

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

**THE NEW YORK STATE DEPARTMENT OF HEALTH
AIDS INSTITUTE**

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INTRODUCTION:

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

Since the inception of the AIDS epidemic, New York State has demonstrated its commitment to combatting this disease and has successfully developed and implemented a comprehensive continuum of HIV prevention and treatment programs and services. As a result of the success of the efforts employed in New York State over many years, ending the AIDS epidemic in New York State is now within reach, and in June 2014, announced a three-point plan to end the epidemic. The plan strives to simultaneously reduce HIV transmission, increase the number of people that know their HIV status, and improve the health of all New Yorkers living with HIV/AIDS with an emphasis on access to HIV treatment to maximize viral suppression and to enhance access to HIV prevention services.

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

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

The AIDS Adult Day Health Care Programs 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 clients to attend additional off-site services. AIDS Adult Day Health Care Programs 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 use, mental health, and rehabilitative services are among those provided.

Effective August 1, 2013, Medicaid Managed Care began authorizing the provision of AIDS Adult Day Health Care Program services for their enrolled members. Medicaid Managed Care Organizations are responsible for authorizing enrollment and for reimbursement for services rendered for the majority of clients enrolled in the service/program.

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

The New York State Department of Health has been working with the Centers for Medicare and Medicaid Services to comply with the Home and Community Based Services requirements. Specifically, the New York State Department of Health has developed and submitted a 5-year Statewide Transition Plan detailing how it will comply with all Home and Community Based Services standards. By design, AIDS Adult Day Health Programs provide services in home and community-based settings. For this reason, AIDS Adult Day Health Care Programs are required to demonstrate compliance with these standards.

The AIDS Adult Day Health Care Program initiates the person-centered service planning process by completing discipline-specific assessments to develop a recommended scope, frequency, and duration of AIDS Adult Day Health Care Program service. Congruent with the Medicaid Managed Care / Family Health Plus/HIV Special Needs Plan/ Health and Recovery Plan Model Contract, Appendix S: New York State Department of Health Requirements for Long Term Services and Supports for Medicaid Managed Care Programs, the Medicaid Managed Care Organization will serve as the Conflict Free Care Manager in accordance with the Federal Home and Community Based Services Managed Care Final Rule.

The AIDS Adult Day Health Program care team will partner with the client and the Medicaid Managed Care Organization Care Manager to develop a federally compliant person-centered service plan which will include documentation of the choices and options afforded the client to meet the clients' goals and objectives. These services must include a choice of both disability and non-disability services. The service plan will be drafted with the client, and anyone identified by the member such as a service provider, family, friend, etc., to contribute to the development of the person-centered service plan.

Regulations require that a referral for program services is obtained from the clients' primary care provider prior to admission to the program, and reauthorization for continued utilization of services is obtained from the primary care provider annually thereafter. In addition, off-site service needs to be determined through the interdisciplinary care plan process and will now be coordinated with and approved by the clients' Managed Care Organization and/or the primary care provider as applicable.

Regulations require that a client's attendance at the AIDS Adult Day Health Care Program be based on individualized need and their readiness and ability to address those needs as assessed by the program and identified by the client. The client's level of attendance in the program should be consistent with the documented interventions on the service plan and the coordination with the Managed Care Organization and/or the primary care provider as applicable. The client must participate in a planned intervention documented on the service plan on each day of attendance, except in instances when the client is directly engaged in assessment/reassessment as required by regulation.

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

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.

SERVICE DELIVERY & OPERATIONS:

GUIDELINE: AIDS Adult Day Health Care Program clients can choose to receive services on-site (in-person services), via telehealth, or through a hybrid model (combination of in-person and telehealth services)

For AIDS Adult Day Health Care Programs that provide services via telehealth and/or a hybrid model, please follow the telehealth workflow below:

Telehealth Workflow

Before the Session

- Set up a professional and welcoming space
- Test platform connection
- Staff to verify client access to chosen platform
- Staff to prepare clients for session

Start the Session

- Audio check
- Introduce all parties
- Verify client's identity
- Ensure private space (secure video sessions)
- Communicate back-up plan if technology fails
- Obtain and document consent for use of telehealth and related charges

During the Session

- Maintain components of in-person session
- Document sessions conducted via telehealth (specifically audio or video)
- Document client and provider locations, other staff/clients included in session, duration of session, and reason for use of telehealth (e.g., client choice)

Wrap Up

- Review questions and next steps
- Counseling and education related to the service(s) provided
- Both parties close out of platform

HOME AND COMMUNITY BASED SERVICES:

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

DESCRIPTION OF STANDARDS: According to the requirements, any residential or non-residential setting where clients live and/or receive Home and Community Based Services must have the following **5** qualities:

- Integrated in and supports full access of individuals to the greater community;
- Selected by individual from setting options including non-disability specific settings;
- Ensures individual rights of privacy, dignity, and respect, and freedom from coercion and restraint;

- Optimizes individual initiative, autonomy, and independence in making life choices (including but not limited to daily activities, physical environment, and with whom to interact); and,
- Facilitates individual choice regarding services and supports, and who provides them.

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

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

AIDS Institute staff, through the Medicaid Policy and Programs Chronic Care Unit Technical Assistance Program and Comprehensive AIDS Adult Day Health Program biennial site visits, will continue to monitor AIDS Adult Day Health Care Program processes, including compliance with Home and Community Based Services.

STAFF EDUCATION AND TRAINING:

GUIDELINE: The AIDS Adult Day Health Care Program must provide orientation specific to the role/responsibilities of the staff, as well as opportunities for staff to participate in ongoing job training and educational programs. (Parts 759.4, 425.4)

DESCRIPTION OF SERVICES: The program model provides physical care and psychosocial support to clients with HIV illnesses or at heightened risk for HIV. As direct caregivers, they are best able to provide HIV prevention education, reinforce sustained interventions, safeguard clients’ rights, and promote clients’ choices. As caregivers, 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 person-centered service planning
- Appropriate clinical documentation of pertinent interventions (client and group) and interactions with client
- Medications/side effects
- HIV confidentiality
- Clinical manifestations of HIV/AIDS
- Infection control practices including occupational exposure which address decreasing the risk of exposure
- Comprehensive information on HIV transmission
- Prevention and control of tuberculosis
- Psychosocial issues
- Clients’ rights
- Stigma
- Home and Community Based Services Final Rule
- Health Equity Person-Centered Service Planning Process

In addition to the initial orientation program, ongoing staff educational programs must be provided by the AIDS Adult Day Health Care Program specific to the most up to date information relevant to the clinical and psychosocial aspects of HIV illness, as well as chronic disease management. More information is available at the Person Centered Planning and Practice Resource Library: [Person-Centered Planning and Practice Resource Library \(ny.gov\)](http://www.personcenteredplanningandpractice.org)

CONFLICT FREE SERVICE PLANNING/CASE MANAGEMENT SERVICES:

GUIDELINE: Interdisciplinary team assessment and **discipline-specific service plan/person-centered service plan** development must be completed for each client no later than 30 days from the date of admission. Managed Care Organizations will maintain a person-centered service plan detailing the services provided by the AIDS Adult Day Health Care Program as well as any other client needs. Reassessments must be performed as the client's needs change, but no less frequently than every six (6) months. The AIDS Adult Day Health Care Program is responsible for ensuring that appropriate care and services are available and accessible for the client and that such services are coordinated through regular case conferencing and follow-up with all providers involved in the client's care. (Parts 759.5, 425.7 and 42 CFR 441.301(c)(2)(xiii)(H))

DESCRIPTION OF SERVICES: The interdisciplinary comprehensive service planning process focuses on assisting clients to develop skills to improve and/or stabilize their medical and psychosocial health status as well as maintaining and/or improving their quality of life. The process involves all disciplines working together with the client to develop a discipline specific service plan. The scope, frequency, and duration of services must be shared with the Managed Care Organization Care Manager, who will develop a federally compliant person-centered service care with the client and with input from the AIDS Adult Day Health Care Program and other pertinent members of the clients' care team.

Nutrition, nursing, and psycho-social assessments will be conducted with the client to identify the health care and supportive service needs and client goals. This information is then utilized to generate a person-centered service plan that specifies health care and supportive services which will be delivered on-site, via telehealth, or both. The completed person-centered service plan should be reflective of documented coordination with the Managed Care Organization, and/or primary care provider and should include language regarding when a client will be ready for graduation and/or transition to a less intensive level of service.

The interdisciplinary system of care delivery for the AIDS Adult Day Health Care Program 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
- Substance use/harm reduction services
- Mental health and psychiatric services
- Activities which promote involvement with community, interpersonal and self-care functions

The person-centered service plan must include all interventions including 1:1 provider – client contact, specific structured group activities, and the frequency in which the client is to participate in these interventions. If a client participates in an intervention that is not included in their person-centered service plan, it must be clearly documented in the medical record why the exception was made. In addition, the person-centered service plan must be accessible to individuals with disabilities and persons who are limited in English proficiency. The person-centered service plan is based on quantifiable goals and interventions and must be reviewed and updated by the interdisciplinary team as appropriate based on reassessment information at least semi-annually, or more frequently if the clients' needs change.

A primary case manager must be assigned to each client within one week of admission to the program. Case management services, while frequently conducted and coordinated by a Licensed Master Social Worker, may be implemented by other members of the interdisciplinary team. These services are designed to assure the coordinated participation of all healthcare professionals and other service providers engaged in the provision of care to the client. Additionally, the primary case manager is responsible for ensuring that all needed services are accessed and delivered as identified in the person-centered service plan. The case manager must also maintain a record of the client's attendance at the program, the number of groups attended, and participation in the interventions specified on the person-centered service plan, regardless of the discipline designated to conduct the intervention.

Interdisciplinary team planning/case management is a multi-step process focusing on coordination and timely access to a range of appropriate medical, psychological, and social services for the AIDS Adult Day Health Care Program client. The goal is to promote and support the independent functioning of the client to the highest degree possible.

In the AIDS Adult Day Health Care Program, the multi-step process includes the following activities:

- Intake assessment (includes an assessment instrument approved by the New York State Department of Health, such as the Client Assessment Instrument or the Uniform Assessment System – New York Community Mental Health Assessment when made available to providers should be completed upon admission, as well as discipline-specific assessments, which together provide the basis for clients' continued engagement in the program)
- Person-centered service plan monitoring/service coordination
- Reassessment/person-centered service plan update/continued stay review (minimally every six months or more frequently if clinically indicated)
- Crisis intervention services
- Exit planning/graduation/case closure

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

Intake Assessment

The Intake Assessment must be completed prior to the development of the initial person-centered service plan. This assessment includes the collection of data and information from various disciplines, as well as information from the Managed Care Organization, the client's primary care provider, and, if appropriate, the client's Health Home or other service providers. This will assist the program in determining whether the client has service needs appropriate for the AIDS Adult Health Care Program setting, what services to make available, and the frequency of attendance.

The Department of Health'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 and social 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
- Level of HIV knowledge and risk reduction awareness.

If a referring agency has conducted the Uniform Assessment System's New York Community Mental Health Assessment and has provided the completed assessment to the AIDS Adult Day Health Care Program, AIDS Adult Day Health Care Program staff must review and update the information provided on the assessment instrument, which can then serve as the basis for identifying service needs to be addressed within the AIDS Adult Day Health Care Program setting.

Person-Centered Service Plan Development

A discipline-specific service plan should be based on the discipline-specific intake assessments. The service plan will include the client's needs and desired outcomes translated into specific goals, objectives, and interventions. The service plan will identify appropriate services needed and specify activities and services to be provided and/or arranged for by the AIDS Adult Day Health Care Program.

The service plan developed by the AIDS Adult Day Health Care Program staff should be documented in the clients' record within 30 days from the date of registration and shared with the clients' third-party care management agency (per Parts 759.5 and 425.18), and should include:

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

The person-centered service plan should denote the frequency of participation in the program and must be authorized/approved by the Managed Care Organization, if applicable.

The Managed Care Organization will incorporate into the Person Center Plan of Care and ensure that Federal Home and Community-Based Services regulations are adequately addressed as follows:

- Reflect that the setting in which the individual resides is chosen by the individual
- The person-centered service plan must ensure that the setting chosen by the individual is integrated in and supports full access of individuals receiving Medicaid Home and Community Based Services in the greater community
- Reflect the individual's strengths and preferences
- Reflect services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports (unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) Home and Community Based Services waiver services and supports)
- Be understandable to the individual receiving services and supports, and the individuals important in supporting them
- At a minimum, the plan must be written in plain language and in a manner that is accessible to individuals with disabilities and person who are limited English proficient
- Identify the individual and/or entity responsible for monitoring the plan
- Be developed with the individual or their representative driving the process whenever possible.
- Be distributed to the individual and other people involved in the plan
- Include those services, the purpose or control of which the individual elects to self-direct; and
- Prevent the provision of unnecessary or inappropriate services and supports
- Document that any modification of the additional conditions, under 42 CFR 441.301(c)(4)(vi)(C) and (D), must be supported by a specific assessed need and justified in the person-centered service

plan. Any deviation from the standards at 42 CFR 441.301(c)(4)(vi)(C) and (D) will be justified and documented in the care plan and will be updated no less frequently than every six (6) months.

Monitoring/Service Coordination

Monitoring and service coordination involves active and ongoing efforts by the AIDS Adult Day Health Care Program (including the program case manager, Managed Care Organization care manager, and other members of the interdisciplinary team as appropriate) and other relevant service providers as needed to ensure that services are accessed in a timely manner. It is essential that programs have systems in place to provide ongoing monitoring of clients' utilization of services to ensure that services are provided in accordance with the person-centered service plan.

In addition to the person-centered service plan denoting specific services provided, documentation of service coordination should also include:

- Discipline-specific progress notes which document each face-to-face contact with the client and any contact with other providers
- A record of group attendance
- Documentation on progress towards completion of identified goals and eventual graduation from services
- Documentation of outreach efforts with clients who are marginally engaged in the program or who have failed to attend scheduled appointments
- Documentation of coordination with the Managed Care Organization, Health Home care manager, Adult Day Health Care Program, or other case management provider as applicable, and/or the primary care provider on a regular basis (as agreed upon by the Managed Care Organization and/or the off-site case management service provider) or as the needs of the client change

Reassessment/ Person-Centered Service Plan Update

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

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

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

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 clients. AIDS Adult Day Health Care Programs must have a written plan describing the provision of crisis intervention and how these services can be accessed by clients.

Crisis intervention activities should be incorporated into each client's person-centered service plan as appropriate. All incidents requiring crisis intervention shall be documented in the clients' record and reported to the case manager.

Exit Planning/Graduation/Case Closure

Exit planning is the responsibility of the case manager with assistance from members of the interdisciplinary team and coordination with the Managed Care Organization and any off-site case management providers. Case closure occurs when the client will no longer be receiving program services.

Cases may be closed under the following circumstances:

- The client meets all identified goals and no longer requires AIDS Adult Day Health Care Program services
- The client cannot be located or contacted for a period not to exceed 60 days
- The client is institutionalized or incarcerated for greater than 30 days
- The death of a client
- The client relocates out of the AIDS Adult Day Health Care Program service area
- The client does not want continued service
- The clients' verbal or physical behavior towards staff or other clients creates an unsafe environment
- The clients' 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 person-centered service plan

In all instances in which the client may need other services upon discharge/graduation from the program, the AIDS Adult Day Health Care Program must refer the client back to the Managed Care Organization/primary care provider and the Health Home, or other case management provider, as applicable, for needed referrals. The person-centered service plan must be amended to include discharge/graduation planning, including interventions that address rescinding of releases, outreach to external providers, and case closure. 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.

MEDICAL SERVICES:

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

DESCRIPTION OF SERVICES: Medical services in AIDS Adult Day Health Care Program will be coordinated with the primary care provider and the Managed Care Organization. Health maintenance/wellness needs will be assessed as a part of the routine comprehensive care planning process and identified health maintenance/wellness activities will be delineated on the person-centered service plan. Evaluation of new symptomatology (sick call/triage by a Registered Nurse), and referral to the primary care provider as appropriate will be available to all clients each day of program operation. Changes in the client's health status and all medical care coordination activities will be documented in the AIDS Adult Day Health Care Program medical record.

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

Intake

All applicants must have a referral from their primary care provider/Managed Care Organization with relevant diagnostic and treatment information that documents the type of services the client 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 provider. (Parts 759.4(6) (i), 425.9(5) (d)).

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

Acceptance into the AIDS Adult Day Health Care Program must be based upon an intake assessment that documents that the potential client needs health care services as defined in the Introduction, does not have communicable tuberculosis, is choosing to enroll in the program, and is able to function in a group setting. Prior to admission, the program must have obtained a referral from the primary care provider indicating the client has care needs that could be addressed through participation in the program. Primary care provider reauthorization for continued stay in the program must be obtained every twelve (12) months thereafter.

Assessment

Within 30 days of admission, a Registered Nurse from the AIDS Adult Day Health Care Program will review all medical information sent by the referring primary care provider/Managed Care Organization/Health Home. The relevant medical information should minimally include current lab work results such as hematology and chemistry tests, as well as sexually transmitted infection screening tests, hepatitis screening, and immunologic blood work (e.g., CD4, viral load), as well as the clients' appropriateness for involvement in AIDS Adult Day Health Care Program.

The medical information initially received should form the basis of the physical health aspects of the interdisciplinary Person Centered Service Plan as appropriate.

Medical Care Coordination

The AIDS Adult Day Health Program, through formal communication/care coordination with the client's primary care provider, obtains and incorporates medical information including results of routine screening laboratory tests into the case record. As appropriate, relevant information obtained from the primary care

provider/Managed Care Organization/Health Home should be utilized to develop or modify the person-centered service plan.

The AIDS Adult Day Health Care Program is expected to review and document care coordination issues with the health Managed Care Organization/Health Home and/or the primary care provider on a routine basis (as agreed upon by the Managed Care Organization and/or Health Home). Care coordination with the Managed Care Organization/Health Home and the primary care provider may be required more frequently, as appropriate, due to changes in the client's condition.

Consultation/Triage/Sick Call

There must be a Registered Nurse (or other qualified health care professional such as Medical Doctor, Nurse Practitioner, or Physician's Assistant) available for consultation and triage during all hours of program operation. Sick call/triage may result in referral to the patient's primary care provider/Managed Care Organization/Health Home, a hospital, emergency department, or urgent care as necessary. In the event a client goes to a hospital emergency department, or other urgent/crisis care setting, the AIDS Adult Day Health Care Program must inform the primary care provider/Managed Care Organization/Health Home of the urgent/crisis care visit immediately (as specified by Managed Care Organization/Health Home policy).

NURSING SERVICES/MEDICATION MANAGEMENT:

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

DESCRIPTION OF SERVICES: Nursing services promote systems for monitoring clients' ongoing healthcare needs. These services must consist of an initial comprehensive assessment, reassessment conducted no less frequently than every six months, and ongoing monitoring of systems and appropriate interventions to meet the client's health care needs. Registered Nurses must conduct assessments, but Licensed Practical Nurses may conduct other nursing services within their scope of practice, under the supervision of a Registered Nurse.

The initial assessment includes information received from the Managed Care Organization/primary care provider and a baseline history such as:

- History of opportunistic infections/neoplasm
- Psychosocial status including psychiatric complications and behavioral deficits
- Neurological status, both motor and cognitive
- Pulmonary status
- Gastrointestinal/Genitourinary status
- Skin integrity
- CD4 count
- Viral load
- Hepatitis A, B and C status
- Complete medication history (including current Highly Active Antiretroviral Therapy treatments, psychotropic medications) which is then updated quarterly, unless otherwise indicated
- Vitamin deficiency
- Pain status
- Level of Activities of Daily Living functioning
- Chemical dependency status
- HIV education/risk reduction

The initial assessment and reassessments should conclude with a list of client needs identified during the assessment process and a statement as to whether a service plan goal/intervention is indicated.

Appropriate nursing interventions are implemented in conjunction with monitoring of clients' 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
- Activities of Daily Living functioning
- Primary health care (reinforcement of follow-up care)
- Coping and stress management
- HIV prevention/risk reduction
- Chemical dependency treatment
- Monitoring of chronic medical conditions (i.e., hypertension, diabetes, hepatitis)

GUIDELINE: The AIDS Adult Day Health Care Program will provide medication management services in accordance with accepted professional practices and applicable federal, state, and local regulations.

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

For every client admitted to the AIDS Adult Day Health Care Program, information should be obtained that 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 clients' enrollment and be incorporated into the plan of care as appropriate. Such services may include, but are not limited to:

- Review of clients' medications by a Registered Nurse, which is conducted at least every six (6) months
- Vital sign monitoring
- Quantifiable compliance with 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 New York State Department of Health recommends that AIDS Adult Day Health Care Programs 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
- Documenting each medication administered, including the time it was administered and the initials of the client who administered it

The above evaluation data is utilized in collaboration with the interdisciplinary team to develop or modify person-centered service plans that address clients' nursing and medication needs.

NUTRITION SERVICES:

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

DESCRIPTION OF SERVICES: Nutritional interventions are an integral component of AIDS Adult Day Health Care Program services focusing on diabetes, hypertension, obesity, and heart disease. AIDS Adult Day Health Care Program staff will ensure that all clients receive appropriate levels of nutritional services, under the supervision of a qualified nutritional professional (Registered Dietitian, Certified Dietitian-Nutritionist). 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 clients. Nutritional groups may be facilitated by qualified nutritional or nursing staff.

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

- Dietary history (food preferences, allergies and aversions, frequency of eating, past diets, physical or psychological factors affecting eating, etc.)
- Medications
- Psychosocial and economic status (including access to cooking facilities)
- Height/weight, recent weight loss or gain, usual weight, percentage of Ideal Body Weight and Body Mass Index
- Level of activity/exercise
- Medical history
- Laboratory values to identify possible vitamin deficiencies

A nutritional reassessment is required every six (6) months, consistent with the date of the person-centered service plan. Ongoing monitoring of clients' 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 person-centered service plans, as appropriate, that address clients' nutritional needs and communicated to the Managed Care Organization.

HIV PREVENTION/RISK REDUCTION SERVICES:

GUIDELINE: HIV prevention/risk reduction services that promote behaviors that reduce the risk for HIV transmission or progression of HIV disease must be provided to clients of the AIDS Adult Day Health Care Program. (Parts 759.8, 425.18)

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

The AIDS Adult Day Health Care Program should provide the following HIV risk reduction services:

- **Initial needs assessment and service planning which includes:**
 - Review of medical charts and other pertinent client-specific records, including information from the referral source
 - Initial assessment addressing the clients' current behavioral practices, knowledge, and attitudes relative to HIV transmission risk
 - Development of an individualized risk reduction plan which is incorporated into the person-centered service plan as clinically indicated
- **Appropriate prevention/risk reduction services are based on the assessment of the client and should address the following:**
 - Harm reduction activities to promote wellness, contribute to reducing physical and behavioral health conditions affecting its patient population, and prevent transmission of HIV, Hepatitis C and Sexually Transmitted Infections to others. Such activities may include policies and interventions tailored to patient-specific needs, including but not limited to:
 - Integrating prevention/harm reduction messaging in all interactions with patients, including the distribution of condoms when appropriate
 - Making referrals to and/or promoting engagement with comprehensive harm reduction programs (e.g., syringe exchange programs), Partner Services, behavioral health services, or other appropriate community programs
 - Providing counseling and education on Pre-exposure Prophylaxis and Post-exposure Prophylaxis
 - Utilizing and/or promoting engagement with peers
 - Utilizing health education and promotion resources and materials available from the AIDS Institute, Centers for Disease Control, or other experts
- **Ongoing monitoring/reinforcement which include:**
 - Periodic review (every six (6) months) of the client risk reduction program
 - 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 person-centered service plans that address clients' needs.

SUBSTANCE USE SERVICES:

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

DESCRIPTION OF SERVICES: Substance Use services will be based on a variety of perspectives including harm reduction and recovery. Substance Use services should be integrated within a health care context which addresses the physiological, psychological, and social impact of addiction. Decisions on the appropriate treatment interventions should be based on a holistic conceptual framework which considers the environmental, behavioral, emotional, cultural, and experiential factors which influence the clients' life. Services must address the use of illegal substances as well as alcohol and tobacco use. The impact that addiction and substance use have on the family/significant other should be considered, and when appropriate, involvement of the family/significant other should be encouraged. Substance Use groups may be facilitated by a Credentialed Alcoholism and Substance Abuse Counselor or a Peer Recovery Support Specialist.

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 use 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
- Clients' perception of their 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 clients' readiness to engage in modifying the behavior. This information will be used in collaboration with the interdisciplinary team to develop person-centered service plans that address clients' chemical dependency needs.

A Service Plan should be developed based on clients' readiness for engagement including:

- Presenting conditions
- Realistic short-term goals
- Specific interventions directed towards goal attainment; and
- Type and frequency of services, both individual and/or group settings

Interventions should include:

- Client, group and family counseling provided, as appropriate
- Education on substance use 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 clients require more intensive services than can be provided by the AIDS Adult Day Health Care Program, and they are receptive to off-site substance use treatment, the AIDS Adult Day Health Care Program shall coordinate with the Managed Care Organization/Health Home concerning the need for off-site referral.

Substance use reassessments are required to be conducted for all clients every six (6) months.

MENTAL HEALTH SERVICES:

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

DESCRIPTION OF SERVICES: Upon admission to the AIDS Adult Day Health Care Program, staff will perform a mental health assessment which includes screening of the clients' cognitive functioning, emotional status, and level of behavioral control. Psychiatric information will be obtained as well as current risk status to self and others. After the initial mental health assessment, reassessments must be conducted, by a qualified mental health professional minimally every 6 (six) months thereafter.

The information obtained during the initial assessment and subsequent reassessments will be used in the development of the mental health component of the client's person-centered service plan, as appropriate. The person-centered service plan will address the client's current mental health status and the need/readiness for mental health services. The plan will also identify which of these services are to be provided within the AIDS Adult Day Health Care Program setting. The initial assessment and reassessments should conclude with a list of needs and goals identified during the assessment.

All programs should make available on-site and via telehealth:

- Psychiatric evaluation
- Supportive client and group counseling
- Medication administration and monitoring
- Crisis intervention
- Peer support

If the client is assessed as needing services that are not available by AIDS Adult Day Health Care Program provider staff, such as weekly psychotherapy, the program will coordinate with the Managed Care Organization/Health Home for evaluation and treatment.

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

- The group is facilitated by a Licensed Creative Arts Therapist; groups run by non-licensed/staff in training must have group notes reviewed and signed by a Licensed Creative Arts Therapist
- The goal/purpose must clearly delineate a mental health focus; (i.e. a diagnosis, symptom, or behavior)
- The specific group(s) and client's expected frequency of attendance must be on the person-centered service plan.

The psycho-social reassessment should incorporate the client's level of engagement in Licensed Creative Arts Therapist services, the effectiveness of Licensed Creative Arts Therapist interventions, and the need for the client to continue with Licensed Creative Arts Therapist-specific interventions.

The Licensed Creative Arts Therapist 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 client and do not have to be listed on the client's person-centered service plan.

Other groups related to mental health, behavioral health, symptom management, etc. may be provided by Master Level Social Workers and Certified Peer Specialists and are subject to the same guidelines regarding assessment and person-centered service plan. Group notes run by these staff must be reviewed and signed by a licensed professional.

REHABILITATION SERVICES:

GUIDELINE: Rehabilitation services, approved by the Managed Care Organization/primary care provider will be based on an assessment of the client's physical, cognitive, behavioral, communicative, emotional, pharmacological, and social needs, and will be provided on-site, as appropriate. (Parts 759.8, 425.13)

DESCRIPTION OF SERVICES: Rehabilitative interventions are directed toward restoring, improving, or maintaining the client'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 client 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 client's ability to perform activities of daily living to varying degrees.

Rehabilitative services can be provided on-site, as appropriate, for each client in accordance with the approval of the Managed Care Organization/primary care provider and the client's multidisciplinary assessment of needs and will be included on the person-centered service plan (Part 759.6 (g)). Prior to the initiation of rehabilitation services, the AIDS Adult Day Health Care Program will evaluate each client to determine their rehabilitation status and need for specific services. Rehabilitation therapy must be documented in the client's record.

The rehabilitation components of the initial assessment for each client should address:

- Functional status
- Prior level of functioning
- Rehabilitation potential
- 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 needs identified during the assessment.

The above evaluation data is utilized in collaboration with the interdisciplinary team to develop person-centered service plans that address rehabilitation needs including:

- Client's personal goals for rehabilitation
- Living, learning, and activity goals
- Behavioral and functional goals
- Implementation of the plan that includes:
 - Coordinated and collaborative rehabilitation interventions directed toward attainable outcomes
 - Documentation of client's response to interventions, change in client's condition, choices for alternative therapies and progress toward meeting goals
 - 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 client'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 client 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 client 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 client by a speech-language pathologist.

The client's rehabilitation responses and progress towards meeting goals must be documented after each contact and reviewed semi-annually at minimum. If more intense rehabilitation services are required, the AIDS Adult Day Health Care Program program will collaborate with the Managed Care Organization/primary care provider.

Exercise groups may be offered, as appropriate to the clients' 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.

ACTIVITIES SERVICES:

GUIDELINE: The AIDS Adult Day Health Care Program can provide an on-site activities program. (Parts 759.8, 425.14)

DESCRIPTION OF SERVICES: The goals of the activity program are:

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

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

A monthly and daily calendar must be produced informing both clients 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
- Functional strengths and limitations (such as chemical dependency, financial constraints, or altered physical status) as they relate to clients' ability to participate in an activities program
- Linkage to Home and Community Based Services

The initial assessment should conclude with a list of needs which will be utilized in collaboration with the interdisciplinary team to develop and execute person-centered service plans, 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.

PASTORAL CARE:

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

DESCRIPTION OF SERVICES: For many clients, having a spiritual connection can be a source of strength, hope and a means of comfort. Thus, the availability of pastoral care services, on site or by referral, can help clients with a variety of needs:

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

On site services may include:

- Group pastoral counseling
- Bereavement support for clients and staff
- Memorial services and arrangements
- Family/crisis intervention
- Clients pastoral counseling

QUALITY ASSURANCE/IMPROVEMENT:

GUIDELINE: The AIDS Adult Day Health Care Program administrator is accountable and responsible for implementing a Quality Assurance and Quality Improvement program that assesses and improves the quality of the governance, management, clinical, and support services. (Parts 759.8, 425.22)

DESCRIPTION OF SERVICES: Three categories of health care characteristics can be used to monitor the quality of health care services provided within the AIDS Adult Day Health Care Program setting. These categories, structure, process, and outcome may be used respectively to address issues specific to resources, the AIDS Adult Day Health Care Program's ability to provide health care services, the way 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 client satisfaction. Outcome measures should examine how effective the AIDS Adult Day Health Care Program is in maintaining and improving health care services for clients.

The AIDS Adult Day Health Care Program is required to develop systems for Quality Assurance and Quality Improvement that describe quality objectives, organization, scope, and methods for determining the effectiveness of their monitoring, evaluation, and problem-solving activities.

Quality Improvement goals include but are not limited to:

- Measure and assess specific care processes
- Improve clinical and non-clinical outcomes
- Eliminate health disparities
- Improve health equity
- Enhance access to and availability of care
- Eliminate inefficiencies, errors and barriers
- Decrease stigma
- Increase patient and staff satisfaction
- Enhance communication and accountability

The scope of health care of the AIDS Adult Day Health Care Program must be reflected in the monitoring and evaluation activities; that is, all services provided to clients in the AIDS Adult Day Health Care Program are monitored and evaluated as an integral part of the quality assessment and improvement program.

The Quality Assurance and Quality Improvement program should target the following components:

- 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/Managed Care Organization, Health Home;
- Nutritional services;
- Social work/case management services;
- Substance use 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.

The AIDS Adult Day Health Care Program must have a Quality Assurance and Quality Improvement subcommittee that meets regularly to plan, implement, monitor, and evaluate Quality Assurance and Quality Improvement projects. The subcommittee should consist of the AIDS Adult Day Health Care Program Director, Quality Assurance and Quality Improvement subject matter experts, and representatives from the AIDS Adult Day Health Care Program staff.

The AIDS Adult Day Health Care Program must document all phases of Quality Assurance and Quality Improvement processes through meeting minutes, staff trainings, presentations, Quality Assurance and Quality Improvement tools, and output/outcome reports. Such documentation must be made available to the AIDS Institute during site visits and upon request.

AIDS ADULT DAY HEALTH CARE PROGRAM COMPREHENSIVE SITE VISITS:

GUIDELINE: The AIDS Adult Day Health Care Program administrator is accountable and responsible for ensuring AIDS Adult Day Health Care Program policies and procedures are implemented and operationalized in alignment with the AIDS Institute’s 2023 AIDS Adult Day Health Care Program Guidelines

DESCRIPTION OF SITE VISITS: AIDS Adult Day Health Care Program designation is renewed every two (2) years by the AIDS Institute based upon a successful site visit (either on-site or remote).

Site visits assess the AIDS Adult Day Health Care Program’s adherence to AIDS Institute standards and guidelines in the following key performance categories:

- Policies and Procedures
- Assessments
- Care Plans
- Progress Notes
- Interventions
- Quality Improvement Plan & Activities
- Home and Community Based Services Final Rule

AIDS Adult Day Health Care Programs will be given four (4) weeks advance notice of an upcoming site visit. All client records requested to be reviewed are to be prepared in digital format in an organized and accessible fashion. Following the site visit, the AIDS Institute will provide the AIDS Adult Day Health Care Program with a site visit report detailing strengths and deficits discovered during the review as well as areas in need of immediate remediation. AIDS Adult Day Health Care Programs in need of immediate remediation will be provided with a Corrective Action Plan outlining specific deficits discovered during the site visit.

For Adult Day Health Care Program’s assigned a Corrective Action Plan, a follow-up site visit may be conducted within six (6) months of the date of the site monitoring report to assess the Adult Day Health Care Program’s remediation of programmatic deficits discovered during the initial site visit.

The follow-up site visit may be less comprehensive in nature while targeting specific performance areas including but not limited to:

- Assessments
- Care Plans
- Progress Notes
- Interventions
- Policies/Procedures

Should the AIDS Institute discover continued deficits within key performance areas, the AIDS Adult Day Health Care Program will be enrolled into a collaborative Technical Assistance for six (6) months in duration. Please see Technical Assistance Program section for further details.

TECHNICAL ASSISTANCE PROGRAM

GUIDELINE: AIDS Adult Day Health Care Programs may be required to participate in a Technical Assistance program led by the AIDS Institute contingent upon site visit findings.

DESCRIPTION OF PROGRAM: The AIDS Institute's Technical Assistance program for AIDS Adult Day Health Care Programs seeks to establish a collaborative environment to ensure AIDS Adult Day Health Care Programs meet programmatic standards in an effective and efficient manner to ensure client's needs are met on a consistent basis. During the Technical Assistance program, AIDS Adult Day Health Care Programs should follow **SMART Goals** while drafting plans to address program deficits. **SMART Goals** are **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**ime-bound.

Technical Assistance Methodology

- Following each AIDS Adult Day Health Care Program site visit and follow-up site visit, the AIDS Institute team compiles all qualitative information gathered and evaluates the Adult Day Health Care Program based on the following key performance areas:
 - Policies and Procedures
 - Assessments
 - Care Plans
 - Progress Notes
 - Interventions
 - Quality Improvement Plan and Activities
 - Home and Community Based Services
- The AIDS Institute team deliberates on each key performance area in an assessment of overall quality, consistency, and timely completion of programmatic components. Technical Assistance determinations are based on the outcome of the assessed areas.

Tiered program levels I, II and III:

- **Tier I AIDS Adult Day Health Care Programs require six (6) month Technical Assistance; One (1) conference call held at one (1) month, three (3) months, and six (6) months.** Tier I AIDS Adult Day Health Care Programs have partially met, and unmet, program standards assessed during AIDS Institute site visits. Partially unmet standards may include items such as lack of detail and incomplete person-centered Plan of Care, inconsistency in completion of Progress Notes and Group notes, incomplete Assessments, or unclear relevance of client Interventions. The Technical Assistance Corrective Action Plan Tool will identify such areas needing improvement.
- **Tier II AIDS Adult Day Health Care Programs require six (6) month Technical Assistance; conference calls for three (3) months and one (1) follow-up call held at six (6) months.** Tier II AIDS Adult Day Health Care Programs have partially met, and unmet, program standards assessed during AIDS Institute site visits. Partially unmet standards may include items such as lack of detail and incomplete service plan, inconsistency in completion of Progress Notes and Group notes, incomplete Assessments, or unclear relevance of client Interventions. The Technical Assistance Corrective Action Plan Tool will identify such areas needing improvement.
- **Tier III AIDS Adult Day Health Care Programs require six (6) month Technical Assistance; conference calls for six (6) months.** Tier III AIDS Adult Day Health Care

Programs have significant unmet program standards assessed during AIDS Institute site visits. Multiple critical programmatic components are unmet and lack consistency and quality of completion. This may include several client records with missing progress notes, missing assessments, lack of detail, and incomplete client service plans, or an inadequate program oversight infrastructure for Quality Assurance and Quality Improvement. The Technical Assistance Corrective Action Plan Tool will identify such areas needing improvement.

CENSUS REPORTING

GUIDELINE: The AIDS Adult Day Health Care Program administrator is accountable and responsible for ensuring the AIDS Adult Day Health Care Program completes and submits quarterly Census Reports to the AIDS Institute for the purpose of monitoring program utilization.

DESCRIPTION OF REPORTING: AIDS Adult Day Health Care Program reports are due on the last Friday of the month which *follows* the end of the reporting period. For example: Quarter one (1) report consists of data from January, February, and March. Therefore, Quarter one (1) reports are due on the last Friday of April. Quarter two (2) report consists of data from April, May, and June. Therefore, Quarter two (2) reports are due on the last Friday of July. Quarters three (3) and four (4) follow suit for the reporting year. The AIDS Institute has provided each AIDS Adult Day Health Care Program Administrator with a formatted Excel reporting template via the Health Commerce System.

The AIDS Institute will compile and analyze the reports to support policy decisions, inform stakeholders, and allocate resources. The AIDS Adult Day Health Care Program is encouraged to utilize the reports for managing internal mechanisms and processes as well as to inform Quality Assurance and Quality Improvement projects.

COVID-19 RESOURCES

The COVID-19 pandemic required AIDS Adult Day Health Care Programs to modify policies and service provision to safely work with clients while adhering to federal and state guidelines during the Public Health Emergency. The Public Health Emergency ended on **5/11/23** and it is expected all providers amend internal policies accordingly while continuing to adhere to safety recommendations.

The most current information on COVID-19 can be found at:

[CMS Nursing Home Visitation Guidelines \(Revised\)](#)

[CDC COVID-19 Guidance](#)

[Core Principles of COVID-19](#)

[COVID-19 Recommendations](#)