Service Category Definition - Ryan White Part B Grant
April 1, 2016 - March 31, 2017

Local Service Category:	**Home and Community-Based Health Services (Facility-Based)**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Cost
DSHS Service Category Definition:	Home and Community-Based Health Care Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following: • **Para–professional care** is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help clients remain in their homes. • **Professional care** is the provision of services in the home by licensed health care workers such as nurses. • **Specialized care** is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high–tech therapies. physical therapy, social worker services. Home and Community-Based Health Care Providers work closely with the multidisciplinary care team that includes the client's case manager, primary care provider, and other appropriate health care professionals. Allowable services include: • Durable medical equipment • Home health aide and personal care services • Day treatment or other partial hospitalization services • Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy) • Routine diagnostic testing • Appropriate mental health, developmental, and rehabilitation services • Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities
Local Service Category Definition:	***Home and Community-based Health Services (facility-based)*** *is* defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. Inpatient hospitals services, nursing home and other long-term care facilities are **NOT** included.

Service Category Definition - Ryan White Part B Grant
April 1, 2016 - March 31, 2017

Target Population (age, gender, geographic, race, ethnicity, etc.):	Eligible recipients for home and community based health services are HIV/AIDS infected persons residing within the Houston HIV Service Delivery Area (HSDA) who are at least 18 years of age.
Services to be Provided:	Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of clients through the provision of treatment and activities of daily living. Services must include: • **Skilled Nursing:** Services to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient care techniques, ongoing monitoring of patients' physical condition and communication with attending physicians (s), personal care, and diagnostics testing. • **Other Therapeutic Services:** Services to include recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation. • **Nutrition:** Services to include evaluation and counseling, supplemental nutrition, and daily nutritious meals. • **Education:** Services to include instructional workshops of HIV related topics and life skills. Services will be provided at least Monday through Friday for a minimum of 10 hours/day.
Service Unit Definition(s):	A unit of service is defined as one (1) visit/day of care for one (1) client for a minimum of four hours. Services consist of medical health care and social services at a licensed adult day.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Client Eligibility:	HIV positive individuals at least 18 years of age residing within the Houston HSDA.
Agency Requirements:	Must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider.
Staff Requirements:	• **Skilled Nursing Services** must be provided by a Licensed Vocational or Registered Nurse. • **Other Therapeutic Services** are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, and LMFTA). • **Nutritional Services** are provided by a Registered Dietician and food managers. • **Education Services** are provided by a health educator.
Special Requirements:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Home and Community-Based Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

Service Category Definition - Ryan White Part B Grant
April 1, 2016 - March 31, 2017

FY 2017 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2016**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/02/2016**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/19/2016**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #2**	Date: **04/26/2016**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

HOME & COMMUNITY-BASED HEALTH SERVICES
2015 CHART REVIEW REPORT

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic, and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring each finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts with one Subgrantee to provide home and community-based health services in the Houston HSDA.

INTRODUCTION

Description of Service

Home and Community-based Health Services (facility-based) is defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. **Skilled Nursing:** Services to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient care techniques, ongoing monitoring of patients' physical condition and communication with attending physicians (s), personal care, and diagnostics testing. **Other Therapeutic Services:** Services to include recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation. **Nutrition:** Services to include evaluation and counseling, supplemental nutrition, and daily nutritious meals. **Education:** Services to include instructional workshops of HIV related topics and life skills. *Inpatient hospitals services, nursing home and other long-term care facilities are NOT included.*

Tool Development

The Home and Community-Based Health Services review tool is based upon the established local standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

Using the ARIES database a file sample was created from a provider population of 46 who accessed home and community-based Health Services in the measurement year. The records of 40 clients were reviewed (representing 87% of the unduplicated population). The demographic makeup of the provider was used as a key to file sample pull.

NOTE: DSHS has changed the file sample percentage which will result in a lower number of files being reviewed in 2016.

RESULTS OF REVIEW

PROGRESS NOTES

Percentage of HIV-positive clients who had clear, concise, and comprehensive progress notes in their record each visit.

	Yes	No	N/A
Number of client records clear, concise, and comprehensive progress notes.	40	0	0
Number of HIV-infected clients in community based health services who were reviewed.	40	40	0
Rate	**100.0%**	0.0%	-

VITAL SIGNS

Percentage of HIV-positive clients who had vital signs taken at least once a week.

	Yes	No	N/A
Number of client records that showed vital signs were taken at each visit.	40	0	0
Number of HIV-infected clients in community based health services who were reviewed.	40	40	0
Rate	**100.0%**	0.0%	-

PHYSICAL THERAPY REFERRAL

Percentage of HIV-positive clients who received a referral in to physical therapy based on the nursing assessment.

	Yes	No	N/A
Number of client records that showed evidence of a physical therapy referral	10	0	30
Number of HIV-infected clients in community based health services who were reviewed and the nursing assessment indicated a need for physical therapy.	10	40	30
Rate	**100%**	0.0%	-

FOOD PANTRY REFERRAL

Percentage of HIV-positive clients who received a referral to food pantry

	Yes	No	N/A
Number of client records that showed evidence of a referral to food pantry	40	0	0
Number of HIV-infected clients in community based health services who were reviewed.	40	40	0
Rate	**100.0%**	0.0%	-

NUTRITIONAL REFERRAL

Percentage of HIV-positive clients who received a referral to nutritional services based on the nursing assessment.

	Yes	No	N/A
Number of client records that showed evidence of a referral to nutritional services.	8	0	32
Number of HIV-infected clients in community based health services who were reviewed that showed a need for nutritional counseling based on the nursing assessment.	8	40	32
Rate	**100%**	0.0%	-

MULTIDISIPLINARY TEAM CONFERENCE

Percentage of HIV-positive clients who received a community based health services that had at least one multidisciplinary team conference

	Yes	No	N/A
Number of client records that showed evidence of at least one multidisciplinary team conference.	40	0	-
Number of HIV-infected clients in community based health services that were reviewed.	40	40	-
Rate	**100.0%**	0.0%	-

HYPERTENSION COMORBIDITY

Percentage of HIV-positive clients who have been diagnosed with elevated blood pressure and are antihypertensive medications

	Yes	No	N/A
Number of client records that showed evidence of a diagnosis of hypertension.	16	24	-
Number of HIV-infected clients in community based health services that were reviewed.	40	40	-
Rate	**40%**	60%	-

DIABETES COMORBIDITY

Percentage of HIV-positive clients who have been diagnosed with elevated blood glucose levels and are diabetic medications

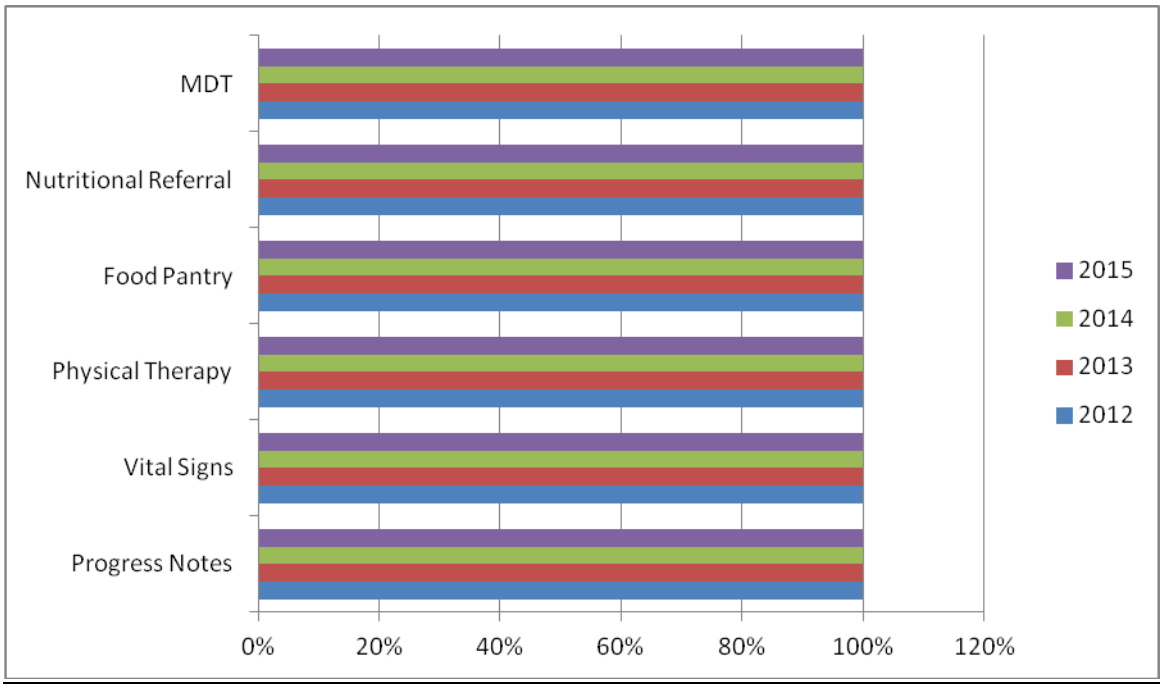
	Yes	No	N/A
Number of client records that showed evidence of a diagnosis of diabetes.	8	32	-
Number of HIV-infected clients in community based health services that were reviewed.	40	40	-
Rate	**20%**	80%	-

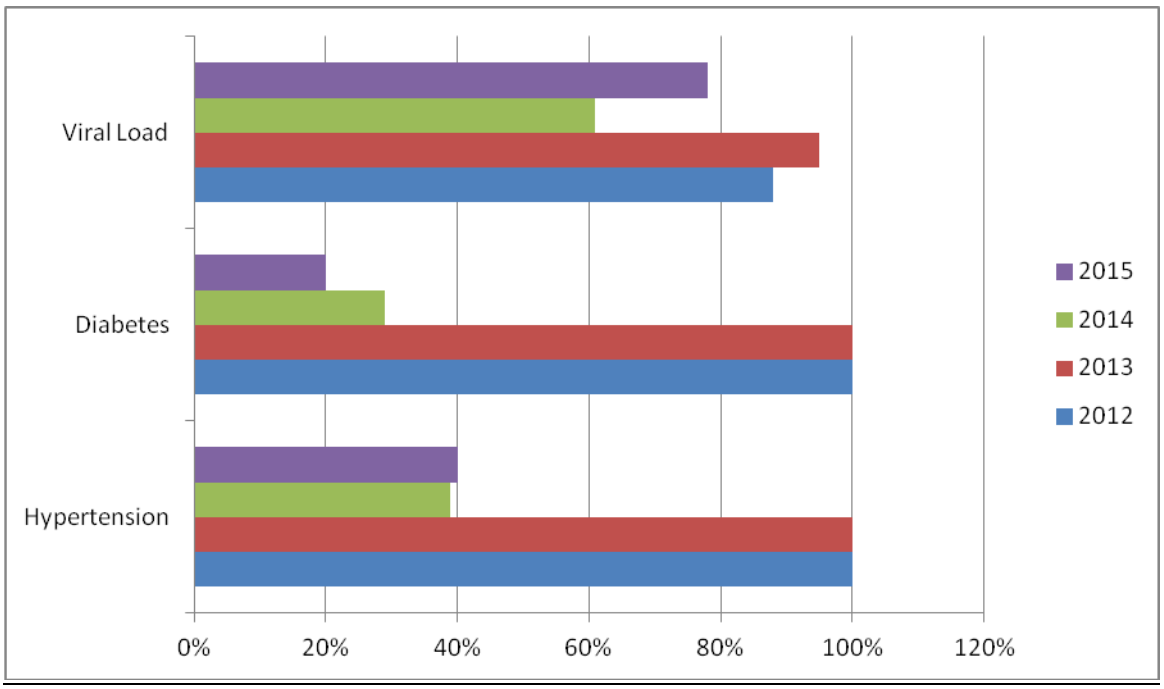
VIRAL LOAD COUNTS

Percentage of HIV-positive clients who have an undetectable viral load

	Yes	No	N/A
Number of client records that showed evidence of an undetectable viral load on their last blood test.	31	9	-
Number of HIV-infected clients in community based health services that were reviewed.	40	40	-
Rate	**77%**	23%	-

HISTORCAL DATA





CONCLUSIONS

Overall, quality of services is good. Through the nursing assessment: 25% (10) of clients were identified as needing physical therapy and a referral was made to 100% of identified clients; 100% (40) received referrals for food pantry; 20% (8) were identified as needing a referral to a dietician, which was completed for 100% of identified clients; 40% (16) were identified with a diagnosis of hypertension and 100% of those showed evidence that their hypertension was controlled (Systolic <140, Diastolic <90) in the past 6 months. Percentage of HIV-positive clients who have an undetectable viral load has improved from 61% in 2014 to 78% in 2015.

Benefits of Adult Day Care

February 9, 2016

By Sarah Lipsky (https://www.longtermsol.com/author/slipsky/)

In today's world, elder caregiving is recognized as a key element of everyday life for millions of families throughout the United States. Adult Day Care is an important care option for families as they transition into the role of primary caregiver for their loved ones.

In greater numbers than ever before, caregiver family members face a crucial dilemma between creating and maintaining a healthy life balance for themselves and for their elderly family members. For many caregivers, finding the balance between caring for their loved one and living a normal outside life for themselves can be incredibly difficult. Family caregivers often become overwhelmed by the sheer amount of work they face when caring for their loved ones. Between medicine schedules, physical stress, and the lack of proper care knowledge to meet ailing senior needs, caregivers often find themselves unable to handle the day-to-day demands while also juggling their own responsibilities.

Adult Day Care is an important source of respite care, providing comprehensive programs specially tailored to adults who need supervision and assistance during the day. The service centers offer social activities and health care programs for adults with

physical disabilities and cognitive impairments, while supervising seniors who are frail and unable to be alone for long periods of time. Being a part of an Adult Day Care program allows the individual to live at home while also receiving the crucial required daily care that many families simply do not have the capacity to provide. Potentially, the family can avoid making the difficult decision to move the elderly relative to a full time assisted living facility if an Adult Day Care program is in place. Additionally, it allows caregivers to have peace of mind and a deserved break from the daily struggle of meeting their family member's needs and balancing their own responsibilities.

Benefits of Adult Day Care

• Preserves independence
• Promotes Social and Cognitive Function
• Safely engages seniors in appropriate physical activities
• Creates routine and daily expectations
• Improves senior health and quality of life
• Social Interaction

About half of the United States population has at least one chronic condition, according to the Centers for Disease Control and Prevention (http://www.cdc.gov/chronicdisease/). Adults

ages 65 and older, 75 percent of whom have chronic conditions, are expected to make up 19 percent of the population by 2030, compared with 12 percent in 2000.

Adult day care helps to remedy these issues by offering older adults a place to go every day and receive care, nutritious meals, mental and physical stimulation, and companionship.

Benefits of Adult Day Care for Caregivers

- Reduce stress
- Improves participant and caregiver relationships
- Reduced anxiety or guilt
- Peace of Mind
- Financial Relief-Adult day care is often less expensive than in-home medical care or full time rehabilitation facilities.
- Freedom to continue working
- Improved Quality of Life

According to the Alzheimer's and Dementia Caregiver Center (https://www.alz.org/care/) Website, here are some of the most important questions to ask when choosing an Adult Day Care center.

- What are the hours, fees and services? (Be sure to ask about the minimum attendance requirements and the notification policy for absences.)

• What types of programs are offered?

• Are people with dementia separated from other participants or included in general activities?

• Will the center evaluate the person's needs? How will this evaluation be accomplished? What types of health care professionals are on staff? How do you screen them?

• How are emergency situations handled?

• How do you ensure the safety of the participants?

• Is transportation available?

When an adult loved one loses the ability care for him or herself, families can be forced into a difficult position to make tough decisions. Adult Day Care is an option that allows the family member to live at home, while the caregiver simultaneously maintains his or her daily life activities.

For more information, the Caregiver Action Network (http://www.caregiveraction.org/)is a non-profit organization providing education, peer support, and resources to family caregivers across the country free of charge.

References:

Abutaleb, Yasmeen. “Caregivers: Two-Fifths Of U.S. Adults Care For Sick, Elderly Relatives.” Http://www.huffingtonpost.com/2013/06/20/caregivers-adults-care-for-elderly-relatives-sandwich-generation_n_3469779.html. Huffingtonpost.com, 20 June 2013. Web. 1 Feb. 2016. <http://www.huffingtonpost.com/2013/06/20/caregivers-adults-care-for-elderly-relatives-sandwich-generation_n_3469779.html>.

2 Adult Day Care | Caregiver Center | Alzheimer’s Association.” Alzheimer’s Association. Www.alz.org, 2016. Web. 01 Feb. 2016. <https://www.alz.org/care/alzheimers-dementia-adult-day-centers.asp>.

Related Links:

Senior Housing 101: Senior Care Types Explained (http://www.aplaceformom.com/senior-care-resources/articles/senior-housing-options)

Adult Day Care Fact Sheet (http://www.eldercare.gov/Eldercare.NET/Public/Resources/Factsheets/Adult_Day_Care.aspx)

Benefits of Adult Day Care (http://www.adultdaycare.org/resources/benefits-of-adult-day-care/)

Seniorliving.org (http://www.seniorliving.org/lifestyles/adult-day-care/)

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

2010

CONTENT

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. However, there may be service needs, determined through the interdisciplinary care plan process that must be scheduled and arranged for off-site, and in those instances collaboration with outside providers occurs. Care and services should be delivered in accordance with the developed comprehensive care plan (CCP).

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 plan of care. A registrant's visit can generate a Medicaid bill if **all** of the following criteria have been met:

1. the registrant must attend the program for a minimum of 3 hours *that day* (Programs are required to track attendance; for each program visit, registrants must sign in and out, denoting times of arrival and departure, regardless of the duration of the visit.); **and**
2. the registrant must receive a minimum of one core health service *that day*; **and**
3. the registrant must receive at least 3 hours of health care services in accordance with his/her care plan *during the billing week, as defined by each program.* (**Refer to most recent AI Policy Statement Update.)**

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 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 and/or arranged for off-site, as appropriate.

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

- HIV general medical services;
- Nursing services;
- Sick call visits;
- 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; and
- Referrals for dental services and sub-specialty care including GYN care.

The CCP must delineate which services will be provided on-site and which services will be arranged off-site. If off-site services are required, the CCP must detail how and where those services will be obtained. Further, the CCP should 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 and his/her family. 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 (the Registrant Assessment Instrument 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, which will assist the program in determining whether or not the individual meets the admission criteria for day health care services. 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, etc.;
- 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;
- Identification of which services can be provided on-site and provider linkages for services which will be provided off-site;
- Time frames for acquisition of services identified;
- 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.

Monitoring/Services Coordination

Monitoring and services coordination involves active and ongoing efforts by the case manager and other members of the interdisciplinary team to ensure that needed services are accessed in a timely manner and that duplication of services is avoided. Activities associated with service coordination and monitoring includes:

- Off-site referrals for medical, social and public health services which cannot be adequately provided on-site (release of information to off-site providers should only occur with proper written consent from the registrant);
- Monitoring of registrant's participation in off-site services should occur and be documented on a quarterly basis, at minimum;
- Follow-up of missed appointments and confirming receipt of needed services as indicated; and
- Case conferences or collaboration with other agencies or providers of service should be documented at least quarterly.

In addition to the CCP denoting specific on-site and off-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.

For registrants receiving other case management services, it is the responsibility of the ADHCP case manager to identify these active case managers and services in order to determine the appropriateness and respective responsibilities of each and prevent possible duplication. Case conferencing between providers must occur at least quarterly. The ADHCP case manager will have the responsibility for coordinating all services for the registrant, as long as the registrant is active in the ADHCP.

Dual enrollment in a COBRA HIV Community Follow-up Program and an ADHCP is permitted for a maximum transition period of 60 days. This will allow sufficient time for the registrant's transition to either the ADHCP or the COBRA program, whichever is appropriate to meet the registrant's needs. If the registrant is enrolled in the COBRA program at the time of admission to the ADHCP, a joint case conference must be scheduled immediately. The case manager should document the case conference and work with the registrant to determine which program is more appropriate to meet the needs of the registrant.

- Coordination of service delivery involves frequent contact with interdisciplinary team members, other on-site and off-site service providers, and the registrant to ensure that services have been arranged and are being received.

<u>Reassessment/CCP Update</u>

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 activities of 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. Substance use or nutrition assessments can be completed every 180 days, if a specific criterion is met. (Part 759.5 (b) (3))

A component of the reassessment process must address the appropriateness of the registrant's continued stay in the program. The registrant 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.

<u>Crisis Intervention Services</u>

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 process for ensuring all necessary services are in place for a registrant upon discharge from the ADHCP. Exit planning is the responsibility of the case manager with assistance from members of the interdisciplinary team. 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 cases, except where the registrant dies or is lost to contact, the ADHCP provider must complete a referral process designed to link the registrant with appropriate ongoing case management and/or other services necessary to meet the registrant's care needs.

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:	Medical services, including initial assessment, monthly visits and evaluation of new symptomatology (sick call) shall be provided to registrants enrolled in the ADHCP.

DESCRIPTION OF SERVICES:

Medical services in AIDS Day Health Care Programs will be a combination of direct service provision, referral to other settings, and coordination with other clinicians providing medical care. The ADHCPs will provide health maintenance, sick call/triage and monthly medical assessment and monitoring. This will require close contact but should minimize appointments with the primary provider of HIV care. On-site medical services will include:

Intake:

All applicants must have a referral from their physician with relevant diagnostic and treatment information that documents that they are HIV-positive and would benefit from program services. All applicants must have a medical examination within six weeks prior to or seven days after the date of admission. (Parts 759.4(6) (i), 425.9(5) (d)). For those applicants who do not have a primary care provider (PCP), the physician at the ADHCP can temporarily perform that function until a PCP is identified.

All applicants to the program must be 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 a minimum of 3 hours 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:
The ADHCP medical staff shall perform a medical assessment within 30 days of admission that will include a medical history and physical examination. (Part 759.5)

Relevant past medical information not provided from the referring physician should be obtained. Lab work results, such as hematology and chemistry tests, as well as sexually transmitted diseases screening tests, hepatitis, toxoplasmosis, and immunologic blood work (e.g., CD4) shall be documented. These tests can be documented from previous medical record or summary.

The initial evaluation at intake by the clinical staff should form the basis of the physical health aspects of the interdisciplinary care plan, as appropriate. The care plan may include a need for medical monitoring.

HIV Medical Services:

- The medical clinician at the ADHCP must evaluate the registrant every 30 days, at a minimum, either as part of a sick call, a scheduled appointment, or through formal communication with the PCP which is documented in the progress notes (Parts 759.6(b), 425.9(b));
- Clinical services should include health maintenance protocols, including documentation of immunizations and results of routine screening laboratory tests obtained from the PCP or provided directly on-site, and either provision or referral for routine gynecologic care;
- Referral arrangements should be made for emergency services, dental services and medical sub-specialty care (Part 425.5(a)(9));
- Treatment of stable medical conditions may be managed in the ADHCP, upon agreement by the ADHCP clinical staff and the registrant's PCP;
- If the registrant does not have an accessible PCP, the ADHCP will assist the registrant in identifying a PCP and will make referrals to link the patient with primary care services within 60 days from the date of admission. The ADHCP will provide medical care until primary care services are obtained; and
- The ADHCP is expected to coordinate medical care with the PCP on an on-going basis. The ADHCP must provide, at a minimum, quarterly summaries of medical services provided and make arrangements to receive the same from the primary care provider.

Sick Call:

- Medical evaluation of registrant's new complaints should be made available during a set time of every program day:
- There must be a MD, NP or PA available for consultation and triage;
- Sick call may result in examination and treatment by the ADHCP clinician, referral to the patient's HIV PCP, or to a hospital Emergency Department. If a sick call visit results in a medication prescription, the PCP must be notified, and this information must be documented in the clinical case record;
- If the registrant presents for a sick call visit at the ADHCP on a day on which he is registered for ADHCP services, and if the diagnosis and treatment of the problem requires less than 20 minutes of practitioner's time, the sick call visit will be routinely considered as part of the ADHCP service;
- If the registrant presents for a sick call visit with a problem of moderate to high severity which involves more than 20 minutes of the practitioner's time for diagnosis and treatment, the visit may be billed as a primary care visit. In this event, time spent at a primary care visit cannot be counted toward ADHCP attendance requirements; and
- For ADHCP registrants who present at the site for a primary or urgent care visit (scheduled or walk-in) on a day when they are not registered for ADHCP attendance, the visit is considered a primary care visit.

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 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 at least every 30 days;
- 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.

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 including, but not limited to:

- Medication effectiveness, including laboratory tests (if appropriate);
- Vital sign monitoring;
- Quantifiable compliance with HAART medication treatment and techniques to aid in adherence such as, but not limited to, direct observation therapy monitoring and pill boxing;
- Techniques for self-administration of medications; and
- Coordination with the PCP.

In addition, the Department recommends that ADHCPs should develop medication-monitoring systems which address:

- Review of registrants' medications by a MD, PA, RN or NP, which is conducted at least every 30 days;
- Prescribing, 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. Progressive weight loss is frequently a major manifestation of HIV disease. In addition, 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 registered dietician (RD), including an initial nutritional assessment, ongoing follow-up and interventions. 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.

The initial comprehensive assessment conducted by the nutritionist is used to identify signs of malnutrition or obesity, as well as conditions that alter nutritional intake. Assessments 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.

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.

Periodic nutritional reassessments are required to be conducted for all registrants. In the presence of existing nutritional needs or problems, reassessments should occur no less frequently than quarterly. Registrants for whom there are no nutritional concerns; reassessments should be conducted every six months.

The initial and subsequent reassessments should conclude with a list of conditions and concerns identified during the assessment. This information will be used in collaboration with the interdisciplinary team to develop CCPs that address registrants' nutritional needs.

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 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 with a list of conditions and concerns identified during the assessment. This information will be used in collaboration with the interdisciplinary team to develop CCPs that address registrants' chemical dependency needs and readiness.

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

- Presenting problem or conditions;
- Realistic short term goals;
- Specific interventions and or referrals directed towards goal attainment;
- Type and frequency of services, both individual and/or groups, to be provided on site; and
- Identification of services to be provided off-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, education strategies, etc.);
- Support/self help groups; and
- Coordination and monitoring of services not provided on-site.

In those instances when registrants are in need of more intensive services than can be provided on-site, and receptive to off-site substance abuse treatment, the ADHCP shall make appropriate referrals to certified substance abuse treatment programs and routinely monitor registrants' engagement in the off-site services. To facilitate access to off-site services the ADHCP should develop linkage agreements for substance abuse services.

Periodic substance abuse reassessments are required to be conducted for all registrants. In the presence of existing substance abuse needs or problems, reassessments should occur no less frequently than quarterly. For instances in which the registrant has no previous substance use history or has been abstinent for three or more years, reassessments are completed every six months, or sooner should the situation change.

VIII. MENTAL HEALTH SERVICES

GUIDELINE:	Mental health services will be provided to registrants in accordance with the 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 on-site and which will require referrals to off-site providers. 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 counseling;
- Medication monitoring;

- Crisis intervention; and
- Peer support.

If the registrant is assessed as needing ongoing psychiatric treatment and it is not available on-site, all ADHCPs must make referrals to the appropriate off-site services. In the case of an outside referral, it will be the responsibility of the ADHCP to arrange for the referral, and maintain contact with the psychiatric provider to ensure a continuity of care. This collaboration shall be documented quarterly at a minimum, or more frequently as indicated

If the registrant is receiving on site mental health services, psychotherapy or medication management from a provider within the organization, the ADHCP must document the provision of these services on a quarterly basis.

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 "core" health service if it meets the following criteria:

- The group is facilitated by a LCAT;
- It is a closed group and documentation occurs after each session. Documentation should include specific registrant participation as relevant and appropriate;
- 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 registrant's participation in creative arts activities is reassessed on a quarterly basis consistent with the CCP.

The LCAT may also provide low threshold engagement type group activities that do not meet the criteria of a core 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, which will be based on an assessment of the registrant's physical, cognitive, behavioral, communicative, emotional, pharmacological and social needs, 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 individual's multidisciplinary assessment of needs and inclusion 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 services. Rehabilitation therapy must be recommended by or in collaboration with the registrant's PCP and 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. A referral should be made to a more intense rehabilitation program, if clinically indicated, and in collaboration with the PCP.

Rehabilitation services provided as described above may be considered a core health service.

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, but should not be considered as a core service..

XI. ACTIVITIES SERVICES

GUIDELINE:	The ADHCP can provide an activities/leisure time needs assessment for program registrants as well as 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 do not need to be on the CCP.

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.

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Only pastoral services which are provided as one-to-one interventions in accordance with the registrant's multidisciplinary assessment of needs, and documented on the registrant's CCP, are considered a core health service. All other pastoral services are considered to be health related services.

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 an 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;
- Nutritional services;
- Social work/case management services;

- Substance abuse services;
- Rehabilitation services;
- Risk reduction services;
- Staff development;
- Exit planning and readmissions to the program; and
- Special projects related to delivery of care.