

GUIDELINES FOR AIDS ADULT DAY HEALTH CARE PROGRAMS
CARING FOR PERSONS LIVING WITH HIV/AIDS AND OTHER HIGH NEED
POPULATIONS

THE AIDS INSTITUTE OF
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I. INTRODUCTION

Treatment advances have prolonged survival and improved the quality of life for many individuals with HIV disease. As a result, the persons living with HIV/AIDS are living longer, and along with this trend there has been an increase in concomitant chronic medical conditions such as cardiovascular disease, hypertension, hepatitis and diabetes. Additionally, while medication management advances have the potential to extend life and assist in reaching clinical stability, it is critically important for individuals to be adherent to their medication regimes in order to achieve optimum results. Medication adherence can be a major challenge associated with any disease. For individuals infected with HIV, adherence is often further compromised by the commonly occurring co-morbidities of substance use and mental illness.

Since the inception of the AIDS epidemic, New York State (NYS) has demonstrated its commitment to combatting this disease and has successfully developed and implemented a comprehensive continuum of HIV prevention and treatment programs and services. As a result of the success of the efforts employed in NYS over many years, ending the AIDS epidemic in NYS is now within reach, and in June 2014, Governor Andrew M. Cuomo announced a three-point plan to end the epidemic. The plan strives to simultaneously reduce HIV transmissions, and improve the health of all New Yorkers living with HIV with an emphasis on access to HIV treatment to maximize viral suppression and to enhance access to HIV prevention services for those at risk for HIV transmission, with the goal of achieving or sustaining optimal health status and to prevent further transmission of HIV disease.

In June 2017, consistent with the Governor's plan to end the AIDS epidemic, the NYS Department of Health (NYSDOH) amended the regulations for AIDS Adult Day Health Care Programs (AIDS ADHCP). The amendments expand the population that may be served by AIDS ADHCP that are approved as providers of specialized services for registrants living with AIDS or HIV to include other high need, high risk populations. The amended regulations enable existing Article 28 licensed providers to expand the population served to include registrants who are not diagnosed as HIV-positive, but are at heightened risk for HIV transmission due to behavioral risks that are often associated with the common co-morbidities of active substance use and/or mental health conditions. In addition, it is anticipated that a significant portion of this expanded population will also have health care needs with respect to assistance with monitoring and developing self-management skills for other commonly reported chronic conditions such as hypertension, diabetes, asthma, and hepatitis C.

Given the risk behaviors associated with heightened risk for HIV transmission (e.g. unsafe sex practices, unsafe injection drug use) active mental health and substance use needs are not only a concern for persons living with HIV/AIDS, but also for the high need/high risk HIV-negative population that is a targeted sub-population of this program model. Service providers are expected to provide HIV prevention education, health education, harm reduction services, mental health and substance abuse supportive counseling, along with other services to address the individualized service needs of the population.

The AIDS ADHCP are a vital component of the continuum of HIV medical services in NYS and are designed to provide a comprehensive and integrated model of service delivery in a cost-effective manner by avoiding duplication of services and minimizing the need for registrants to attend additional off-site services. AIDS ADHCP provide a comprehensive range of services in a community-based, non-institutional setting. General medical care, including treatment adherence support, nursing care, nutritional services, case management, HIV risk reduction, substance abuse, mental health and rehabilitative services are among those provided.

Effective August 1, 2013, Medicaid managed care began covering AIDS ADHCP services. As registrants' enrollment in managed care has substantially increased, managed care organizations (MCOs) became responsible for authorizing program participation and for reimbursement for services rendered for the majority of clients enrolled in the service/program. Therefore, as applicable to those enrolled in managed care, all care and services should be delivered in accordance with the developed comprehensive care plan (CCP)/person-centered service plan (PCSP) as authorized by the MCO.

Regulations require that a referral for program services is obtained from the registrant's primary care provider (PCP) prior to admission to the program, and reauthorization for continued utilization of services is obtained from the PCP every six months thereafter. In addition, off-site service needs to be determined through the

interdisciplinary care plan process will now be coordinated with and approved by the registrant's MCO and/or the PCP as applicable.

Regulations require that a registrant's attendance at the AIDS ADHCP must be based on individualized need and the registrant's readiness and ability to address those particular needs as assessed by the program. The registrant's level of attendance in the program should be consistent with the documented interventions on the plan of care and the coordination with the MCO and/or the PCP as applicable. The registrant must participate in a planned intervention documented on the care plan on each day of attendance, except in instances in which the registrant is directly engaged in assessment/reassessment as required in regulations.

A program visit should minimally include the provision of at least one structured group activity (group counseling or educational session) or an individual counseling/assessment session, as specified on the care plan, along with a meal. The provision of services such as Directly Observed Therapy (DOT) to assist registrants with medication compliance or unstructured socialization activities should be provided in conjunction with other care planned activities on any given day in which the registrant attends the program.

In 2014, Centers for Medicare & Medicaid Services (CMS) published new requirements that settings where people receive Home & Community Based Services (HCBS) must meet to remain eligible for Medicaid payment. [HCBS](#) allow people with significant physical and cognitive limitations or needs to receive services and live in their home or the community rather than restrictive, isolated settings. These updated standards are designed to ensure these settings protect the rights and choices of registrants and promote integration in and full access to the community.

NYSDOH has been working with CMS to comply with the new HCBS requirements. Specifically, NYSDOH has developed a 5-year plan (Statewide Transition Plan) detailing how it will change its HCBS programs to meet these standards. By design, ADHCs provide services in home and community based settings. For this reason, they are required to demonstrate compliance with these standards.

The following program guidelines are intended to provide guidance and direction to AIDS ADHCP providers in the development of their programs, in the provision of services, and in documentation required to substantiate Medicaid reimbursement, as required by 10 NYCRR Parts 425 and 759.

II. INTERDISCIPLINARY COMPREHENSIVE CARE PLANNING/CASE MANAGEMENT SERVICES

GUIDELINE: Interdisciplinary team assessment and comprehensive care plan/person-centered service plan (PSCP) development must be completed through a person-centered planning process for each registrant no later than 30 days from the date of admission. Reassessments must be performed as the registrant's needs change, but no less frequently than every six (6) months. The AIDS ADHCP is responsible for ensuring that appropriate care and services are available and accessible for the registrant, and that such services are coordinated through regular case conferencing and follow-up with all providers involved in the registrant's care. (Parts 759.5, 425.7 and 42 CFR § 441.301 (c)(1)(i) through (ix))

DESCRIPTION OF SERVICES:

The interdisciplinary comprehensive care planning process focuses on assisting registrants to develop skills to improve or stabilize their medical and psychosocial health status; and maintaining and/or improving quality of life. The process involves all disciplines working together with the registrant to develop an individualized PCSP containing clear and individually identified measurable goals, objectives and interventions that registrants can choose from. Each member of the interdisciplinary team conducts an individual assessment of the registrant, to identify the health care and supportive service needs of the registrant, and develop a problem list. This information is then utilized to generate a PCSP that specifies health care and supportive services which will be delivered on-site. The completed PCSP should be reflective of documented coordination with the Managed Care Organization (MCO) and/or primary care provider (PCP).

The federal Home and Community Based Services (HCBS) regulations require that the process must meet the following requirements:

- Includes people chosen by the individual as needed.
- Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
- Is timely and occurs at times and locations of convenience to the individual.
- Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency.
- Includes strategies for resolving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
- At a minimum, individuals conducting the comprehensive assessment and developing the PCSP for an individual must not be any of the following:
 - a) Related by blood or marriage to the individual, or to any paid caregiver of the individual;
 - b) Financially responsible for the individual;
 - c) Empowered to make financial or health-related decisions on behalf of the individual;
 - d) Holding any financial interest, as defined in 42 CFR § 411.354, in any entity that is paid to provide care for the individual; and
 - e) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, except when the only willing and qualified entity to provide case management and/or develop PCSPs in a geographic area also provides HCBS.
- Offers informed choices to the individual regarding the services and supports they receive and from whom.
- Includes a method for the individual to request updates to the plan as needed.
- Records the alternative home and community-based settings that were considered by the individual.

The interdisciplinary system of care delivery for the AIDS ADHCP should include, but is not limited to:

- Nursing services (including triage and referral as appropriate for new symptoms);
- Case management services;
- Food and nutrition services;
- Social services (housing, legal, family support, etc.);
- Medication adherence;
- Counseling for HIV risk reduction;
- Chemical dependency/harm reduction services;

- Mental health and psychiatric services; and,
- Activities which promote involvement with community, interpersonal and self-care functions.

The PCSP must include all on-site interventions including 1:1 provider – registrant contact, specific structured group activities, and the frequency in which the registrant is to participate in these interventions. In addition, the PCSP must be accessible to individuals with disabilities and person who are limited English proficient. The PCSP is based on quantifiable goals and interventions and must be reviewed and updated by the interdisciplinary team as appropriate based on reassessment information at least semi-annually, or more frequently if the registrant's needs change.

A primary case manager must be assigned to each registrant within one week of admission to the program. Case management services, while frequently conducted and coordinated by an Licensed Master Social Worker, may be implemented by other members of the interdisciplinary team. These services are designed to assure coordinated participation of all health care professionals and other service providers engaged in the provision of care and services to the registrant. Additionally, the primary case manager is responsible for ensuring that all needed services are accessed or delivered as identified in the PCSP. The case manager must document a monthly summary progress report which includes the registrant's attendance at the program, number of groups attended and participation in the interventions specified on the PCSP regardless of the particular discipline designated to conduct the intervention.

Interdisciplinary team planning/case management is a multi-step process focusing on coordination and timely access to a range of appropriate medical, psychological and social services for the AIDS ADHCP registrant. The goal is to promote and support the independent functioning of the registrant to the highest degree possible. In the AIDS ADHCP, the multi-step process includes the following activities:

- Intake Assessment (includes an assessment instrument approved by the NYSDOH, such as the Registrant Assessment Instrument or the Uniform Assessment System – NY Community Mental Health Assessment when made available to providers should be completed upon admission, as well as discipline-specific assessments, which together provide the basis for registrant's continued engagement in the program);
- PCSP Development;
- Monitoring/Services Coordination;
- Reassessment/PCSP Update/Continued Stay Review;
- Crisis Intervention Services; and
- Exit Planning/Case Closure.

The recommended components for each of the above activities are described below:

Intake Assessment

The Intake Assessment should be completed prior to the development of the initial PCSP. This assessment includes the collection of data and information by various disciplines, as well as information from the MCO, the registrant's PCP, and, if appropriate, the client's health home or other service providers, which will assist the program in determining whether the registrant has service needs appropriate for the AIDS ADHCP setting, what services to make available, and the frequency of attendance. The DOH's AIDS Institute recommends that the following components be included (per Parts 759.4, 425.6, 425.18):

- Identification, referral and demographic information;
- Medical history and status;
- Medication management needs;
- Alcohol/substance/tobacco history and status;
- Nutritional status;
- Education/vocational history;
- Financial resources;
- Family composition;
- Social support system;
- Housing/living arrangements;
- Mental health history and status;
- History of involvement with the criminal justice system;

- Advanced directives, permanency planning, living will, health care proxy,
- Level of independent functioning and mobility; and,
- Level of HIV knowledge and risk reduction awareness.

If a referring agency has conducted the Uniform Assessment System's NY Community Mental Health Assessment (UAS – CMHA) and has provided the completed assessment to the AIDS ADHCP, AIDS ADHCP staff must review and update the information provided on the assessment instrument, which can then serve as the basis for identifying service needs to be addressed within the AIDS ADHCP setting.

PCSP Development

A PCSP, which is part of the AIDS ADHCP interdisciplinary care planning process, translates the discipline-specific intake assessments and resulting problem lists into specific goals, objectives and interventions; identifies appropriate services needed; and specifies activities and services to be provided and/or arranged for by the AIDS ADHCP. The care plan should be developed and documented in the registrant's record within 5 visits or 30 days from the date of registration, whichever comes first (per Parts 759.5 and 425.18), and should include:

- Problem statement;
- Individually identified, measurable goals and desired outcomes;
- Quantifiable interventions/activities to achieve goals, including anticipated frequency of the interventions, the type of encounter (group or registrant), and identification of person(s), including the registrant, responsible for activities;
- Signature of each team member participating in the PCSP meeting denoting review and approval of the plan; and
- Signature of the registrant, with informed consent, indicating participation in the development of the PCSP and agreement with the PCSP. The registrant's declination of any part of the plan must also be documented.

The PCSP should denote the frequency of participation in the program, and must be authorized/approved by the MCO.

In addition, the federal Home and Community Based Services (HCBS) regulations require the PCSP to:

- Reflect that the setting in which the individual resides is chosen by the individual.
 - The PCSP must ensure that the setting chosen by the individual is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community.
- Reflect the individual's strengths and preferences.
- Reflect services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports (unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports).
- Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, the plan must be written in plain language and in a manner that is accessible to individuals with disabilities and person who are limited English proficient.
- Identify the individual and/or entity responsible for monitoring the plan.
- Be distributed to the individual and other people involved in the plan.
- Include those services, the purpose or control of which the individual elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports.
- Document that any modification of the additional conditions, under 42 CFR 441.301(c)(4)(vi)(C) and (D), must be supported by a specific assessed need and justified in the PCSP. Any deviation from the standards at 42 CFR 441.301(c)(4)(vi)(C) and (D) will be justified and documented in the care plan and will be updated no less frequently than every 6 months.

Monitoring/Services Coordination

Monitoring and services coordination involves active and ongoing efforts by the AIDS ADHCP (including the assigned case manager and other members of the interdisciplinary team as appropriate) and the health home or other case management service providers to ensure that services are accessed in a timely manner. It is essential that programs have systems in place to provide on-going monitoring of registrants' utilization of services to ensure that services are provided in accordance with a plan of care.

In addition to the PCSP denoting specific on-site services provided, documentation of service coordination should also include:

- Discipline-specific progress notes which provides documentation of each face-to-face contact with the registrant and any contact with other providers;
- Documentation by the designated case manager, on a monthly case management form, which summarizes the registrant's participation in registrant and/or group interventions listed on the PCSP;
- Documentation of outreach efforts with registrants who are marginally engaged in the program or who have failed to attend scheduled appointments; and,
- Documentation of coordination with the MCO, Health Home care manager or other case management provider as applicable, and/or the primary care physician on a regular basis (as agreed upon by the MCO and/or the off-site case management service provider) or as the needs of the registrant change.

Reassessment/ PCSP Update

Reassessment is a scheduled or event-generated formal reexamination of the registrant's situation, functioning and clinical and psychosocial needs since the last assessment that addresses the appropriateness of the registrant's continued participation. Discipline-specific reassessments identify the changes or barriers encountered in attaining the goals identified in the previous PCSP, and are used to update, revise, modify or discontinue PCSP problems, goals and/or interventions. Each discipline's reassessment should be documented in the registrant's record prior to the date of the PCSP. Update of the PCSP includes all care coordination activities associated with care plan development. Reassessments and care plan updates should be performed as the registrant's needs change or at the request of the registrant, but no less frequently than every six (6) months. Any change in the registrant's PCSP should be coordinated with the registrant's MCO and health home care managers, and documented in the clinical record.

A component of the reassessment process must address the appropriateness of the registrant's continued stay in the program. The registrant's continued stay evaluation must include at a minimum:

- The appropriateness of the registrant's continued stay in the program;
- The necessity and suitability of services provided;
- The potential for transferring responsibility for the care of the registrant to other more appropriate agencies or service providers; and,
- The registrant's progress toward meeting stability goals.

Crisis Intervention Services

Crisis intervention services provide assessment and referral for acute medical, social, physical or emotional distress. Crisis intervention must be made available 24 hours a day and must be easily accessed by registrants. AIDS ADHCP must have a written plan describing the provision of crisis intervention and how such services can be accessed by registrants.

Crisis intervention activities should be incorporated into each registrant's PCSP, as appropriate. All incidents requiring crisis intervention shall be documented in the registrant's record and reported to the case manager.

Exit Planning/Case Closure

Exit planning is the responsibility of the case manager with assistance from members of the interdisciplinary team and coordination with the managed care organization and any off-site case management provider. Case closure occurs when the registrant will no longer be receiving program services. Cases may be closed under the following circumstances:

- The registrant improves and does not require further AIDS ADHCP services;
- The registrant cannot be located or contacted for a period not to exceed 60 days;
- The registrant will be institutionalized for greater than 30 days and discharge to community-based care is not anticipated;
- The death of a registrant;
- The registrant relocates out of the AIDS ADHCP service area;
- The registrant does not want continued service;
- The registrant's verbal or physical behavior towards staff or other registrants creates an unsafe environment; or,

- The registrant's medical condition or functional or cognitive abilities deteriorate to the point that participation in the day program is no longer feasible as determined by the PCSP.

In all instances in which the registrant may need other services upon discharge from the program, the AIDS ADHCP provider must refer the registrant back to the MCO/PCP and the health home or other case management provider, as applicable, for needed referrals. A closure summary noting case disposition and measures of progress toward identified goals must be documented in the case record within one month of discharge from the program.

III. MEDICAL SERVICES

GUIDELINE: AIDS ADHCP will ensure clients' access to medical services through coordination with a PCP, and, as applicable, the MCO the client is enrolled with or other care coordination programs such as a Health Home. Services shall include medical history review, health maintenance and wellness activities to promote health stabilization, and evaluation of new symptomatology (sick call).

DESCRIPTION OF SERVICES:

Medical services in AIDS ADHCP will be coordinated with the PCP and the MCO. Health maintenance/wellness needs will be assessed as a part of the routine comprehensive care planning process, and identified health maintenance/wellness activities will be delineated on the PCSP. Evaluation of new symptomatology (sick call/triage by an RN), and referral to the PCP as appropriate will be available to all clients each day of program operation. Changes in the client's health status, and all medical care coordination activities will be documented in the AIDS ADHCP medical record.

Regulations require that programs designate a licensed practitioner (M.D., N.P., or P.A.) to serve as the Medical Director of the program who has responsibilities for overseeing the development and amendment of clinical policies and procedures, providing general oversight and supervision of medical services within the program, establishing procedures for emergency practitioner consultation and coverage, and advising the operator of medical and medically related problems.

Intake:

All applicants must have a referral from their physician/MCO with relevant diagnostic and treatment information that documents the type of services the registrant would benefit from by engaging in program services. All applicants must have a medical examination within six weeks prior to or seven days after the date of admission by their primary care physician. (Parts 759.4(6) (i), 425.9(5) (d)).

All applicants to the program must have been screened for active TB. For HIV positive registrants, the screening should be based on the clinical guidelines for **Primary Care Approach to the HIV Infected Patient**, Section IV. Laboratory Assessment and Diagnostic Testing (<http://www.hivguidelines.org/clinical-guidelines/adults/primary-care-approach-to-the-hiv-infected-patient>).

Acceptance into the AIDS ADHCP must be based upon an intake assessment which documents that the potential registrant needs health care services as defined in the Introduction, does not have communicable TB, is interested in registering, and is able to function in a group setting. Prior to admission, the program must have obtained a referral from the PCP indicating the registrant has care needs that could be addressed through participation in the program. PCP reauthorization for continued stay in program must be obtained every six (6) months thereafter.

Assessment:

Within 30 days of admission, an RN from the AIDS ADHCP will review all medical information sent by the referring PCP/MCO/Health Home. The relevant medical information should minimally include current lab work results such as hematology and chemistry tests, as well as sexually transmitted diseases screening tests, hepatitis screening, and immunologic blood work (e.g. CD4, viral load), as well as the registrant's appropriateness for involvement in AIDS ADHCP.

The medical information initially received should form the basis of the physical health aspects of the interdisciplinary PCSP, as appropriate.

Medical Care Coordination

- The AIDS ADHCP, through formal communication/care coordination with the client's PCP, obtains and incorporates medical information including results of routine screening laboratory tests into the case record. As appropriate, relevant information obtained from the PCP/health home/MCO should be utilized to develop or modify the PCSP.
- The AIDS ADHCP is expected to review and document care coordination issues with the health home/MCO and/or the PCP on a routine basis (as agreed upon by the MCO and/or health home).

Care coordination with the MCO/health home and the PCP may be required more frequently as appropriate to changes in the registrant's condition.

Consultation/Triage/Sick Call:

- There must be an RN (or other qualified health care professional such as MD, NP or PA) available for consultation and triage during all hours of program operation. Sick call/triage may result in referral to the patient's PCP/MCO/health home, or to a hospital emergency department as necessary. In the event of a referral to a hospital emergency department, or other urgent/crisis care setting, the AIDS ADHCP must inform the PCP/MCO/health home of the urgent/crisis care referral immediately (as specified by MCO/Health Home policy) upon referral for such care.

IV. NURSING SERVICES/MEDICATION MANAGEMENT

GUIDELINE: Nursing services must provide for initial and ongoing assessments, appropriate nursing interventions and the evaluation of health care needs that enable registrants to improve their health status and maintain an optimal level of wellness. (Parts 425.10, 425.18, 759.8)
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DESCRIPTION OF SERVICES:

Nursing services promote systems for monitoring registrants' ongoing health care needs. These services must consist of an initial comprehensive assessment, reassessment conducted no less frequently than every six months, and ongoing monitoring of systems and appropriate interventions to meet registrant's health care needs.

The initial assessment includes information received from the MCO/PCP and a baseline history such as:

- History of opportunistic infections/neoplasms;
- Psychosocial status including psychiatric complications and behavioral deficits;
- Neurological status, both motor and cognitive;
- Pulmonary status;
- GI/GU status;
- Skin integrity;
- CD4 count;
- Viral load;
- Hepatitis A, B and C status;
- Complete medication history (including current HAART treatments, psychotropic medications) which is then updated quarterly, unless otherwise indicated
- Pain status;
- Level of ADL functioning;
- Chemical dependency status; and
- HIV education/risk reduction.

The initial assessment and reassessments should conclude with a list of problems identified during the assessment and a statement as to whether a Care Plan goal/intervention is indicated.

Appropriate nursing interventions are implemented in conjunction with monitoring of registrant's health status.

The interventions are based on physical, cognitive and psychosocial factors related to:

- Medication adherence;
- Signs and symptoms of opportunistic infections;
- Changes in neurological functioning;
- Changes in mental health status;
- Skin and wound care;
- Nutritional needs;
- ADL functioning;
- Primary health care (reinforcement of follow-up care);
- Coping and stress management;
- HIV prevention/risk reduction;
- Chemical dependency treatment; and
- Monitoring of chronic medical conditions (i.e., hypertension, diabetes, hepatitis).

GUIDELINE: The AIDS ADHCP will provide medication management services in accordance with accepted professional practices and applicable federal, state and local regulations.

DESCRIPTION OF SERVICES:

Medication management is a vital component of treatment for registrants prescribed medical and psychiatric medications. It is important that registrants understand the purpose of the medications, their side effects and toxicity, and potential interactions with other drugs and substances

For every registrant admitted to the AIDS ADHCP, information should be obtained which identifies the present medication regime including, but not limited to:

- A profile of all medical and psychiatric medications and treatments including over the counter drugs;
- Enrollment in clinical trials; and,
- History of allergies, adverse reactions, interactions and contraindications.

Ongoing assessment and monitoring of medication regimes should continue throughout registrants' enrollment as appropriate to assessed need and a plan of care. Such services may include, but are not limited to:

- Review of registrants' medications by an RN, which is conducted at least every six months;
- Vital sign monitoring;
- Quantifiable compliance with medication treatment and techniques to aid in adherence such as direct observation therapy, and pill boxing; and,
- Techniques for self-administration of medications.

In addition, the NYSDOH recommends that AIDS ADHCP should develop medication management systems which address:

- Dispensing, administering, controlling, storing, and disposing of medications in compliance with State and Federal regulations;
- Disposing of medical waste and sharps in compliance with State and Federal regulations; and,
- Documenting each medication administered, including the time it was administered and the initials of the registrant who administered it.

Coordination of medication services requires ongoing monitoring by the nurse to ensure registrants are responding to the medication regime, as well as communication with the PCP, as appropriate.

The above evaluation data is utilized in collaboration with the interdisciplinary team to develop or modify PCSPs that address registrants' nursing and medication needs.

V. NUTRITION SERVICES

GUIDELINE: Nutrition services must provide for initial and ongoing nutritional assessments, appropriate interventions and ongoing monitoring for the purpose of maintaining or improving registrants' nutritional status. (Parts 759.8, 425.11)

DESCRIPTION OF SERVICES:

Nutritional interventions are an integral component of AIDS ADHCP services focusing on diabetes, hypertension, obesity and heart disease. AIDS ADHCP will ensure that all registrants receive appropriate levels of nutritional services, under the supervision of a qualified nutritional professional (RD, CDN). A daily meal program will be available which ensures daily caloric and protein intake. The intended outcome of these services is to improve, maintain and/or delay decline in the nutritional status of registrants.

An initial evaluation of each registrant is required. The initial nutritional assessment should include the following recommended elements:

- Dietary history (food preferences, allergies and aversions, frequency of eating, past diets, physical or psychological factors affecting eating, etc.);
- Medications;
- Psychosocial and economic status (including access to cooking facilities);
- Height/weight, recent weight loss or gain, usual weight, percentage of IBW and body mass index (BMI);
- Level of activity/exercise;
- Medical history; and,
- Laboratory values, if available.

A nutritional reassessment is required every six months, consistent with the date of the PCSP. Ongoing monitoring of registrants' nutritional health status is based on the initial and continuous monitoring of nutritional factors including:

- Weight loss or gain;
- Anorexia;
- Dysphagia and odynophagia;
- Dysgeusia;
- Obesity;
- Nausea/vomiting;
- Diarrhea;
- Dementia;
- Depression or other psychological problems;
- Drug-nutrient interactions;
- Substance abuse;
- Fatigue and dyspnea;
- Social and economic factors such as living arrangements, cooking facilities and finances;
- Nutritional and dietary counseling;
- Referrals to emergency community-based food resources;
- Facilitating the acquisition of nutritional supplements; and,
- Monitoring and support for food intake.

Any assessment should conclude with a list of identified conditions and concerns. This information will be used in collaboration with the interdisciplinary team to develop PCSPs, as appropriate, that addresses registrants' nutritional needs and communicated to the MCO.

VI. 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 registrants of the AIDS ADHCP. (Parts 759.8, 425.18)

DESCRIPTION OF SERVICES:

Risk reduction includes education about behaviors which decrease the likelihood of HIV transmission and decrease activities/behaviors which negatively impact upon the registrant's health. Educational interventions should be grounded in the harm reduction model which recognizes gradations in behaviors which pose risks to the registrant and others, and address desired behavioral changes in a manner that is consistent with the abilities of the registrant.

The AIDS ADHCP should provide the following HIV risk reduction services:

- Initial needs assessment and service planning which includes:
 - Review of medical charts and other pertinent registrant-specific records, including information from referral source;
 - Initial assessment addressing the registrant's current behavioral practices, knowledge and attitudes relative to HIV transmission risk; and,
 - Development of an individualized risk reduction plan which is incorporated into the PCSP as indicated.

- Appropriate prevention/risk reduction services are based on the assessment of the registrant and should address the following:
 - Information about transmission of HIV and other pathogens;
 - Instruction in safer behaviors using a harm reduction model;
 - Information about needle exchange programs;
 - Provision of, 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 behaviors which would increase the risk for contracting other infections/diseases;
 - Information about the potential risks associated with re-infection with HIV; and,
 - Engagement of significant others in appropriate risk reduction activities.

- Ongoing monitoring/reinforcement which include:
 - Periodic review (every six months) of the registrant risk reduction program; and,
 - Ongoing 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 PCSPs that address registrants' needs.

VII. CHEMICAL DEPENDENCY SERVICES

GUIDELINE: Chemical dependency services which include assessments, education pertaining to drug and alcohol use, low threshold interventions, and coordination of referrals, as necessary, to ensure access to the appropriate treatment modality must be provided in the AIDS ADHCP. (Parts 759.8, 425.12, 425.18)

DESCRIPTION OF SERVICES:

Chemical dependency will 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 interventions should be based on a holistic conceptual framework which considers those environmental, behavioral, emotional, cultural, and experiential factors which influence a registrant'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 chemical dependency initial needs assessment and service planning should include the following:

- Past and current substance use history, type of substances used, method of administration and pattern of use;
- History of substance abuse treatment, including modality (e.g. inpatient, outpatient, residential, methadone maintenance, etc.);
- Family history of drug dependency or alcoholism;
- Employment history and educational background;
- Psychiatric and medical history;
- Interpersonal relations and social supports;
- Leisure/recreational interests; and,
- Registrant's perception of his/her drug dependence and readiness to participate in treatment (e.g. stages of change).

The initial and subsequent reassessments should conclude with a list of conditions and concerns identified during the assessment as well as a statement of the registrant's readiness to engage in modifying the behavior. This information will be used in collaboration with the interdisciplinary team to develop PCSPs that address registrants' chemical dependency needs.

A Care Plan should be developed based on registrant's readiness for engagement including:

- Presenting problem or conditions;
- Realistic short-term goals;
- Specific interventions directed towards goal attainment; and,
- Type and frequency of services, both registrant and/or groups, to be provided on site.

On-site interventions should include:

- Registrant, group and family counseling provided, as appropriate;
- Education on substance abuse and addiction;
- Crisis intervention;
- Relapse prevention;
- Harm reduction strategies, recovery readiness; stages of change; education strategies, etc.); and,
- Support/self-help groups.

In those instances when registrants require more intensive services than can be provided on-site, and are receptive to off-site substance abuse treatment, the AIDS ADHCP shall coordinate with the MCO/health home concerning the need for off-site referral.

Substance abuse reassessments are required to be conducted for all registrants every 6 months.

VIII. MENTAL HEALTH SERVICES

GUIDELINE: Mental health services will be provided to registrants in accordance with the referral from the MCO, Health Home, and/or multi-disciplinary assessment of needs and comprehensive care plan. (Parts 759.8, 425.12, 425.18)

DESCRIPTION OF SERVICES:

Upon admission to the AIDS ADHCP, the program will perform a mental health assessment which includes screening of the registrant'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. After the initial mental health assessment, reassessments must be conducted, by a qualified mental health professional, no less frequently than every six months thereafter.

The information obtained during the initial assessment and subsequent reassessments will be used in the development of the mental health component of the registrant's PCSP, as appropriate. The PCSP will address the registrant's current mental health status and the need and readiness for mental health services. The plan will also identify which of these services are to be provided within the AIDS ADHCP setting. The initial assessment and reassessments should conclude with a list of problems identified during the assessment.

All programs should make available on-site:

- Psychiatric evaluations;
- Supportive registrant and group counseling;
- Medication administration and monitoring;
- Crisis intervention; and,
- Peer support.

If the registrant is assessed as needing services that are not available by AIDS ADHCP provider staff, such as weekly psychotherapy, the program will coordinate with the MCO/health home for evaluation and treatment.

Licensed Creative Arts Therapists (LCATs) can provide services to any registrant, in which it is determined through the assessment process, that creative arts therapeutic interventions are appropriate to address identified mental health needs. The New York State Department of Education defines the practice of the profession of creative arts therapy as: "the assessment, evaluation, and the therapeutic intervention and treatment, which may be either primary, parallel or adjunctive, of mental, emotional, developmental and behavioral disorders through the use of arts as approved by the department; and the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate creative arts therapy services".

Creative arts group therapy can be considered a mental health service if it meets the following criteria:

- The group is facilitated by a LCAT;
- The goal/purpose must clearly delineate a mental health focus; i.e. a diagnosis, symptom or behavior; and,
- The specific group(s) and registrant's expected frequency of attendance must be on the PCSP.

The mental health reassessment should incorporate the client's level of engagement in LCAT services, the effectiveness of LCAT interventions, and the need for the client to continue with LCAT-specific interventions.

The LCAT may also provide low threshold engagement type group activities that do not meet the criteria of a closed creative arts therapy group. In such instances, the creative arts activities may be available for any registrant and do not have to be listed on the registrant's PCSP.

IX. STAFF EDUCATION AND TRAINING

GUIDELINE: The AIDS ADHCP must provide an orientation specific to the particular role responsibilities of the staff, as well as opportunities for staff to participate in ongoing job training and educational programs. (Parts 759.4, 425.4)

DESCRIPTION OF SERVICES:

The program model provides physical care and psychosocial support to registrants with HIV illnesses or at heightened risk for HIV. As direct care givers, they are best able to provide HIV prevention education, to reinforce sustained preventions, and to safeguard registrants' rights and promote registrants' choices. As care givers, they also must recognize that they may be at risk for acquiring HIV through occupational exposure.

Education and training programs for new employees should be specific to their role responsibilities, and must include the following components:

- Role of interdisciplinary team and PCSP;
- Appropriate clinical documentation of pertinent interventions (registrant and group) and interactions with registrant;
- Medications/side effects;
- HIV confidentiality;
- Clinical manifestations of HIV/AIDS;
- Infection control practices including occupational exposure which addresses decreasing the risk of exposure;
- Comprehensive information on HIV transmission;
- Prevention and control of tuberculosis;
- Psychosocial issues; and,
- Registrants' rights.

In addition to the initial orientation program, ongoing staff educational programs must be provided by the AIDS ADHCP specific to the most up to date information relevant to the clinical and psychosocial aspects of HIV illness, as well as chronic disease management.

X. REHABILITATION SERVICES

GUIDELINE: Rehabilitation services, approved by the MCO/PCP will be based on an assessment of the registrant's physical, cognitive, behavioral, communicative, emotional, pharmacological and social needs, and will be provided on-site, as appropriate. (Parts 759.8, 425.13)

DESCRIPTION OF SERVICES:

Rehabilitative interventions are directed toward restoring, improving, or maintaining the registrant's functioning, self-care, self-responsibility, independence and quality of life.

Central nervous system complications and reduced functional capacity associated with HIV illness and its treatment can seriously compromise the mobility of the registrant and cause significant pain syndromes. Central nervous system manifestations of HIV disease may include deficits in cognitive skills, neuropathy, loss of balance and coordination, hemiplegia and paraplegia. Basic therapy techniques may facilitate restoring the registrant's ability to perform activities of daily living to varying degrees.

Rehabilitative services can be provided on-site, as appropriate, for each registrant in accord with the approval of the MCO/PCP and the registrant's multidisciplinary assessment of needs, and will be included on the comprehensive care plan (Part 759.6 (g)). Prior to the initiation of rehabilitation services, the AIDS ADHCP will evaluate each registrant to determine their rehabilitation status and need for specific services. Rehabilitation therapy must be documented in the registrant's record.

The initial rehabilitation assessment process for each registrant should address:

- Functional status;
- Prior level of functioning;
- Rehabilitation potential; and,
- When appropriate, the type, frequency and duration of treatment, procedures, modalities and use of special equipment applicable to physical, speech and occupational therapy needs.

The initial assessment should conclude with a list of problems identified during the assessment.

The above evaluation data is utilized in collaboration with the interdisciplinary team to develop PCSPs that address rehabilitation needs including:

- Registrant's personal goals for rehabilitation;
- Living, learning and activity goals;
- Behavioral and functional goals; and,
- Implementation of the plan that includes:
 - Coordinated and collaborative rehabilitation interventions directed toward attainable outcomes;
 - Documentation of registrant's response to interventions, change in registrant's condition, choices for alternative therapies and progress toward meeting goals; and
 - Referral to a more intensive rehabilitation program, if clinically indicated.

Rehabilitative services are provided in accordance with accepted professional practice by a qualified physical therapist, speech-language pathologist, occupational therapist or qualified assistant:

- Physical Therapy: provide evaluation, treatment or prevention of disability, injury, disease, or other condition of health using physical, chemical, and mechanical means. Such treatment shall be rendered pursuant to a referral (which may be directive as to treatment) by the registrant's primary care physician or other specialists such as dentist, podiatrist, nurse practitioner or licensed midwife, each acting within his or her lawful scope of practice, and in accordance with their diagnosis.
- Occupational Therapy: provide the functional evaluation of the registrant and the planning and utilization of a program of purposeful activities to develop or maintain adaptive skills, designed to achieve maximal physical and mental functioning of the registrant in his or her daily life tasks. Such treatment shall be rendered on the prescription or referral of a physician or nurse practitioner.
- Speech Therapy: provide evaluation and treatment of disorders of speech, voice, swallowing, and/or language by designing an individualized program of activities to improve the targeted areas of speech, language, or voice disability or delay. Such treatment shall be rendered pursuant to a diagnosis and evaluation of the registrant by a speech-language pathologist.

The registrant's rehabilitation responses and progress towards meeting goals must be documented after each contact and reviewed semi-annually at minimum. If more intense rehabilitation services are required, the AIDS ADHCP program will collaborate with the PCP/MCO.

The registrant's rehabilitation responses and progress towards meeting goals must be documented after each contact and reviewed quarterly at minimum. A referral should be made to a more intense rehabilitation program, if clinically indicated, and in collaboration with the PCP.

Exercise groups may be offered, as appropriate to the registrant's capabilities and interests, for the purpose of promoting healthy physical activities. These general exercise sessions should be facilitated by appropriately credentialed staff. Exercise groups should be utilized as an adjunct service, and should not be the only care planned activity a client engages in on any given day of attendance in the program.

XI. ACTIVITIES SERVICES

GUIDELINE: The AIDS ADHCP can provide an on-site activities program. (Parts 759.8, 425.14)

DESCRIPTION OF SERVICES:

The goals of the activity program are:

- To support the concept of the therapeutic milieu;
- To help registrants structure leisure time when away from the program;
- To promote a greater level of independent living;
- To help introduce registrants into the program community;
- To enhance interpersonal and socialization skills; and
- To link registrants to community socialization/recreational resources.

Interventions related to these goals have the purpose of sustaining program registrants at the highest level of bio-psycho-social functioning.

A monthly and daily calendar should be produced informing both registrants and staff of the activity schedule.

The initial activities assessment, if conducted, will include:

- Recreational interests;
- Current use of leisure time;
- Affiliations with community recreational and socialization groups and/or organizations; and,
- Functional strengths and limits (such as chemical dependency, financial constraints, and altered physical status) as they relate to registrants' ability to participate in an activities program.

The initial assessment should conclude with a list of problems which will be utilized in collaboration with the interdisciplinary team to develop and execute PCSPs, where appropriate. Groups that have a recreational or socialization focus should be considered adjunct services, and should not be the only reason the client attends the program on any given day.

XII. PASTORAL CARE

GUIDELINE: Pastoral care may be available for all registrants. (Parts 759.8, 425.15)

DESCRIPTION OF SERVICES:

For many registrants, having a spiritual connection can be a source of strength, hope and a means of comfort for facing and dealing with their illness and mortality. Thus, the availability of pastoral care services, on site or by referral, can help registrants with a variety of needs:

- To gain a sense of purpose and wholeness; and
- To reconnect with life and spirituality.

On site services may include:

- Group pastoral counseling;
- Bereavement support for registrants and staff;
- Memorial services and arrangements;
- Family/crisis intervention; and,
- Registrant pastoral counseling.

XIII. QUALITY ASSURANCE/IMPROVEMENT

GUIDELINE: The AIDS ADHCP administrator is accountable and responsible for implementing a quality assurance/improvement program that assesses and improves the quality of the governance, management, clinical and support services. (Parts 759.8, 425.22)

DESCRIPTION OF SERVICES:

Three categories of health care characteristics can be used to monitor the quality of health care services provided within the AIDS ADHCP setting. These categories, structure, process and outcome, may be used respectively to address issues specific to resources, the AIDS ADHCP's ability to provide health care services, the manner in which care is delivered and the quality of care provided. Structural measurements address resource requirements, organizational management, operations, and policies and procedures directed toward the quality of care. Process measurements examine the characteristics of care delivered or not delivered. In addition, components of care can be evaluated using criterion that considers professional standards of quality care or measures of registrant satisfaction. Outcome measures should examine how effective the AIDS ADHCP is in maintaining and improving health care services for registrant registrants.

The AIDS ADHCP is required to develop systems for quality assessment and improvement that describe quality objectives, organization, scope, and methods for determining the effectiveness of their monitoring, evaluation, and problem-solving activities.

The scope of health care of the AIDS ADHCP must be reflected in the monitoring and evaluation activities; that is, all services provided to registrants in the AIDS ADHCP 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 and their timeliness:

- Appropriateness of admission to program;
- Interdisciplinary team planning/case management;
- Clinical services including medical, nursing, mental health and medication administration practices;
- Collaboration with primary care physician/MCO;
- Nutritional services;
- Social work/case management services;
- Substance abuse services;
- Rehabilitation services;
- Risk reduction services;
- Staff development;
- Appropriateness of continued stay in program;
- Exit planning and readmissions to the program; and,
- Special projects related to delivery of care.

XVI. HOME AND COMMUNITY BASED SERVICES

GUIDELINE: The AIDS ADHCP is required to meet federal standards for settings that provide Home and Community Based Services (HCBS). The AIDS ADHCP is responsible for ensuring that the choices and rights of registrants are protected, promoting community integration, and creating a PCSP through a person-centered planning process (refer to in Guideline II).
42 CFR § 441.301 (c)(4)(i) through (v) and 42 CFR § 441.301 (c)(4)(vi)(A) through (F)

DESCRIPTION OF STANDARDS:

[According to the requirements](#), any residential or non-residential setting where registrants live and/or receive HCBS must have the following 5 qualities:

- Integrated in and supports full access of individuals to the greater community;
- Selected by individual from setting options including non-disability specific settings;
- Ensures individual rights of privacy, dignity, and respect, and freedom from coercion and restraint;
- Optimizes individual initiative, autonomy, and independence in making life choices (including but not limited to daily activities, physical environment, and with whom to interact); and,
- Facilitates individual choice regarding services and supports, and who provides them.

In addition, because the AIDS ADHCP is considered a “provider-owned setting”, the following conditions must be met (42 CFR § 441.301 (c)(4)(vi)(A) through (F)):

- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Individuals are able to have visitors of their choosing at any time.
- The setting is physically accessible to the individual.
- Any modification of the additional conditions, under 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the PCSP.