STATE OF NEW YORK

DEPARTMENT OF HEALTH MEMORANDUM

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PUBLIC HEALTH SERIES:

SUBJECT:

INTRODUCTION

Residential Health Care Facilities (RHCFs) that receive enhanced reimbursement to provide services for residents with HIV/AIDS must ensure that special services are provided including: medical services by a physician who has experience in the care and clinical management of persons with HIV/AIDS; sub-speciality physician services; nursing services supervised by a registered professional nurse with experience in the care and management of persons with HIV/AIDS; substance abuse services; mental health services; HIV/AIDS education and harm reduction; comprehensive case management and pastoral counseling.

Treatment advances have prolonged the survival of individuals with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS). The current guidelines are intended as an update to the Standards of Care that were issued in 1990.

While an individual does not require an AIDS diagnosis to be admitted to the facility, the person must be HIV symptomatic (NYSDOH/AI list), meet federal and state requirements for skilled nursing care and have an HIV related medical need.

These program guidelines are intended to provide guidance and assistance to RHCFs with residents with HIV/AIDS in the development of their programs and in the provision of services to registrants of their programs. These guidelines are based on:

- **HCFA- Part 483 Long Term Care Facility regulations (42CFR)**
- **Section 415.37 New York State regulations (10NYCRR)**
- **Protocols for Primary Care of HIV/AIDS in Adults: HIV/AIDS Institute/New York State Department of Health**
- **Standards for Clinical/Symptomatic Illness: New York State Department of Health HIV/AIDS Institute**

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GUIDELINES FOR RESIDENTIAL HEALTH CARE FACILITIES CARING FOR PATIENTS WITH HIV/AIDS

THE AIDS INSTITUTE OF

THE NEW YORK STATE DEPARTMENT OF HEALTH

1999

I. PREADMISSION AND ONGOING TB SCREENING/MONITORING

GUIDELINE:	**Prior to admission, the RHCF must ensure that each resident is free of infectious TB. Further, the RHCF must provide ongoing monitoring for active disease and infection. This includes those residents with a history of active TB, those who are known to be infected, as well as those at risk.**

DESCRIPTION OF SERVICES

Prevention of transmission of tuberculosis is of particular importance in congregate settings where immunocompromised people reside. Pre-admission screening must occur to ensure that new admissions do not have infectious TB. Admission screening may identify individuals who have latent TB infection. PPD+ residents should be evaluated for initiation of prophylaxis to prevent development of active tuberculosis disease. Ongoing monitoring of residents and staff should be performed to identify infection and/or symptoms to prevent further transmission. Facilities must have procedures in place for effective isolation of individuals suspected of having infectious TB prior to transfer to acute care facilities. Finally, while residents with non infectious pulmonary TB can properly receive care in RHCFs, they must be monitored closely to ensure that they remain non infectious.

A. PREADMISSION TB SCREENING

Individuals being considered for admission to an RHCF must have: 1) symptom review for cough, hemoptysis, laryngitis, fever or pleuritic chest pain; 2) chest x-ray; and 3) smear and culture as appropriate. The following categories are specific to residents who are being referred for admission to the RHCF for HIV/AIDS care. These categories should be used to identify the necessary screening data prior to admission to the RHCF:

Category 1- Patient has infectious pulmonary (PTB)/laryngeal TB during current hospitalization
Criteria for admission:
- Three consecutive negative AFB smears within one week prior to discharge.
- Chest x-ray (CXR) within one week prior to discharge.
- Free of TB symptoms as identified above.

Category 2- Patient has PTB, has not been infectious during this hospitalization, and is on TB medications
Criteria for admission:
- One negative AFB smear within one month prior to discharge.
- CXR within two weeks prior to hospital discharge.
- Free of TB symptoms as identified above.

Category 3- Patient has extra pulmonary TB
Criteria for admission:
- CXR within one month prior to admission with no evidence of active pulmonary disease.
- Free of TB symptoms as identified above.

Category 4- Patient has TB infection, and is on TB prophylaxis
Criteria for admission:
- CXR within one month prior to admission with no evidence of active PTB.
- Free of TB symptoms as identified above.

Category 5- Patient has TB infection/history of TB infection, not on TB prophylaxis
Criteria for admission:
- CXR with no evidence of active PTB within one month prior to admission.
- Free of TB symptoms as identified above.
- Patient should be evaluated for TB prophylaxis if previously untreated.

Category 6- Patient does not have TB infection or disease
Criteria for admission:

- CXR with no evidence of active PTB prior to admission.
- Results of PPD within the last year are recommended.
  If there is no PPD, then one must be done within three days of admission to the RHCF.
- Free of TB symptoms as identified above.

* **Note:**

- **Copies of all AFB and CXR reports are required as applicable.**
- **The RHCF's Universal Referral Form which is completed by the referring hospital or other provider includes a section which addresses the above TB categories.**
- **All residents being referred to the RHCF must have an attestation by a physician that the person is free of infectious TB.**

B. IDENTIFYING TB IN THE RHCF

1. TB SCREENING

All residents known to be infected with TB should be evaluated for TB prophylaxis and monitored closely for active TB.

PPD testing should be performed at least annually on all residents except for those with a history of positive PPD or TB.

Any recent skin test converter should be immediately evaluated for active disease. In the absence of active disease, the resident should be evaluated for TB prophylaxis.

All residents must be monitored through vigilant assessment of pulmonary and constitutional symptoms suggestive of TB and a CXR obtained as indicated.

2. MANAGEMENT OF PERSONS SUSPECTED OF HAVING ACTIVE TB

AFB smear/culture and CXR should be obtained on any resident exhibiting symptoms of PTB such as productive cough, hemoptysis, fever, laryngitis or pleuritic chest pain.

Immediately place any resident with signs and symptoms suggestive of active pulmonary tuberculosis on respiratory isolation. If the facility has an approved respiratory isolation room, the diagnostic work-up can be conducted on-site. The facility must also have the ability to obtain a 24 hour turnaround on AFB smears.

If the environmental or patient management conditions cannot be met, anyone who is diagnosed with or suspected of active infectious tuberculosis must be transferred from the facility despite any DNR orders or advance directives. Health care proxy or next-of-kin should be notified that the transfer is to occur. Infectious TB supersedes any reason to keep the resident in the facility because of the risk to the other immunocompromised residents.

Arrangements for acute care transfer should be made in advance to avoid any unnecessary stays in the ER. The acute care facility and any transport personnel should be notified of the patient's condition.

Report all confirmed and suspect cases to NYCDOH (212-788-4162) and the NYSDOH (518 473-4439). For facilities outside the NYC area, the local health department should be contacted (see attached listing).

3. MANAGEMENT OF INFECTIOUS TB IN THE RHCF

There may be rare instances where the facility has the capability to completely manage the TB from diagnosis to treatment.

I. PREADMISSION AND ONGOING TB SCREENING/MONITORING ..... Continued

If the facility has respiratory isolation capability approved by the Department of Health, and the resident does not require acute care for the management of their tuberculosis, the resident must be isolated until the resident's symptoms resolve and sputum smears become negative. The RHCF must have policies and procedures specific to the care of infectious TB in the facility.

Residents must remain in respiratory isolation until they have had three consecutive negative smears

Respiratory isolation is defined as a private room with negative airflow relative to corridor, six or more air exchanges per hour, and at least two fresh air exchanges directly exhausted to the outside.

If the above conditions for air exchange and airflow cannot be met, supplemental air disinfection with HEPA filtration and adjunctive use of UV irradiation should be utilized.

* **Note:**

The doors to AFB isolation rooms should remain closed at all times except when staff are entering and leaving the room.

Residents should not be cohorted.

Monitoring of environmental conditions should be performed on each respiratory isolation room at least monthly, and prior to any new admission for the purpose of respiratory isolation. Every facility should consult with an engineer to ensure that isolation rooms comply with current guidelines. In addition, smoke tube testing should be performed daily while the room is in use.

C. MONITORING THE RESIDENT WITH ACTIVE PTB DISEASE

- Obtain sputum for AFB smear and culture at least monthly, until there are two consecutive negative cultures that are at least one month apart. The final culture should be obtained at the completion of TB therapy. For MDR TB, cultures must be obtained on a monthly basis until therapy is completed.

- Sputum induction should be performed when residents are unable to produce a sputum specimen on their own. This should only be performed by RHCF personnel in a controlled environment using strict measures to control the potential spread of AFB. The most current NYSDOH guidelines should be followed.

- There must be ongoing assessment for pulmonary and constitutional symptoms such as night sweats, fever, unexplained weight loss.

- TB medications should be administered via Directly Observed Therapy.

- When a resident refuses to continue taking their TB medication regimen, the RHCF needs to consult with their local DOH.

- Identify all staff or residents who have had close contact with the resident with active TB. Screen all exposed staff and residents with PPD, who do not have a documented past positive PPD. Notify the NYSDOH Infection Control Reporting Program in the event of suspected nosocomial or active disease transmission in a resident or employee

- Perform a baseline skin test for screening of all staff and residents who have been exposed and do not have a documented past positive PPD if they have not been tested within the last three months. Staff should be retested 12 weeks after initial exposure.

- Following exposure, closely monitor all residents and staff, especially those who are determined to be anergic or have a prior positive PPD, for any clinical signs and symptoms of pulmonary TB and evaluate for prophylaxis.

- Upon the identification of individuals who have become infected as a direct result of exposure to

the resident or staff with TB, the investigation must be expanded to include additional staff and residents who had contact with the resident with TB. Any clusters of TB skin test conversions should be reported to the NYSDOH Infection Control Reporting Program (518-473-4439).

D. SCREENING OF HEALTH CARE WORKERS

- Health care workers must be screened for TB prior to employment and on an annual basis thereafter (Title 10 NYCRR 415.26 (c) (1) (v) (a) (1))

- Two-step testing should be performed on all newly employed health care workers who have an initial negative test at the time of employment and have not had a documented negative test during the 12 months preceding the initial test.

- The second test should be performed within one to three weeks after the first test.

- Health care workers who have a history of a positive test and can substantiate the results by written documentation are exempt from Tuberculin skin testing. Further testing is required in evidence of symptoms.

- Routine chest x-rays are not required for asymptomatic PPD negative health care workers. Health care workers with a positive PPD should have a chest x-ray as part of the initial evaluation. If negative, repeat chest x-rays are not needed unless symptoms develop that could be attributed to active disease.

- Any health care worker who has a persistent cough, especially in the presence of other signs and symptoms compatible with active TB should be evaluated promptly for active TB.

II. COMPREHENSIVE CARE PLANNING

GUIDELINE:	**Interdisciplinary team assessment and comprehensive care planning must be performed for each RHCF resident. Assessments must be completed no later than 14 days after admission and comprehensive care plans within 7 days after the assessments. Reassessments must be performed as the registrant's needs change, but no less frequently than every month.**

DESCRIPTION OF SERVICES:

The interdisciplinary team process focuses on the development and implementation of a comprehensive, individualized plan of care that is based on the assessment of the resident; and periodic reevaluation of each resident's plan of care to determine whether established goals are being addressed and whether change in the resident's condition requires modification of the plan. The comprehensive care plan (CCP) is based on quantifiable objectives, interventions listing the responsible team member or discipline, and time frames for addressing resident's needs. The interdisciplinary team consists of qualified professionals representing medical, nursing, psychosocial, case management, nutrition, activities, and other disciplines or services as appropriate, such as a substance abuse counselor (SAB) or rehabilitation therapist, to develop the CCP. The CCP must delineate which services will be provided on-site and which services will be arranged off-site. If off-site services are required, the plan must detail how and where those services will be obtained.

The interdisciplinary system of care delivery for RHCFs with residents with HIV/AIDS, in addition to state and federal regulations, includes:

- primary care which includes HIV/AIDS general medical services and routine GYN care;
- sub-specialty care;
- case management services (family support, permanency planning, discharge planning, etc.);
- pastoral counseling for any resident requesting such services;
- counseling for HIV/AIDS risk reduction;
- alcoholism/chemical dependency services;
- mental health services; and
- discharge planning.

* **Note:**

- **RHCFs with approved HIV/AIDS scatter beds must provide or arrange for all services identified above based on the resident's needs**.

III. CASE MANAGEMENT/DISCHARGE PLANNING

GUIDELINE: **Case management services must ensure that all needed services are accessed or delivered as identified in the CCP. Services to be available to the resident must include mental health, substance abuse, HIV/AIDS risk reduction and crisis intervention services. In addition, case management must also address discharge planning which includes obtaining entitlements and other services necessary for a safe discharge.**

DESCRIPTION OF SERVICES

Case management is a multi-step process focusing on establishing and maintaining continuity of care. Based on the resident's needs the RHCF will provide information to the resident regarding the availability of on-site and off-site services. Each resident must be assigned a case manager who will have responsibility for obtaining needed services based on the interdisciplinary team assessments and CCP. The case manager's name should be documented in the resident's record. In addition the case manager is responsible for monitoring the resident's need for:

- crisis intervention;
- discharge planning;
- case closure.

A. CRISIS INTERVENTION

The case manager initiates crisis intervention when the resident has an episode of acute medical, social, physical or emotional distress. Crisis services may be needed for a variety of reasons such as an emergency medical condition, drug use, or unsafe behavior to self or others.

B. DISCHARGE PLANNING

Discharge planning is the responsibility of the case manager with assistance from members of the interdisciplinary team. During the initial assessment, the RHCF must determine the resident's potential to be discharged from the facility within the next three months.

Residents with HIV/AIDS have a right to live in the least restrictive environment that meets their needs. Discharge planning must be addressed in the CCP every three months and whenever the resident's health has improved sufficiently so that the resident no longer needs the services provided by the RHCF.

Prior to discharging the resident, the case manager must ensure that all necessary services are in place. This includes working either with the NYC Division of HIV/AIDS Services and Income Support (DASIS)or other local social service agencies to:

- Obtain entitlements and appropriate housing placement in a timely manner;
- Ensure linkages for health care services including HIV primary care, dental care and GYN care as appropriate;
- Ensure linkages as necessary to mental health and chemical dependency programs.

C. CASE CLOSURE

Case closure occurs when the resident will no longer be receiving RHCF services. Cases may be closed under the following circumstances when the resident:

- expires;
- is hospitalized for greater than 21 days;
- leaves AWOL and cannot be located.

D. DISCHARGE SUMMARY

In all cases, except where the resident expires, the RHCF must complete a referral process designed to link the resident with appropriate ongoing case management and other vital services necessary to meet the resident's care needs.

The discharge summary/case closure must include:

- A recapitulation of the resident’s stay;
- A final summary of the residents medical, physical and mental health status and need for special treatments or procedures;
- A post-discharge plan of care that is developed with the participation of the resident and/or significant other, which will assist resident in adjusting to new living arrangements.

IV. CLINICAL SERVICES

GUIDELINE: **The RHCF must provide appropriate medical services for residents with HIV/AIDS. Specialty oversight of the HIV/AIDS program is to be provided by a physician with experience in the care and management of persons with HIV/AIDS. Nursing services are to be supervised by a registered nurse with significant experience in the care of persons with HIV/AIDS.**

DESCRIPTION OF SERVICES

There have been critical shifts in the profile of the epidemic and consequently the care and management of persons with HIV/AIDS. RHCF residents with HIV/AIDS must receive the following as appropriate:

- Ongoing education about, and access to, highly active antiretroviral therapy (HAART);
- Regular ongoing assessments and education regarding medication adherence;
- Laboratory testing at regular intervals, consistent with AIDS Institute "Criteria for the Medical Care of Adults with HIV Infection" to measure immune system response to HAART;
- Prophylaxis against opportunistic infections;
- Vaccines which prevent pneumonia, influenza, hepatitis A & B;
- Subspecialty care, including but not limited to:*
    - dermatology,
    - ophthalmology,
    - neurology,
    - gastroenterologyl
    - urology,
    - nephrology;

    * **These services may be provided on-site or arranged off-site.**
- STD screening, and safer sex education;
- Regular dental care;
- Psychiatric care;
- Access to clinical drug trials;
- Basic HIV/AIDS clinical services must be based on a primary care model, i.e. residents are to be seen consistently by the same provider whenever possible;
- All HIV/AIDS residents are to be seen by a physician on a monthly basis for a comprehensive review of the medical problems noted on the individual resident's problem list. Residents with more intensive needs should be seen by the physician as often as clinically necessary; and
- The facility must make provision for onsite physician coverage sufficient to meet the medical needs of residents seven days a week.

In the event that the chronic care needs of a resident intensify beyond the facility's capabilities, the resident should be transferred to a RHCF which provides the necessary intensity of care.

All RHCFs must have systems in place to provide prompt physical examination and laboratory work-up for residents with serious medical needs. For routine evaluations, samples for basic laboratory testing must be obtained on-site, though analysis may be performed off-site. Basic tests include routine complete blood counts (CBC) with differential, blood chemistry profiles, lymphocyte subsets, and HIV viral load. The RHCF must have

IV. CLINICAL SERVICES . . . . . **continued**

a system in place for prompt access to laboratory test results. Radiologic examinations and results must also be obtained promptly, as clinically indicated.

All RHCFs with HIV/AIDS beds must have a written transfer agreement with a designated AIDS center or other hospital with HIV expertise for the transfer of residents in need of emergency or acute inpatient services. The RHCF must have specific transfer procedures.

V. HIV PREVENTION/RISK REDUCTION SERVICES

GUIDELINE: HIV prevention/risk reduction services that promote behaviors which reduce the risk for HIV transmission or progression of HIV disease must be provided to residents of the RHCF.

DESCRIPTION OF SERVICES:

Risk reduction includes instructions in behaviors which decrease the likelihood of HIV transmission and decrease activities which would negatively impact upon the resident's health. Educational interventions should be grounded in the harm reduction model which recognizes gradations in behaviors which pose risks to the resident and others, and address desired behavior changes in a manner that is consistent with the abilities of the resident. Risk reduction services are particularly important for this population since residents frequently leave the facility on day passes during their stay at the RHCF.

- The RHCF must perform an initial needs assessment and CCP which includes:
  - review of medical charts and other pertinent resident-specific records, including information from referral source;
  - initial assessment addressing the resident's current behavioral practices, knowledge and attitudes relative to HIV transmission risk; and
  - development of an individualized risk reduction plan that is incorporated into the CCP.

The RHCF should provide or make available the following HIV risk reduction services:

- Appropriate prevention/risk reduction services which are based on the assessment and should address:
  - information about transmission of HIV and other pathogens;
  - instruction in safer behaviors using a harm reduction model;
  - information about needle exchange programs;
  - provision or referral for appropriate barrier methods that reduce the spread of sexually transmitted diseases;
  - identification of barriers to adopting behaviors which reduce the risk of HIV transmission;
  - risk reduction counseling which addresses sexual behavior and drug use behavior;
  - skills development activities relevant to initiating and maintaining risk reduction behaviors;
  - information about behavior which would increase the risk for contracting other infections/diseases;
  - information about the potential risks associated with reinfection with HIV;
  - engaging significant others in appropriate risk reduction activities; and
  - any sexual or needle sharing partners who need to be notified in accordance with the Partner Notification regulations.
- On-going monitoring/reinforcement which include:
  - periodic review (at least monthly) of the individual risk reduction program;
  - on-going supportive reinforcement of risk reduction strategies.

The above prevention/risk reduction services will be utilized in collaboration with the interdisciplinary team to develop and execute CCP's that address residents' needs.

VI. CHEMICAL DEPENDENCY SERVICES

GUIDELINE: **Chemical dependency services which include assessment, education pertaining to drug and alcohol use, low threshold interventions, and referrals, as necessary, to ensure access to the appropriate treatment modality must be provided in the RHCF.**

DESCRIPTION OF SERVICES:

Chemical dependency services should be based on a variety of perspectives including harm reduction and recovery. Chemical dependency services should be integrated within a health care context which addresses the physiological, psychological and social impact of addiction. Decisions on the appropriate treatment intervention should be based on a holistic conceptual framework which takes into account those environmental, behavioral, emotional, cultural, and experiential factors which influence a resident's life. Services must address the use of both illegal substances as well as alcohol and tobacco use. The impact that addiction and substance abuse have on the family/significant other should be considered, and when appropriate, involvement of the family/significant other should be encouraged.

The following chemical dependency services should be provided by the RHCF:

- Chemical dependency assessment addressing the following areas:
  - History of substance abuse treatment;
  - Past and current substance use history, type of substances used, method of administration and pattern of use;
  - Family history of drug dependence or alcoholism;
  - Employment history and educational background;
  - Psychiatric and medical history;
  - Leisure/recreational interests;
  - Interpersonal relations and social supports; and
  - Resident's perception of his/her drug dependence and readiness to participate in treatment.
- Individualized chemical dependency treatment planning which includes:
  - Presenting problem;
  - Treatment experiences - what has and has not worked for the resident in the past;
  - Short and long term treatment goals;
  - Specific activities, methods directed towards goal attainment;
  - Type and frequency of services to be provided; and
  - Identification of services to be provided off-site.
- On-site interventions:
  - Individual, group, and family counseling provided on-site as appropriate;
  - Education on substance abuse and addiction;
  - Crisis intervention;

- Relapse prevention (provided on-site to residents with a history of chemical dependency);
- Harm reduction strategies;
- Recovery readiness (i.e. individual/group interventions, education strategies, etc.);
- Support/self help groups provided on-site; and
- Coordination and monitoring of services not provided on-site.

In those instances when residents are in need of substance abuse treatment, the RHCF may make appropriate referrals to certified substance abuse treatment programs and routinely monitor residents' engagement in off-site services. To facilitate access to off-site services the RHCF should develop linkage agreements for substance abuse services (particularly detoxification and methadone maintenance).

Facilities which have on-site pharmacies can prescribe and dispense methadone at the facility in accordance with OASAS regulations.

The above assessments and interventions will be utilized in collaboration with the interdisciplinary team to develop and execute CCPs that address residents' chemical dependency needs.

VII. MENTAL HEALTH SERVICES

GUIDELINE: **Mental health services will be provided to residents in accordance with the interdisciplinary assessment of needs and the comprehensive care plan.**

DESCRIPTION OF SERVICES:

Upon admission to the RHCF, the facility will perform a mental health assessment which includes screening of the resident's cognitive functioning, emotional status and level of behavioral control. Psychiatric information will be obtained as well as current status of risk to self and others.

The information obtained during this assessment will be used in the development of the mental health component of the resident's comprehensive care plan. The comprehensive care plan will address the resident's current mental health status and the need for mental health services. The plan will also identify which of these services are to be provided on-site and which will require referrals to off-site providers.

All programs should make available on-site:

- Psychiatric evaluations;
- Supportive counseling;
- Peer support, both in individual and group settings;
- Therapeutic milieu;
- Family counseling;
- Medication monitoring; and
- Crisis intervention.

If the resident is assessed as needing ongoing psychiatric treatment and it is not available on-site, the RHCF must make referrals for the appropriate off-site services. In the case of an outside referral, it will be the responsibility of the RHCF to arrange for the referral, and maintain contact with the off-site psychiatric provider to ensure continuity of care.

The above assessments and interventions will be utilized in collaboration with an interdisciplinary team to develop and execute CCPs that address the resident’s mental health needs.

VIII. STAFF EDUCATION AND TRAINING

GUIDELINE: **The RHCF must provide an orientation specific to staff role responsibilities. In addition, the RHCF should provide staff with opportunities to attend educational programs relevant to the clinical and psychosocial aspects of HIV illness.**

DESCRIPTION OF SERVICES:

RHCF staff provide physical care and psychosocial support to residents with HIV illness. Education and training programs for new staff and employees should be specific to the discipline providing care and should at a minimum address the following components:

- The role of interdisciplinary team and comprehensive care planning;
- HIV/AIDS reporting and partner notification;
- HIV confidentiality;
- Clinical manifestations of HIV/AIDS;
- HIV medication;
- Infection control practices including occupational exposure which addresses decreasing the risk of exposure, and the provision of post exposure prophylaxis when indicated;
- HIV risk education and harm reduction
- Chemical dependency
- Tuberculosis screening and management
- Psychosocial issues including support for terminal residents and their families and significant others;
- Stress management and prevention of burnout for care providers
- Residents' rights.

In addition to the initial orientation program, ongoing staff educational programs must be provided by the RHCF specific to the most recent information about the clinical and psychosocial aspects of HIV illness as it pertains to the long term care setting.

Facilities are strongly encouraged to link with the Clinical Education Initiatives (CEI) program that is in closest proximity to the RHCF. Additionally, clinical staff should be participating in continuing education programs which focus on the latest antiretroviral therapy regimens.

IX. PATIENT RIGHTS

GUIDELINE:	**Residents in RHCFs have rights guaranteed to them under Federal and State law. In addition, residents have the right to be informed about the RHCF's substance abuse program before, or at the time of admission.**

DESCRIPTION OF SERVICES

When treating residents with co-morbidities of HIV and chemical dependency it is important to discuss the issue of chemical dependency before, or at the time of admission to the RHCF, the facility's substance abuse program. Conceptualizing and communicating with each resident about chemical dependency as a disease in a "HIV/AIDS medical model" will promote an environment for open dialogue.

Residents will be asked as part of their comprehensive care plan to participate in an individualized substance abuse treatment plan of care. The facility may seek to have the resident sign an agreement of participation in the substance abuse care plan. These contracts may be helpful in establishing behavioral expectations and reinforcing the RHCF substance abuse policies. If the resident is unable to understand what is expected of him/her, and is unable to follow through with the plan of care for their substance abuse, then the facility will review the care plan to determine their medical and psychosocial issues and the need for continued stay at the facility.

X. QUALITY ASSURANCE/CONTINUOUS QUALITY IMPROVEMENT

GUIDELINE:	**The RHCF administrator is accountable and responsible for implementing a quality assurance program that assesses and improves the quality of the governance, management, clinical, and support services.**

DESCRIPTION OF SERVICES:

The RHCF is required to develop systems for quality assessment and improvement that describe quality assurance objectives, organization, scope, and methods for determining the effectiveness of these systems with respect to monitoring, evaluation, and problem solving activities.

The scope of health care of the RHCF must be reflected in the monitoring and evaluation activities; that is, all services provided to residents in the RHCF are monitored and evaluated as an integral part of the quality assessment and improvement program. The quality assessment and improvement program should address the following components:

- Appropriateness of admission to program including pre-admission TB screening, medical eligibility and need for skilled nursing services.

- parameters to measure the efficacy and standards of medical care being given to residents with HIV/AIDS including, but not limited to:

  - HAART and treatment or prophylaxis of opportunistic infections;
  - Adherence assessments and education;
  - Gynecological care;
  - Subspeciality physician services;
  - TB screening,
  - Access to laboratory test results;
  - Nutritional services;
  - Complementary therapies;
  - Substance abuse services;
  - HIV/AIDS education and harm reduction services; and
  - Staff development.

The facility should also insure that there is close monitoring of antiretroviral utilization by a clinician with the appropriate expertise.