DOH Memorandum

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Subject: Supplement to DOH Memorandum 86-32 Update of Program Standards For Designated AIDS Center Hospitals

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Background

Department of Health Memorandum 86-32, dated March 1986 and titled "Request for Applications for Designation of AIDS Centers", set forth the initial administrative and clinical service prerequisites for hospitals to become AIDS Centers. These AIDS Center program requirements reflect the coordination of a full continuum of health and human services from a hospital-based program.

Since 1986, however, there have been several significant changes in the HIV epidemic which have had a direct effect on the evolving implementation of this program. In the second decade of the epidemic, community and provider education, along with widely available HIV counseling and testing allow those who are infected to be identified long before they become symptomatic. In addition, early treatment and improved clinical care have greatly extended both the asymptomatic and symptomatic periods. Consequently, HIV infection is now considered to be a chronic, long term disease. The median time from infection to CDC-defined AIDS is 8 to 10 years, with survival even after AIDS is diagnosed being several years.

In terms of absolute numbers of patients requiring medical management and social support, these developments challenge the AIDS Centers to respond effectively to the needs of persistently increasing caseloads. The small 20 bed "AIDS unit" that was an appropriate approach to organizing services within AIDS Centers in the first decade of the epidemic is no longer responsive to a daily census that may approach and frequently exceed 100 patients in some of the larger Centers. A more systemic, hospital-wide approach to organizing and allocating acute, chronic and primary care resources is increasingly necessary.

Development of Revised AIDS Center Program Standards

In 1991, administrative and clinical representatives from the AIDS Center hospitals were convened to evaluate the existing program standards as summarized in DOHM 86-32 and recommend modifications to address these evolving program needs. These recommended standards were widely circulated to the AIDS Centers, the hospital associations and other interested parties. Comments received from all parties have been incorporated into the current program standards and interpretive discussions presented below.

The existing regulations in 10 NYCRR, Section 405.22 (g) & (i) continue as the foundation of the AIDS Center program. The original standards of care explained in DOHM 86-32 represent a summary of these regulations, emphasizing certain program elements over others. The program elements described in this memorandum further supplement the original AIDS Center program standards, placing new emphasis on issues that AIDS Center administrators, case managers and clinicians have identified as having increased significance during the second decade of the HIV epidemic.

Summary of Significant Changes

- Expanded discussion and clarification of existing standards in light of evolving clinical and program experience, especially in the areas of:

  - Organization of HIV services (Standard 1)
  - Patient and staff education (Standard 11)
  - Infection control, occupational exposure management and employment of HIV-infected health care workers (Standard 13)

- Integration of Pediatric/Maternal HIV Services into overall AIDS Center program requirements; as explained in DOHM 89-95, both symptomatic and asymptomatic infants, children, adolescents and pregnant women are eligible for AIDS Center services, including children less than 15 months of age whose HIV status

- Increased emphasis on coordination of care and linkages to other community providers (refer especially to Standards 3, 9 and 17 for outpatient services, community education and case management)

- Specification of core clinical services for AIDS Centers (Standard 2)

- Access to investigational new drugs (INDs) is referenced in the clinical research standard (Standard 14)

- Revision of case management standard (Standard 17); incorporation of previously separate standards addressing: crisis intervention, housing, home care, nursing facility care and hospice. The revised standard:

  - clarifies inpatient case management program components, emphasizing patient assessment, multidisciplinary team care, crisis intervention, initial service plan development and discharge planning;

  - clarifies outpatient case management program components and defines more narrowly those patients requiring the development and implementation of a comprehensive, long term service plan by the hospital-based case manager and,

  - emphasizes coordination of case management services in inpatient, outpatient and community-based settings to enhance effectiveness and minimize duplication of efforts.

- Explicit inclusion, or significant expansion within the program standards of the following:

  - Substance abuse services (Standard 5)
  - Dental services (Standard 6)
  - Mental health services (Standard 7)
  - Nutritional services (Standard 8)
  - Community education (Standard 9)
  - HIV counseling and testing (Standard 10)
  - Data and information management (Standard 15)
  - Tuberculosis management (Standard 16)

Questions regarding these Designated AIDS Center program standards should be referred to:

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UPDATED PROGRAM STANDARDS FOR DESIGNATED AIDS CENTERS

Standard 1

Integrated and comprehensive services are provided on-site to all patients with clinical HIV illness.

Discussion:

To effectively and efficiently accomplish the goal of providing AIDS Center services to all clinically eligible patients, the designated AIDS Center hospital shall develop an organization plan for the coordination of all AIDS/HIV services being provided throughout the hospital. This plan shall also encompass the regulatory requirements for Pediatric Maternal HIV Services contained in 10 NYCRR, Section 405.22(i) which mandate subspecialty coordination between the hospital Departments of Medicine, Obstetrics and Pediatrics.

This plan shall specifically address the organizational arrangements to manage and monitor the coordination of inpatient and outpatient care throughout the hospital, including subspecialty services, case management services, HIV counseling and testing, prevention and education programs. Strategies to effect this coordination may include an HIV management or steering committee or designated managers to coordinate interdepartmental activities. At a minimum, the plan must describe the responsibilities of, and the structural and functional relationships and lines of communication between the AIDS Center Director, the AIDS Center Administrator and program staff and the:

- Hospital Medical Director
- Academic departments
- Hospital's central administrative authority
- Steering or executive committee
- Hospital-wide clinical services
- Patient admissions, ambulatory care
- Hospital financial management
- Hospital quality management authority to monitor that AIMS standards of care and program requirements are met.

The AIDS Center hospital shall develop policies and procedures that govern the administrative implementation of this plan.

In relation to this plan, the Department continues to view a discrete, dedicated unit as a highly desirable concentration of hospital resources, organized specifically for the delivery of enhanced clinical and case management services. A dedicated unit effectively provides both a clinical and administrative "home" to this hospital-wide, multi-disciplinary, interdepartmental program.

As the demand for AIDS Center services exceeds the capacity of the discrete unit, admission of AIDS Center patients to "scatter beds" will be necessary. For certain populations, such as children and adolescents, placement of the individual in an age-appropriate unit will take precedence over discrete unit placement. Ongoing, integrated and comprehensive medical, nursing and case management Center services must be delivered to these patients. Accordingly, the Department encourages a systematic approach to admitting patients to these scatter beds to facilitate the assignment of an AIDS Center physician and other staff necessary to provide these enhanced services.

STANDARD 2

The full range of clinical services appropriate for the care of patients in the AIDS Center hospital, more fully described in the Criteria Manual for the Treatment of AIDS and the Guidelines for the Care of HIV-infected Children and Adolescents, shall be provided directly or arranged through formal referral agreements.

Discussion:

At a minimum, all hospitals designated as AIDS Centers shall have the capacity to provide the following core clinical and subspecialty services Core Clinical Services: surgery, gynecology, neurology, psychiatry, dentistry, including oral surgery (refer to standard 6), critical care, radiology (including computerized tomography), ophthalmology and dermatology.

Subspecialty Services: infectious disease and pulmonary medicine, gastroenterology, rheumatology, nephrology, hematology and oncology.

If an AIDS Center has a Pediatric Maternal HIV Service, the hospital shall have onsite capacity to provide the core clinical and subspecialty services by staff with appropriate training in pediatric medicine and/or obstetrics, consistent with the hospital's certified services.

The following services should be readily available, although they need not be delivered onsite. If not provided onsite, formal referral agreements should be developed to assure the timely delivery of these services: obstetrics, pediatrics, neurodevelopmental developmental services, hemodialysis, nuclear magnetic resonance imaging, radiation oncology, neurosurgery and physical medicine and rehabilitation.

STANDARD 3

Ambulatory or outpatient services for screening, diagnostic and treatment services specifically for AIDS Center patients are provided.

Discussion:

It is expected that the AIDS Center will provide ambulatory HIV care services through a coordinated network of the hospital's own outpatient clinics and other community-based primary care providers, including private practitioners, community health centers and substance abuse treatment programs.

Central to this concept is a systematic approach to monitoring the continuity of care between inpatient and ambulatory services, whether provided onsite or on a referred basis. At a minimum, the AIDS Center should include the capacity to: 1) link AIDS Center patients to primary care and specialty clinics which can provide comprehensive ambulatory care and which participate in chemotherapy and clinical drug trials; 2) link clinical services with all modalities of substance abuse treatment, and; 3) identify and refer persons with known or suspected HIV infection from general outpatient clinics, walk-in clinics and the emergency room to appropriate ambulatory and inpatient AIDS Center programs. Reasonable efforts to accommodate each patient's preferred treatment venue and schedule of services should be made.

AIDS Centers having a Pediatric Maternal HIV Service (PMHS) should ensure that family-centered services, which promote coordination/collaboration between adult (including gynecology/obstetrics)

and children's services, are available in the ambulatory setting. The ultimate goal of these programs should be single-site access to comprehensive services.

AIDS Center hospitals also shall provide enhanced primary care services for persons with early or asymptomatic HIV infection, consistent with signing the "NYS Department of Health HIV Primary Care Provider Agreement".

STANDARD 4

Emergency services for the treatment of HIV-infected patients are to be available 24 hours a day.

Discussion:

The emergency services of the AIDS Center hospital should effectively promote: 1) the continuity of care of all patients being managed by the AIDS Center program, including the Pediatric Maternal HIV Service, who are seen on an episodic basis in the emergency service, and 2) link newly identified cases and patients with suspected HIV to the Center's program of comprehensive services.

To facilitate these goals, emergency service staff should be trained in the Center's protocols specific to the needs of HIV-infected patients, including HIV-positive children and pregnant women. A routine system of communicating emergency service reports on known or suspected HIV-infected patients to the Center should be established.

STANDARD 5

Substance abuse services are provided onsite and are integrated into multidisciplinary team planning.

Discussion:

The AIDS Center hospital is expected to provide onsite comprehensive substance abuse assessment, including laboratory screening. The impact of substance abuse on the family unit should be addressed and translated into the identification and delivery of needed psychological and social services, including child care and respite services.

The AIDS Center hospital should offer basic therapeutic interventions including, but not limited to, crisis intervention related to drug treatment, methadone therapy for patients already on prescribed therapy, psychological counseling, management of acute alcoholic and narcotic withdrawal and basic therapy for patients using crack/cocaine. Follow-up substance abuse services should be included in the patient's discharge plan.

Formal agreements must be available for providing the following services: inpatient drug and alcohol detoxification, methadone maintenance treatment programs, residential drug treatment programs, ongoing group support services, including both drug-free and drug-using, long-term psychological counseling and work rehabilitation programs.

The AIDS Center shall develop a preliminary treatment plan for the patient for the period the patient is in the hospital.

STANDARD 6

Dental services, including periodontics, oral surgery and pediatric dentistry shall be provided directly or arranged through formal referral agreements.

Discussion:

At a minimum, all hospitals designated as AIDS Centers shall provide emergency and urgent dental services to HIV-infected patients. Routine dentistry, including periodontics, oral surgery and pediatric dentistry should be provided onsite to the extent that they are currently offered to all other patients in the hospital. Specialty services should be readily available. Formal referral agreements should be developed to ensure their timely delivery.

STANDARD 7

A clinical psychologist or psychiatrist shall be a participating member of the HIV treatment team.

Discussion:

An initial cognitive and neuropsychological assessment, or neurodevelopmental assessment as appropriate for children, is available for all patients, either on an inpatient or outpatient basis. In addition, neuropsychological evaluation and intervention is recognized as an important component of clinical service for many patients with HIV illness. Periodic updates of each patient's cognitive function and psychological status should be recorded by a member of the multidisciplinary team at appropriate intervals, and follow-up psychiatric consultation should be requested as needed.

Direct participation of a clinical psychologist or psychiatrist in multidisciplinary rounds is encouraged to enable discussions of the changing psychological needs of patients during the course of their HIV infection.

STANDARD 8

A nutritionist shall be a participating member of the HIV treatment team.

Discussion:

As a member of the treatment team, the nutritionist will provide nutritional care to patients through assessment, counseling, monitoring of metabolic parameters, designing and evaluating nutrition care plans, and ongoing communication with the multidisciplinary team.

The nutritionist will serve as an information resource to AIDS Center staff, patients and their families regarding the nutritional aspects of managing HIV infection.

STANDARD 9

Within the community that constitutes its catchment area, the AIDS Center shall sponsor programs that increase awareness of the modes of HIV transmission and the means of HIV prevention, as well as knowledge about HIV-related services offered by the hospital and other providers within the community. In addition, the center should be proactive in strengthening provider linkages across the continuum of care.

Discussion:

The AIDS Center shall cooperatively participate, along with other HIV medical and human service providers in its catchment area, in community educational planning programs.

The ultimate aim of such programs is to make the population aware that HIV is a problem within the community, advise the community of prevention strategies, and inform the community about local resources for services such as: HIV counseling and testing; peer support groups; case management services; health care services and other HIV-related services which are available.

The AIDS Center shall additionally sponsor programs for the education of primary care practitioners in its community, including pediatricians, obstetricians, and dentists, with the goal of increasing the sophistication and number of clinical providers to HIV-infected persons.

Formal and informal linkages (networks) between community providers and the ADC shall be promoted. AIDS Centers will support community nursing facility, day health care, home health care, hospice and primary care providers not only through ongoing clinical education, but also by providing needed ancillary support such as diagnostic radiology. Referral relationships shall be developed with: a.) one or more nursing facilities, certified home health agencies and hospices to meet the post-discharge and ongoing medical and functional needs of patients, and; b.) community-based HIV primary care providers for acute care back-up and certain referred ambulatory services not available to patients at the primary care site.

STANDARD 10

Confidential HIV counseling and testing services should be readily available to all patients and staff. Off-site referral arrangements should also be readily available when appropriate.

Discussion:

All hospital patients and staff should be made aware that confidential HIV counseling and testing is available on site. Specific targeted HIV counseling and testing programs shall be available to patients seen in settings such as STD & Family Planning clinics, drug treatment programs, obstetrical clinics, and inpatient obstetrical services (as demonstrated through the DOH Obstetrical Initiative). These programs should include one-to-one educational/counseling sessions to promote informed decisions regarding HIV testing.

Designated staff shall be appointed to implement the counseling and testing program to ensure that confidential practices are maintained in accordance with Public Health Law. Furthermore, the hospital shall ensure that all individuals performing counseling and testing have been trained in accordance with Article 27F of the Public Health Law.

STANDARD 11

Ongoing HIV educational and support programs are provided to all regular and volunteer hospital staff, patients and their families.

Discussion:

The AIDS Center shall develop and provide ongoing in-service education programs for all hospital personnel which address the medical and psychosocial needs of multiculturally diverse patients with

HIV disease, confidentiality and legal issues (in accordance with Public Health Law), and the impact of HIV disease on the family unit.

It is expected that, as an AIDS Center, all hospital staff will receive an appropriate orientation prior to providing care to patients to sensitize them to the problems of patients and families affected by HIV disease and to prepare them to meet the needs of patients. AIDS Centers should incorporate concepts related to family-centered care into their educational programs.

Ongoing educational programs should reflect current treatment modalities and the changing needs of multiculturally diverse patients and their families. Clinical and public health issues such as substance abuse and tuberculosis as cofactors in HIV treatment and prevention should be addressed specifically.

Because of the challenges and potentially overwhelming emotional toll of providing care to patients with HIV disease, ongoing stress management and psychosocial support shall be offered to all hospital staff caring for patients with HIV disease. Stress management should be incorporated into the educational programs, and ongoing crisis counseling and support services for staff should be provided.

Patient education programs should operate on at least two levels. Posters, pamphlets, and audio/visual materials concerning HIV/AIDS should be visible and available to all patients in the hospital. These materials should stress a variety of themes, including strategies to prevent HIV transmission, opportunities for and the value of early clinical intervention and basic epidemiological information about HIV. The language, message and emphasis of the materials should be appropriate to the hospital patient population.

Hospitals that are designated as AIDS Centers should provide more intense, targeted education to patient care sites in the AIDS Center hospital where high HIV seroprevalence may be expected. AIDS Center program staff are expected to coordinate this activity within the hospital. These areas will include, but are not limited to, STD clinics, drug treatment programs, HIV inpatient and outpatient services and prenatal clinics.

These programs should contain patient-appropriate materials regarding modes of HIV transmission and specific methods to prevent HIV transmission and exposure.

Whenever practical, AIDS/HIV information packets should be provided to each patient who utilizes these services within the hospital. The ultimate goal of this program is to speak to each patient personally about HIV prevention issues and about counseling and testing opportunities on site and elsewhere (refer to Standard 10).

STANDARD 12

A quality of care review program which includes a review of the appropriateness of HIV services provided throughout the hospital is developed and implemented as an integral part of the AIDS Center program.

Discussion:

The AIDS Center staff shall participate in the evaluation of the quality of care provided to HIV-infected patients. Specific quality of care assessment protocols for HIV-infected patients should be developed and monitored with active participation by AIDS Center staff. The AIDS Center quality of care review program should be an integrated part of the hospital Quality Assurance system.

The HIV quality of care review program shall address specific areas identified by the peer review process (AIMS). The goals of this program shall include continuous quality improvement of patient care, and identification of target areas for continuing education programs.

STANDARD 13

Policies and procedures for infection control, occupational exposure to HIV and for employment of HIV-infected health care workers are developed, based on currently available scientific evidence about HIV and its transmission, and implemented as an integral part of hospital services.

Discussion:

Federal and State legislation regulations and guidelines shall be considered in the development of hospital-wide policies and procedures, including policies for:

- Infection control that include initial orientation and continuing education and training of all health care workers on the epidemiology, modes of transmission, and prevention of HIV and other blood-borne infections and the need for routine use of universal precautions for all patients;

- Occupational exposure management, with policies regarding 24 hour employee access to medical and psychological management of exposures, comprehensive and continuing medical and psychological follow-up services, including long term counseling, and financial responsibility for the medical and psychological management of exposed workers, including payment for post-exposure drug prophylaxis;

- Employment of the HIV-infected health care worker.

AIDS Center representatives should participate in infection control, environmental safety and other hospital committees responsible for the development and implementation of policies and procedures that address these issues.

STANDARD 14

The Designated AIDS Center shall facilitate access to clinical research programs, including those for investigational new drugs (INDs).

Discussion:

Since treatment for HIV infection and AIDS continues to evolve, it is essential that AIDS Centers be linked to state-of-the-art clinical treatments and that AIDS Center staff are knowledgeable about investigational drugs that are under study for the treatment of HIV infection.

Physicians in designated centers should be aware of AIDS Clinical Trial Groups and research protocols, including those for drugs for compassionate use, both in their centers and in other hospitals for which their patients may be eligible. Those hospitals which do not offer clinical trials should have close linkage with hospitals in which these protocols are available.

AIDS Centers should have policies for managing patients on protocols who are admitted, including notification of the investigator.

For pediatric patients, access to clinical drug trials may be their only access to therapy; accordingly, it is critical that these trials be available to them. Policies and procedures should be developed and implemented to facilitate such access, including access by children in foster care.

STANDARD 15

The AIDS Center shall have an information management program with the capacity for monitoring and analyzing case-specific records that include, at a minimum, basic demographic information, clinical staging of HIV infection and CD4 counts, as well as admission/discharge, inpatient and outpatient utilization data for all HIV-related diagnoses.

Discussion:

This information management system should be designed to be consistent with institutional objectives, including monitoring HIV service delivery, financial and strategic service planning, as well as complying with specific data requirements of the AIDS Intervention Management System (AIMS.)

The AIDS Center should have ready access to these data, in accordance with internal objectives and uniform program reporting requirements developed by the AIDS Institute and implemented through AIMS.

STANDARD 16

Specific procedures and protocols are developed for the management of HIV-infected patients exposed to or co-infected with tuberculosis.

Discussion:

The hospital shall have specific policies for: the management of tuberculosis, including policies for the clinical diagnosis, prophylaxis and treatment of M. tuberculosis infection; identification of household and family members of infected patients, with appropriate referral for tuberculosis screening; ensuring adequate airborne isolation for individuals suspected to have pulmonary/laryngeal TB; investigation of possible nosocomial transmission; occupational exposure to M. tuberculosis; and, the identification, management and containment of resistant tuberculosis. (Refer also to Department of Health Memorandum 92-07, "Control of Tuberculosis in Hospitals".)

STANDARD 17

The AIDS Center is required to ensure that each eligible patient receives case management services, including at a minimum a comprehensive assessment of medical, social and psychological needs and a plan for appropriate follow-up services, coordinated by a designated case manager and developed in consultation with the patient and/or patient designee. The case management services, as further described below, must encompass coordination of multidisciplinary care, the provision of crisis intervention, counseling and referral/service linkages, and discharge planning.

These services must address the patient's identified needs in the context of his/her personal support network for both inpatients and outpatients. AIDS Center case managers must ensure coordination of these services in inpatient, outpatient and community-based settings.

Discussion:

All AIDS Center inpatients should receive case management including the following components:

a) Intake/Assessment/Reassessment

On first admissions, meeting the criteria defined in AIDS Institute guidelines, an intake and comprehensive assessment of medical, social and psychological needs to determine service needs and available support systems, and whether there is an outpatient or community-based case manager who should be consulted.

On readmissions, as specified in the guidelines, meeting the following criteria, a comprehensive reassessment to update service needs, available support systems, and information concerning other case managers to be consulted.

b) Multi-Disciplinary Team Care

Documented multi-disciplinary team care including meetings of all disciplines (clinical and ancillary personnel as more fully described in Standards 2, 5, 7, 8) appropriate to the needs of the patient, including the designated AIDS Center case manager whose primary role is coordination of care and services for the patient.

c) Crisis Intervention, Counseling, Service Plan Development

Documented crisis intervention, counseling and service plan development appropriate to the needs identified during the assessment process, and coordinated with any other involved case managers.

d) Discharge Planning

Discharge planning coordinated through the case manager, which is in compliance with all applicable rules and regulations and provides for the patient's post-hospital needs, which may include home health care, personal care and homemaker services, tuberculosis management, adult day care, nursing facility care, hospice, residential, living services, or specialized services for children and families, such as day care, foster care, adoption, developmental and education services.

Discharge planning includes all activities necessary to arrange needed services for the patient, including completion of any necessary applications for services, contacting agencies and scheduling first date of service and following-up to ensure delivery of services post-discharge.

All AIDS Center outpatients should receive case management services as follows:

a) Intake/Assessment

For any outpatient new to the AIDS Center, the outpatient case manager conducts an intake and comprehensive assessment of medical, social and psychological needs, to determine needs, available support systems and whether there is a community-based case manager who should be consulted.

For any former AIDS Center inpatient, the outpatient case manager reviews the patient's record and, in consultation with the patient, communicates with any involved case manager (inpatient or community-based) and assesses current needs and available support systems.

b) Multi-Disciplinary Care Coordination

All AIDS Center outpatients should receive documented assistance in coordinating care provided by multiple disciplines. This assistance includes coordination of appointments, follow-up for missed appointments and sharing of relevant information among care providers and with a community-based case manager, as appropriate.

c) Service Plan Development, Implementation, Monitoring and Periodic Reassessment

Comprehensive, long term case management as defined in guidelines developed by the AIDS Institute in collaboration with providers, is required for outpatients who have needs for assistance with any of the following: housing, substance abuse treatment, social service entitlements, mental health services, home care from other than a certified home health agency, or negotiating the health and human service delivery system resulting from the lack of an intact support system, and are not currently receiving comprehensive case management from an identified case manager in the community (i.e., from any of the following providers: long term care facility, HIV adult day care, certified home health agency, HIV community service program or other community-based organization, COBRA community follow-up program).

Comprehensive case management for outpatients meeting the above criteria may be provided by the AIDS Center case manager or, with the patient's agreement, by assisting the patient in linking with a community-based case manager. It should be noted that as an AIDS Center patient receiving case management services in the community advances to more serious illness, it may be appropriate for this responsibility to be assumed by the AIDS Center. This option should be offered to the patient.

d) Crisis Intervention

All AIDS Center outpatients should receive documented crisis intervention services to assist in addressing immediate problems presented during the course of outpatient medical follow-up.