

GUIDELINES FOR ADULT DAY HEALTH CARE PROGRAMS
CARING FOR PATIENTS WITH AIDS OR HIV DISEASE

THE AIDS INSTITUTE OF
THE NEW YORK STATE DEPARTMENT OF HEALTH

May, 2013

CONTENT

I.	INTRODUCTION	1
II.	INTERDISCIPLINARY PLANNING/CASE MANAGEMENT	2
III.	MEDICAL SERVICES	5
IV.	NURSING SERVICES/MEDICATION MANAGEMENT	6
V.	NUTRITION SERVICES	8
VI.	HIV PREVENTION/RISK REDUCTION SERVICES	9
VII.	CHEMICAL DEPENDENCY SERVICES	10
VIII.	MENTAL HEALTH SERVICES	11
IX.	STAFF EDUCATION AND TRAINING	12
X.	REHABILITATION SERVICES	12
XI.	ACTIVITIES SERVICES	14
XII.	PASTORAL COUNSELING	14
XIII.	QUALITY ASSURANCE	15

I. INTRODUCTION

Treatment advances have prolonged the survival of and improved the quality of life for many individuals with HIV disease. As a result, the HIV infected population is aging, 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 (HAART) 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. Clearly, 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.

While the original intent of the AIDS Adult Day Health Care Program (ADHCP) model, to assist individuals with AIDS and HIV disease live more independently in the community and prolong or eliminate the need for residential health care services, continues to be a major objective, ADHCPs have evolved over the past eight years to meet the emerging needs of the population. These programs now service an increasing number of registrants with medication adherence issues and those who are dually or triply diagnosed with HIV/AIDS, substance abuse and mental illness.

The ADHCPs are a vital component of the continuum of HIV medical services in New York State 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. ADHCPs 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.

In 2013 Medicaid Managed Care went into effect for the ADHCPs; fee for service payment was eliminated and the Managed Care Organization (MCO) became responsible for authorizing program participation and for reimbursement for services rendered. As a result, all care and services should be delivered in accordance with the developed comprehensive care plan (CCP) as authorized by the MCO. In addition, off site service needs determined through the interdisciplinary care plan process will now be coordinated with and approved by the MCO.

Regulations require that a registrant's attendance at the ADHCP must be based on individualized need and the registrant's readiness and ability to address that particular need, 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. The registrant must participate in a planned intervention documented on the care plan, or receive a required one-to-one assessment on each day of attendance.

The distinction between core and health related service is no longer necessary given that ADHC participation and reimbursement will be determined by the client's managed care organization, including the care planned issues/interventions.

The following program guidelines are intended to provide guidance and direction to AIDS Adult Day Health Care 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 development must be completed for each ADHCP 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 three (3) months. The 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)

DESCRIPTION OF SERVICES:

The interdisciplinary comprehensive care planning process focuses on minimizing disabilities resulting from HIV disease; assisting registrants to develop skills to 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 comprehensive plan of care containing clear and measurable goals, objectives and interventions. Each member of the interdisciplinary team conducts an individual assessment of the registrant, in order to identify the health care and supportive service needs of the registrant and develops a problem list. This information is then utilized to generate a comprehensive care plan that specifies health care and supportive services which will be delivered on-site. The completed comprehensive care plan should be reflective of documented coordination with the Managed Care Organization (MCO) and/or Primary Care Physician (PCP).

The interdisciplinary system of care delivery for the 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;
- Activities which promote involvement with community, interpersonal and self-care functions.

The CCP 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. The CCP is based on quantifiable goals and interventions and must be reviewed by the interdisciplinary team at least quarterly.

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 LMSW, 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 CCP. 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 comprehensive care plan 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 ADHCP registrant. The goal is to promote and support the independent functioning of the individual to the highest degree possible. In the ADHCP, the multi-step process includes the following activities:

- Intake Assessment (an assessment instrument approved by the Department of Health, such as the Registrant Assessment Instrument or the Uniform Assessment System – NY Community

Assessment should be completed prior to admission and provides the basis for whether it is appropriate to proceed with the intake assessment);

- Comprehensive Care Plan Development;
- Monitoring/Services Coordination;
- Reassessment/CCP Update;
- 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 CCP. This assessment includes the collection of data and information by various disciplines, as well as information from the MCO, and, if appropriate, the client's health home, which will assist the program in determining whether the individual has service needs appropriate for the ADHC 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

Comprehensive Care Plan Development

A CCP, which is part of the 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 ADHCP. The care plan should be developed and documented in the registrant's record within five visits or 30 days from the date of registration, whichever comes first (per Parts 759.5 and 425.18), and should include:

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

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

Monitoring/Services Coordination

Monitoring and services coordination involves active and ongoing efforts by the ADHC case manager and other members of the interdisciplinary team 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 CCP 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 individual and/or group interventions listed on the CCP; and
- Documentation of outreach efforts with registrants who are marginally engaged in the program or who have failed to attend scheduled appointments.
- Documentation of coordination with the MCO, Health Home care manager, and/or the primary care physician on a regular basis (as agreed upon by the MCO and/or health home) or as the needs of the individual change

Reassessment/CCP 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 CCP, and are used to update, revise, modify or discontinue CCP problems, goals and/or interventions. Each discipline's reassessment should be documented in the registrant's record prior to the date of the CCP. Update of the CCP includes all care coordination activities associated with care plan development. Reassessments and care plan updates should be performed as the registrant's needs change, but no less frequently than every 90 days. Any change in the registrant's plan of care should be coordinated with the registrant's MCO and health home care managers, and documented in the clinical record.

Note: Chemical Dependency and nutrition reassessments may be completed every 180 days; if specific criterion is met (Refer to Chemical Dependency Services and Nutrition Services sections of the guidelines for specific criteria).

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; and
- The potential for transferring responsibility for the care of the registrant to other more appropriate agencies or service providers.

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. 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 CCP, 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 health home care managers. Case closure occurs when the registrant will no longer be receiving program services. Cases may be closed under the following circumstances:

- The registrant cannot be located or contacted for a period not to exceed 60 days;
- The registrant improves and does not require further ADHCP services;
- 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 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 CCP.

In all instances in which the registrant may be in need of other services upon discharge from the program, the ADHCP provider must refer the registrant back to the MCO/PCP and the health home, 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: ADHCP will ensure clients' access to medical services through coordination with a Primary Care Physician (PCP). 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 Day Health Care Programs 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 comprehensive care plan. 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 ADHCP medical record.

Intake:

All applicants must have a referral from their physician/MCO with relevant diagnostic and treatment information that documents that they are HIV-positive, and 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 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 ADHCP must be based upon an intake assessment which documents that the potential registrant is in need of 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.

Assessment:

Within 30 days of admission, an RN from the ADHCP will review all medical information sent by the referring primary care physician/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 ADHC.

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

Medical Care Coordination

- The ADHCP, through formal communication/care coordination with the client's Primary Care Physician, 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 comprehensive care plan.
- The 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 or 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 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, the appropriate nursing interventions and the evaluation of health care needs that enable registrants to maintain an optimal level of wellness. (Parts 425.10, 425.18, 759.6 (i))

DESCRIPTION OF SERVICES:

The complexity of care for persons with AIDS and HIV-related illnesses may require medical/nursing intervention at any point along the continuum of the illness. Changes in the individual's health status can occur rapidly. Symptoms or infections may emerge requiring immediate medical attention and treatment. Nursing services promote systems for monitoring registrants' ongoing health care needs. These services must consist of an initial comprehensive assessment, 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 specific to HIV illnesses 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 should conclude with a list of problems identified during the assessment and a statement as to whether a Care Plan 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 ADHCP will provide medication management services in accordance with accepted professional practices and applicable federal, state and local regulations. (Parts 759.6, 425.17)

DESCRIPTION OF SERVICES:

Medication management is a vital component of treatment for registrants with HIV/AIDS. 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 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;
- 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 quarterly;
- Vital sign monitoring;
- Quantifiable compliance with HAART medication treatment and techniques to aid in adherence such as direct observation therapy, and pill boxing;
- Techniques for self-administration of medications

In addition, the Department recommends that ADHCPs 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 individual 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 CCPs 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 759.6 (d), 425.11)

DESCRIPTION OF SERVICES:

Nutritional interventions are an integral component of ADHCP services for registrants with HIV disease. Malnutrition may have an adverse impact on the function of the immune system. As registrants with HIV/AIDS are living longer on HAART, other chronic conditions are manifesting, including diabetes, hypertension, obesity and heart disease. Interventions that focus on improving nutritional status and alleviating symptoms will enhance the quality of life throughout the disease process.

ADHCPs 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 will be required only if the need for a nutritional assessment or a nutritional issue is indicated by the MCO or health home, or if a current nutritional issue is diagnosed by the ADHC MD or RN. The initial comprehensive assessment if conducted 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.

For registrants who are actively being followed by the nutritionist in the ADHCP, a reassessment is required at least quarterly, consistent with the date of the care plan. 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 CCPs, as appropriate, that addresses registrants' nutritional needs and communicated to the MCO.

Clients who do not have an acute nutritional issue can be reassessed every six months.

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 ADHCP. (Parts 759.6 (k), 425.18 (b) (4))

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 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 CCP 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 (at least quarterly) of the individual 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 CCPs 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 ADHCP. (Parts 759.6 (m), 425.12, 425.18 (b) (2))

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 takes into account 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 CCPs 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;
- Type and frequency of services, both individual and/or groups, to be provided on site.

On-site interventions should include:

- Individual, 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.);
- Support/self-help groups.

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

Periodic substance abuse reassessments are required to be conducted for all registrants who have been referred for substance use interventions or who relapse during their involvement with ADHC. In the presence of existing or newly identified substance abuse needs or problems as indicated on the care plan,

reassessments should occur no less frequently than quarterly. However registrants with no substance use history or who have been in full recovery for more than one year can be reassessed 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 759.6 (n), 425.12, 425.18 (b) (3))

DESCRIPTION OF SERVICES:

Upon admission to the 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. Subsequent to the initial mental health assessment, reassessments must be conducted, by a qualified mental health professional, no less frequently than every 90 days 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 comprehensive care plan, as appropriate. The comprehensive care plan 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 ADHC 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 individual 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 ADHC 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;
- The specific group(s) and registrant's expected frequency of attendance must be on the CCP; and

The mental health quarterly assessment 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 CCP.

IX. STAFF EDUCATION AND TRAINING

GUIDELINE: The 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 providing updates about the clinical and psychosocial aspects of HIV disease and treatment. (Parts 759.3 (d), 425.4 (2) (iv))

DESCRIPTION OF SERVICES:

Adult Day Health Care programs provide physical care and psychosocial support to registrants with HIV illnesses. 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 comprehensive care planning;
- Appropriate clinical documentation of pertinent interventions (individual 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 ADHCP specific to the most recent information relevant to day care about the clinical and psychosocial aspects of HIV illness.

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 759.4 (a) (2), 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 individual'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 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 addresses:

- 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 CCPs 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 quarterly at minimum. If more intense rehabilitation services are required, the ADHC program will collaborate with the PCP/MCO.

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.

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 ADHCP can provide an on-site activities program. (Parts 759.6(h), 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 CCPs, 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 759.6 (j), 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; and
- Family/crisis intervention
- Individual pastoral counseling.

XIII. QUALITY ASSURANCE/IMPROVEMENT

GUIDELINE: The 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 ADHCP setting. These categories, structure, process and outcome, may be used respectively to address issues specific to resources, the 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 ADHCP is in maintaining and improving health care services for individual registrants.

The 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 ADHCP must be reflected in the monitoring and evaluation activities; that is, all services provided to registrants in the 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.