *[brief statement on the main reason why patient is referred for care through a Home Health Care facility]* Other Diagnosis, comorbidities and complications not covered in previous points:	
4.1	Reasons for Home Health Care Referral. Note: Patient can be referred to Home Health Care Services only if he/she is Homebound (status where patient is medically confined to his/her home and require skilled health care services)
4.1.1	Homebound: A status where patient is medically confined to his/her home and require skilled health care services as certified by the Referring Physician due to:
4.1.1.1	An illness or injury resulting in the patient's inability to leave the patient's place of residence without assistance by another individual or the aid of a supportive device; or
4.1.1.2	Having a condition such that leaving the place of residence requires a taxing effort or is medically contraindicated; and
4.1.1.3	May only leave his/her residence or for absences that relate to seeking medical care, and concern attending religious service, family event, or memorial service.
4.2	Medication

4.2.1	• Administration of, IM injections, IV infusions or enteral multiple medications;
4.2.2	• Infusion of IV medication for >1hour/day (Cumulative)
4.2.3	• Chemotherapy administration
4.3	**Functional Status**
4.3.1	• ADL assistance/passive exercises for immobile patient on invasive MV or with unstable fracture of spine, long bone(s)
4.3.2	• Special efforts in ADL for immobile patients at high risk of serious physical harm due to severe spasticity refractory to medication (MAS >3/4)
4.3.3	• Careful bed positioning & ADL assistance for completely immobile patient with intractable overwhelming pain
4.4	**Feeding**
4.4.1	• Continuous enteral feeding via mechanical pump
4.4.2	• Daily intravenous fluids management for patient 'at risk' nutritional status
4.4.3	• Ongoing intervention and monitoring of Total Parenteral Nutrition (TPN)
4.5	**Continence & Renal Care**
4.5.1	• Sterile Intermittent catheterization • Catheter care with daily Bladder irrigation/wash
4.5.2	• Close monitoring for high risk patient on Peritoneal dialysis.
4.6	**Breathing**
4.6.1	• Tracheostomy care includes frequent suctioning of copious secretions • Respiratory care for patient on continuous O2 therapy for patients with advanced RF
4.6.2	• Dual therapy of O2 at least 16 hrs/day with BiPAP. • Tracheostomy care for paediatric patient <6 years of age diagnosed with Tracheomalacia
4.6.3	• Observation and continuous monitoring for MV dependent patient (CPAP excluded)
4.7	**Skin Integrity**
4.7.1	Wound care for: • Stage 3-4/4 pressure sore • Multiple >2 wounds/pressure ulcers stage 2/4 in various areas of the trunk and pelvis
4.7.2	Wound car for: • Severe Epidermolysis Bullosa (Junctional or Dystrophic) • Stage 4/4 wound/pressure ulcer(s) that requires debridement, continuous monitoring and frequent daily dressing
4.7.3	• Care for patient with multiple >2 wounds/pressure ulcers at stages 3-4/4 in various body areas

4.8	**Communication**
4.8.1	• Patient unable to communicates, on speech therapy & regular assessment by speech language pathologist
4.9	**Palliative Care**
4.9.1	• Daily care for patient with advanced stage D Heart Failure
4.9.2	• Daily Assessment and symptoms relief for patient with terminal illness includes the use of Narcotics for pain management
4.10	**Devices and Aids Needed**
4.10.1	Patient needs devices and aids
4.10.2	Patient does not any devices and aids
4.10.3	Needs the following devices: - - - - - -

Required Home Health Care Services

The patient needs the following Home Health Care services *[selection required]*

	Required Services	Frequency	Duration
1	Skilled Nursing Services		
2	Physiotherapy		
3	Occupational Therapy		
4	Speech Therapy		
5	Respiratory Therapy		

Date of the next follow up:

I certify that a face-to-face encounter was performed on the above-named patient on [date] by [physician name].

Physician Details Treating physician	Referring Physician
Name Specialty License Number Signature	Name Specialty License Number Signature

15. Appendix 5: Patient Care Plan and Assessment

The Healthcare Plan is a coordinated plan between the Referring Physician and the Home Health Care provider, and should be aligned on the elements in the table below.

Details the minimum requirements to be completed for a patient-specific care plan for healthcare services in the patient's home. Providers must ensure that each patient provided with healthcare services in the home has a care plan completed as a part of the assessment of the need for healthcare services by a multi-disciplinary team in accordance with the fields detailed in Table 1.
The Care Plan is monitored on a regularly basis and is subject to evaluation and re-assessment based on the patient's health condition or outcomes. All fields must be completed and agreed with the Referring Physician following face-to-face assessment with the patient.

Table1.

1. Assessment (Subjective/ Objective)	2. Mental State	3. Related Diagnosis	4. Rehabilitation potential Functional limitation and activities permitted	5. Safety measures to protect against injury	6. Nutritional Requirements
7. All Medication and treatments	8. Inference	9. Planning (Goals, Objectives and outcomes)	10. Type of Intervention & Responsible Healthcare Professional	11. Rationale	12. Duration

Name of Referring Physician: Signature: Date:

16. Appendix 6: Scoring Matrix for the reimbursement of HHC services

The reimbursement is based on 4 levels of care LOC (Simple, Intermediate, Intensive, Complex) that determined by the following weighted evaluation matrix:

Table 1. Evaluation Matrix

SCORING METRICS					
Provided Services		Supportive Services		Comorbidities	
1	1	1	• PT, OT, RT & ST • RN & TM services	1	0 - 8
2	2	Specialized Services		2	9 - 12
3	3	3	• Psychotherapy • Consultation	3	13 - 15
4	≥4	4	MV care.	4	>15

LEVEL OF CARE	TOTAL SCORE
1	1-3
2	4-5
3	6-7
4	>7

Provided Service: Services that related to the medical professional scope of practice and provided as per the required time frame.

Supportive care: Physiotherapy, Occupational therapy, Respiratory therapy, speech therapy, OT, Registered Nurse services, Telemonitoring services which are billed bundled with the Perdiem payment.

Specialized Services:

- Psychotherapy: Therapy sessions that recommended by Psychiatrist and requires prior authorization to be billed separately by scoring the relevant domains.
- Consultation: Specialty Physician Visits, requires prior authorization to be billed separately by scoring the relevant domains.
- MV care: Can be scored when multidisciplinary team visit indicated and recommended by the treating physician for:
  1. Initiating/reinitiating, management of invasive MV related complications.
  2. Management of invasive MV for Pediatrics age ≤3 years.

Comorbidities: Coexistent illnesses/conditions that clearly reported by the treating physician and defined by Charlson comorbidity index score.

NB: The elements of service domain are used for billing purpose and do not necessarily reflect the eligibility criteria of Home Health Care. Any scored element in the service domains must be verified and supported by the treating physician report.

Table 2. Service Domain including both health and non-health services. To be used for billing purposes only

SERVICE DOMAIN	1	2	3
MEDICATION	Administration of, IM injections, IV infusions or enteral multiple medications.	Infusion of IV medication for >1hour/day (Cumulative).	Chemotherapy administration
FUNCTIONAL STATUS	ADL assistance/passive exercises for immobile patient on invasive MV or with unstable fracture of spine, long bone(s).	Special efforts in ADL for immobile patients at high risk of serious physical harm due to severe spasticity refractory to medication (MAS >3/4).	Careful bed positioning & ADL assistance for completely immobile patient with intractable overwhelming pain.
FEEDING	Continuous enteral feeding via mechanical pump.	Daily intravenous fluids management for patient 'at risk' nutritional status	Ongoing intervention and monitoring of Total Parenteral Nutrition (TPN)
CONTINENCE & RENAL CARE	• Sterile Intermittent catheterization. • Catheter care with daily Bladder irrigation/wash.	Close monitoring for high risk patient on Peritoneal dialysis.	N/A
BREATHING	• Tracheostomy care includes frequent suctioning of copious secretions. • Respiratory care for patient on continuous O2 therapy or patients with advanced RF.	• Dual therapy of O2 at least 16 hrs/day with BiPAP. • Tracheostomy care for paediatric patient <6 years of age diagnosed with Tracheomalacia.	Observation and continuous monitoring for MV dependent patient (CPAP excluded).
SKIN INTEGRITY	Wound care for: • Stage 3-4/4 pressure sore. • Multiple >2 wounds/pressure ulcers stage 2/4 in various areas of the trunk and pelvis.	Wound car for: • Severe Epidermolysis Bullosa (Junctional or Dystrophic). • Stage 4/4 wound/pressure ulcer(s) that requires debridement, continuous monitoring and frequent daily dressing.	Care for patient with multiple >2 wounds/pressure ulcers at stages 3-4/4 in various body areas.
COMMUNICATION	Patient unable to communicates, on speech therapy & regular assessment by speech language pathologist	N/A	N/A
PALLIATIVE CARE	Daily care for patient with advanced stage D Heart Failure.	Daily Assessment and symptoms relief for patient with terminal illness includes the use of Narcotics for pain management.	N/A