Feedback from a Coalition of Ohio's ADS Providers
for Clarifications on the Adult Day Services Order/Guidelines

Thank you for this opportunity to review the areas on which we are seeking clarification from this week's ADS order/guidelines. Our comments begin with clarification on topics surrounding our clients, then moving to those about staff and, finally, ending with concerns/issues about the sustainability of the ADS model.

I. Challenges of a joint order for Adult Day and Senior Centers

Providers are wondering if it makes sense that Adult Day Centers and Seniors Center Guidelines are in the same order and feel it may be better to separate these guidelines. These are two different types of services; while there is some overlap, there are significant differences too. For example, 9 b vi – This pertains to senior centers more so than adult day centers, as participants of ADS can choose which activities they wish to participate in; activities at a Senior Center are typically at a set schedule of time.

II. Comments

Comorbidities

- Significant numbers of older adults have chronic medical conditions that place them at-risk, and most adult day participants fall into this category. Furthermore, senior centers are typically NOT gathering this information about their participants, as it is private health information. For those settings, these questions are an invasion of privacy and we believe that we must respect the dignity and choice of capable older adults in assessing their risk. For adult day, participants/families may be more accustomed to providing this information.
- Does the Department have recommendations on who should determine if a participant has a health condition that places them at-risk (and should be excluded from this phase of reopening)? Is it the adult day center, the nurse, a doctor, case manager? ADS centers are not able to consider the current health condition of a client, since they will have been closed for 6 months and have not been able to evaluate the client. From a liability perspective, we would like to make sure the correct person is gathering this information.
- DODD developed a communication tool for the assessment of risk in a participant returning to service. The tool does not necessary exclude an individual but allows all members of the "team" (provider, family, etc.) to discuss risk verses benefit in a participant's return. Health of the individual is a significant factor in the discussion as well as the need for supervision during the day, socialization, etc. A similar tool would be helpful for our aging population.

Screening, entry & log

- Please provide a rationale for the mandatory phone call before arriving at the site. This is an extremely time-consuming process, and not as reliable as on-site

screening. With DODD, providers can rely on participants' self-assessment. For childcare facilities, many have screened individuals for temperature and symptoms at the door/prior to entering the building, with success. Under the order, 9 a iv 3 – telephone prescreening – the link does not work. Is there a timeframe as to when this should occur?

- In lieu of a log, can a facility document in each person's personal chart?

Large groups/gatherings

- Are we following the 10 individuals in a congregate setting rule, including staff?
- Under 9bii, what constitutes "large group events"?

PPE and facial coverings

- Does cognitive impairment fall under the exceptions for mask use for "health reasons?" For individuals who have cognitive impairment, wearing a face mask could be challenging. If ADS centers encourage or require all participants to wear a face mask, it may provide difficulty for some individuals and make reopening an impossibility. As previously mentioned, it will force an even smaller census and lower revenue.
- Providers are also wondering if there a minimum recommendation of adequate PPE supplies and equipment within the facility?
- Are there official recommendations on what constitutes a sanitation station? Is a sanitation station simply a hand sanitizer dispenser?
- Cost/access to gowns and shields needed repetitively for toileting assistance will add significantly to PPE needs.
- The language in the order was limited to stating that participants "unable to wear masks" were not allowed during the "initial phase." Are we to assume that this means that masks must be worn at all times (except for eating) or are there exceptions?

Social distancing

- Providers are seeking clarity regarding social distancing requirements.
- Is the six-foot distance a requirement *to use best practices* or is it mandated? Especially in regards to individuals with dementia or DD, despite best efforts by providers, providers cannot guarantee that all individuals will maintain this distance at all times given the cognitive barriers. 6-ft distancing is impossible for persons needing to be assisted with toileting, bathing, eating, and other basic human services.
- With ADS centers being gathering sites for seniors, are providers able to use plastic barriers if participants are not six feet apart?
- Is there a formula ADS will be required to follow to determine limited capacity that complies with safe distancing related to 6 feet? Is this only when participants are sitting or should providers look at the square footage of a space and determine the social distancing based upon square footage?
- "Discretion of the facility" is much too loose – providers would prefer firm guidance so they can stay in compliance, similar to what we have seen with childcare facilities.

Cohorting

- Is it mandated or optional to have a specific room for staff or participants who may be COVID-positive?

Cleaning

- The order states it is mandatory to have a hand washing station at the entrance, but many sites are not configured that way. Would it be acceptable to directly walk individuals to the handwashing station upon entry? As noted under the PPE question above, is a sanitation station simply a hand sanitizer dispenser?
- Sign-in stations also present complications; many ADS centers require this – should they discontinue the practice, or is sanitizing between signatures sufficient?
- Will there be specific recommendations on how often to "frequently perform enhanced environmental cleaning" (e.g. every 2 hours?) Shortages and cost increases of hand wipes and other cleaning supplies are also a factor for providers, so any opportunity to obtain these affordably would be welcome.

Transportation (9.e.)

- Curb-to-curb pickup is not feasible for this population. They need "through the door" support, and many aging services providers have been providing this transportation throughout the pandemic—for example, to dialysis or other medical appointments. Non-ambulatory participants cannot be expected to maneuver out of homes without assistance.
- Should drivers also be tested?
- In lieu of the morning phone call, can drivers be required to conduct the same temperature/symptom screen prior to allowing a participant board the vehicle?

Note: Third-party transportation providers will need similar screening and stability of drivers to sustain the limited cohort of exposure

Testing

- While we support the concept of testing and recognize its benefits, we are very concerned that the State has not yet shared how it will support ADS centers in testing, either through support in connecting with testing supplies and labs, or financially in terms of paying for it. With the lag in testing results, it seems nearly impossible that a provider would be able to operationalize this requirement and receive staff testing result by September 21. Furthermore, there are questions about the frequency of testing, the type of tests that would be deemed acceptable, who would administer tests and transport them to labs, how employees would communicate results and how providers would be asked to interact with local health departments, that all remain unanswered.

Staffing & workforce questions

- We are concerned about the impact of any future closure on staff. We believe that closure should only happen for a confirmed case—not an exposure/not yet confirmed.
- If a facility opens and must re-close, are staff eligible to again get unemployment if laid off?
- Will facility staffing requirements remain the same as pre COVID levels?
- Related to sick leave policies mentioned in 8b ("ensure sick leave policies are… non-punitive"), please provide clarification. Does this mean retaining employment while an employee is self-quarantining or ill? If they are ill, does this allow for FMLA or do we need to retain (long-term) an individual not eligible for FMLA? Is allowing time off (unpaid) enough or is paid sick leave expected?

Infection rate in surrounding areas

- Naturally, there is concern that ADS will be closed again if numbers spike. Is there a specific number of cases or color-coded counties/surrounding counties that will cause ADS centers to be shut down again? Are there recommended levels within the Public Health Advisory Systems which should be used as guidelines for reopening and possible closures?
- Providers also have questions on hospital capacity. Can more clarification be provided about local hospital capacity, and where adult day providers can access county data to inform their decision? Is this in reference to the number of beds within the local hospital system(s) that are available and/or ability to treat COVID-19?

Financial Implications

- ADS is an effective, cost-efficient way to serve people, and saves the state money when compared to alternatives. The required reduced census, while necessary for safety, has a dangerous financial impact on ADS programming that is already woefully underfunded. Furthermore, most of the population served in ADS has comorbidities that place them at higher risk, and many have dementia and may struggle to wear a mask. While we understand these as necessary infection control measures, the real effect is that several adult day services have already closed in Ohio, and many (most) may not be able to open under these guidelines.

- Significant financial relief—whether through retainer payments or a PASSPORT rate adjustment-- is necessary to offset the impact of the reduced census, even temporarily. Financial relief should also include transportation issues, as the census/distancing requirements will be felt there, also. Ohio has done this in other similar settings, including Child Day Care and DD day services. Other states have made retainer payments to adult day providers during closure/low census periods. ADS providers operate on very tight budgets, so the additional costs associated with many of the items in the guidelines are not easily covered.

Survey & oversight

- New orders can produce new criteria for provider audits and surveys. Will the state's new order be a part of any future oversight for ADS centers? If an adult day center is not in compliance and putting participants at risk, who should be the contact person to report this information to? How is the state monitoring the cohorting in ADS centers?

Telehealth/remote services

- Are we to assume that remote and in-person ADS will continue to be allowed during this phase and if so, will there be additional reimbursement for this intensive service?
- It appears the guidance is still allowing services being provided remotely by recommending use of Zoom, skype and other platforms. Is that correct?

III. Other comments

- We suggest looking at the DODD guidelines for reopening allowing for partitioning, cohorts, etc. DODD has already done the heavy lifting here or many of these concerns; Their reopening guidelines have allowed providers to create fairly safe environments.
- Could ODA provide us with standardized signage to use, to cut the cost of having to recreate the wheel?
- We have not set eyes on our clients for 5 ½ months, and we are concerned they may now be unsuitable to attend the center and/or we cannot accommodate their needs. Does ODA have recommendations on reassessing these individuals?
- Prior to clients attending we will need to receive all updated authorizations prior to their return. Are Case Managers anticipating this, so they can deliver these timely?