ALE/CAADS' Guidance for Phased Transition to Congregate CBAS

Ready, Set -- Go!

Overview of Public Health Emergency Response by CBAS Centers

Initiation of Temporary Alternative Services (TAS) Through ACL 20-14 in March 2020:

Temporary Alternative Services (TAS) were initiated in March, 2020 by the State of California in response to the state and national COVID-19 public health emergency declarations (see *CDA ACL 20-14 CBAS Temporary Alternative Services (TAS) Guidance on Provision of In-Center Services*).

The COVID-19 pandemic created an immediate need to protect older and vulnerable adults, including the thousands of low-income individuals enrolled in Community Based Adult Services (CBAS), which is provided through licensed adult day health care programs as a Medi-Cal benefit. TAS was rapidly set into motion to serve as an emergency model of care, built on CBAS centers' comprehensive knowledge of chronically ill populations. By April 2021, 268 CBAS programs across the state had worked intensively for over a year to provide this alternative support to 37,764 participants and their caregivers isolated in community settings, thus ensuring their safety.

The Transition to Congregate In-Center Services Via ACL 21-04, Starting April 2021:

The release of CDA All Center Letter (ACL) 21-04, effective April 8, 2021, marks a turning point in TAS. ADHC/CBAS centers must now begin planning for resumption of center-based services and the re-establishment of full CBAS. ACL 21-04 essentially initiates the transitional period during which centers may continue to operate under the TAS flexibilities (as established in ACL 20-14 and modified through subsequent ACLs) while gradually resuming their usual ADHC/CBAS practices.

To ensure that centers address this challenge in a safe and orderly manner, a phased approach has been designed. As vaccinations increase and community conditions improve, centers will be able to work within the guidelines specified in ACL 21-04 to progressively restore in-center services, while providing the flexible support that participants continue to require. Centers can design their own plans and move somewhat at their own pace but must complete CDA's requirements by specified dates. This is intended to enable centers to respond to factors such as staff and participant readiness, current community spread, vaccination rates, the need to serve fewer participants at one time to maintain distancing, and transportation safety.

Should statewide conditions make it necessary, the target dates set in ACL 21-04 could change in subsequent ACLs. It is hoped, however, that case rates will continue to drop, and the path forward will be as smooth as possible.

CDA's deadlines for the completion of required steps:

By June 1, 2021, all centers must have submitted **CDA 7027** (the CBAS Congregate Center Services checklist) to their CDA Analyst.

- Program Directors (and/or designated staff) must prepare their programs and facilities according to the steps laid out in the 7027 Checklist**.**
- **Congregate in-center services are not allowed prior to CDA's approval of this document**. (Approval should be received within about a week after submission, per CDA, assuming that no correction is needed.)
- **Signing the 7027 form verifies that all of the referenced national, state, and local guidelines and safety measures have been read, understood, and implemented; , that centers have completed all steps and met requirements specified on the form, and that centers are now prepared to provide safe in-center services.**

Beginning with TAR dates of July 1, 2021 and each month thereafter through December 2021, the renewing **Treatment Authorization Requests (TARs)** that centers submit (either to their managed care plans or to the state) must include these items in the Individual Plan of Care (IPC):

- A care plan, specified in boxes 13 and 14, that includes:
  - The participant's needs, based on updated assessments completed by the MDT
  - The **in-center** and remote services to be provided in response
  - The anticipated start date for these services

- Summary information, in boxes 15 and 16, describing:
  - Other TAS (besides the services provided in-center and remotely that are described in boxes 13 and 14) that are needed by the participant, why these services are needed, and how these services will be provided.
  - Clear overall information about the participant's current status and the services that will be offered to them during this transition period.

By (no later than) October 31, 2021, all participants who will be returning to in-center services must be regularly scheduled for a minimum of one in-center day per week and should have begun regular attendance**.**

IMPORTANT: Further information will be provided at a future date regarding how to address participants who are not expected to return to in-center services yet continue to have medical necessity for CBAS.

The phased approach to the need to resume regular CBAS allowed through ACL 21-04 represents best practice planning akin to when centers were in their initial start-up periods, prior to opening for the first time.

It also reflects the reality that circumstances remain uncertain at this time due to the continuing emergency.

For this reason, centers should not rush to re-open congregate services on July 1, 2021 if they are not prepared or it isn't in their participants' best interests. But neither should they wait until October 2021 to begin providing regularly

scheduled in-center services. Instead, centers must begin by strategically planning how they will complete the requirements of ACL 21-04 while maintaining the ability to provide their participants with good support throughout the transition period.

> **Example:** The need to continue serving the full group of participants while conducting in-center assessments for those with renewing TARS may mean that centers will find it best to delay offering a regular four-hour program day. ACL 21-04 allows this. Instead, the center might choose to offer a modified program day, and/or to limit the number of days in the week on which in-center services are provided, beginning on the center's planned date to re-start these services.

Although we know many participants are eager to get back to their centers, some may be unwilling or unable to return immediately. Centers may need to approach these participants almost as though they are new to the program, due to physical and mental health changes that have occurred over the extended amount of time that has passed. The goal is to achieve safe, orderly progress toward a normalcy, consistent with the well-being of all participants.

Transition Phase A – Readiness Overview

CDA Requirements in Transition Phase A per ACL 21-04

As of April 8, 2021, centers must begin the strategic preparation of their facilities and staff teams to be ready to safely serve participants in-center using modified congregate services and TAS (as allowed under ACL 21-04).

Time Period for Phase A: April 1-June 30, 2021

Core Activities:

1) Strategic planning and preparation
2) Submission of required forms
3) Reassembling of MDT and other needed staff

The following form(s) should be updated and submitted to CDA before June 1, 2021 (June 1, 2021 is the absolute deadline):

- **ADH 0006** (revised 04/20) **Updated Staffing / Services Arrangements**, to reflect staffing changes that have occurred since the time of submission of the prior ADH 0006. This should include any related changes in staff hours.
- **CDA 7027** (04/2021) **TAS Congregate Center Services Checklist**, per CDA instructions to self-attest readiness to serve participants in the center

Phase A Requirements and Recommendations for Planning and Preparation:

During Phase A, all centers must begin good faith efforts to prepare for initiation of congregate services within the required time frames. Along with facility readiness, as specified in Form 7027, centers must consider staff readiness. Centers may need to initiate the return of furloughed staff or hire new staff to meet the modified transition period requirements, and thereafter must maintain staff in sufficient numbers to meet the health and safety and other needs of participants.

Since hiring can take time, staff planning and recruitment should begin as soon as is practical. Overall, centers must re-assemble staff teams such that they are able to fully engage the Multi-Disciplinary Team members needed to evaluate participant readiness to resume in-center services, determine priority needs, and conduct assessments and reassessments.

Expanded care planning must also begin (i.e., looking ahead over the usual six-month TAR period and identifying planned services to be provided based on participants' assessed needs). Group services should gradually be reinstated under safe specified conditions that may include capacity limits, distancing, wearing of masks and tracking vaccination levels for staff and participants.

Remember to continue to address emerging needs on an on-going basis along with the more usual development of 6-month care plans required in ADHC/CBAS.

These overall steps should be addressed in addition to and as part of the process of completing the required CDA forms listed above:

1) **Continue to follow appropriate safety precautions at all times**, based on the current status of participants and staff and local COVID-19 conditions.

2) **Ensure facility readiness** through the measures described in **Form 7027**, as well as by addressing other aspects of facility upkeep and the staging of participant care and activity areas that may be needed. (Example: Furniture may need to be replaced to make it easier to clean and sample furniture arrangements created that allow for 6-foot distancing in order to determine the modified capacity of program areas when following COVID safety guidelines.)

   Note that many aspects of Form 7027 must be maintained on an on-going basis after the form is submitted and approved. For example, the center must continue to address emerging guidelines and update policies and procedures as needed in response and ensure training of staff and new hires.

3) **Expand use of planned TAS modes of operation** to include in-center individual and group service provision.

4) **Ensure that TAS Teams includes all core team members and necessary disciplines to conduct evaluations, assessments, re-assessments, and direct services (RN, SW, Activities, PT, OT, ST, RD and LCSW)**, to ensure a comprehensive understanding of current participant status.

5) **Begin evaluating participants' conditions to identify priority needs to be addressed through in-center or other services with a focus on:**
   a. Needs for strengthening, reconditioning, fall risk mitigation
   b. Participant and /or family readiness to resume in-center services modified to fit the transitional phases.
   c. Transportation plan and ppts ability to embark/disembark and endure time on vehicle

Such evaluation may be conducted in-person in the center to the extent possible per the previously approved plan of operation and may also be done via telehealth or at the participant's home (either outside or within the home) as is most appropriate. (See ALE/CAADS Sample Triage Tool)

6) **Once CDA has approved Form 7027, begin conducting full participant assessments** as TARs are renewed, beginning with July TAR renewal dates.

7) **Return to completing Boxes 13 and 14** by adding transitional care plans that reflect the anticipated services to be provided on scheduled days in-center as well as services that are expected to be delivered at the home or remotely.

8) **For participants enrolled after March 15, 2020 (during TAS) who have never been assessed in person**, the following requirements must also be met:
   - ✓ TB clearance confirmed (For those now needing a TB test, tests should be administered no sooner than 5 weeks after a COVID-19 vaccination, if applicable)
   - ✓ Full MDT assessment (as if a new participant), as TARS are renewed

   Note: Assessments conducted for participants not previously served in CBAS do not have to be confined to three assessment days, and these assessments qualify as a TAS service. Assessments may be completed in the safest manner but should be as thorough as possible.

9) **Continue to evaluate and document the current status of each participant and provide continuing TAS in accordance with action planning** to address emerging needs while also identifying consistent care plans that can be addressed using TAS flexibilities for in-home, doorstep, remote and in-center services as described in ACL 20-14. *(CBAS Temporary Alternative Services (TAS) Guidance on Provision of In-Center Services).*

10) **Evaluate all participants for readiness to be transported and attend the Center on a regular or intermittent basis. Determine if participant is able**, to take part in safe programming to meet their medically necessary needs. Evaluation in this case means a process similar to what is needed for safely bringing participants back to center services after an extended illness or absence, i.e., evaluation of current status based on appropriate factors for each individual.

11) **Continue vaccination efforts**, including identifying and recording vaccination status, type of vaccine received, and when doses were administered (copy vaccination record card).

    For those not yet vaccinated, continue to encourage participants and staff to be vaccinated, using empathetic listening skills and factual information from trusted sources. Remember, "No" is not "never" and some participants need ongoing support through education about risks and benefits of vaccination.

Sample Checklist for Successful Completion of Phase A:

- ✓ Preparations required by Form CDA 7027 have been completed and Form 7027 has been approved by CDA.
- ✓ CalOSHA COVID-19 Safety Plan has been created and implemented.
- ✓ The center has set a start date for in-center service provision and designed what those initial in-center services will look like (for example: anticipated length of day; services to be provided; and numbers of participants to be served at one time.)
- ✓ Necessary staffing is in place, staff training has been updated, and an updated Staffing and Services Form has been submitted to CDA.
- ✓ Participants have been triaged for priority needs and readiness to resume modified in-center services and no participants are scheduled to begin in-center services until their current status has been evaluated.

- ✓ Transportation services are in place
- ✓ Participants with TARS renewing in July have been re-assessed and approved for continuing services by their managed care plans.

Transition Phase B - Overview

Time Period for Phase B: July 1 - October 31, 2021

Core Activities: Restore Modified In-Center Congregate Services and Reduce Out-of-Center TAS

Phase B Requirements and Recommendations for Service Provision

After receiving CDA approval, regular provision of congregate services may begin on the date selected by the Center, which should be based on a number of planning factors, including staff and participant readiness and community COVID-19 conditions.

Participants identified as ready be transported to the Center on a regular basis to take part in safe group programming will begin this during Phase B after a process of assessment and/or "evaluation," as follows:

- Starting with July 1, 2021, if the participant's TAR has already come up for renewal, the participant will have been fully reassessed, and services will be provided as described in their updated IPC.
- If the participant's TAR was not yet due for renewal, the center has evaluated and documented the participant's current status and needs and planned the services that they will receive in the center prior to serving them on a regularly scheduled basis. This evaluation process can be thought of as similar to how the center evaluates a participant who is returning to CBAS after an extended absence, such as a hospitalization or extended illness.

While centers have the latitude to select their own start dates for beginning regularly schedule congregate services, they should not postpone the reinstatement of modified in-center services without appropriate reasons.

For example, a center might identify a group of participants whose urgent needs can best be served through interventions provided in the facility. The center might also need to limit capacity in order to maintain distancing. As a result, the center might initially plan to schedule only this priority, high-acuity group for in-center services during a defined period of time.

The continued flexibility under TAS is based on the good faith assumption that all centers will conduct a thoughtful evaluation of their readiness, the COVID-19 disease environment and the person-centered needs of the participants and families being served.

Centers are strongly encouraged not to wait until the last minute to reinstitute in-center services.

Centers encountering challenges with their transition efforts should seek guidance from CDA and/or CAADS

PHASE B OPERATIONS

The following specific aspects of the requirements under which centers can or must operate during Phase B, during which the transition to regularly scheduled in-center service provision will take place, are important to understand:

1) **AUTHORIZED DAYS:** Each participant's total days on which either in-center or other modalities of TAS services can be claimed are the total days identified in the current IPC and authorized by the managed care plan.

   As always, centers should not ask for more days a week of service to be authorized than are actually needed by each participant and requests for change in days must clearly describe the need.

Example: A participant whose TAR renews July 1, 2021 may be assessed as needing 5 days a week of services due to living alone and lacking an IHSS provider, such that the center is providing meals, doing laundry, setting up medications, and meeting therapy needs on the doorstep through outdoor walks with the therapist.

The participant needs to resume their more usual therapy in the center once regularly scheduled in-center services start up again. For July, the center plans to provide all 5 days/week of service for this participant out of the center and through telehealth because in-center services are planned to resume on August 1st (to allow additional time for the full participant group to be vaccinated, for example, or because new staff need to be hired.)

The resulting care plan specifies 5 days a week of service. The detail of the care plan specifies the services that will be provided through telehealth and out of the center throughout July, as well as that, effective August 1st, this participant will return to in-center attendance 3 days a week while continuing to receive telehealth or doorstep services 2 days a week, based on continuing needs.

2) **EXCESS-ENROLLMENT DURING THE EMERGENCY:** If centers have added participant days during TAS in excess of the number they can serve under their licensed capacity, adjustments in requested days of service will have to be considered as in-center services resume.

   Consideration of these adjustments should begin as soon as possible because in-center services may initially resume at reduced capacity to maintain distancing. Some participants may be able to resume meeting their needs independently, (for example, being vaccinated creates a feeling of being able to safely go out and get groceries) and centers should help such participants to safely regain their previous independence. Each individual's current status and continuing needs need to be carefully considered.

Example of a Change in the Level of Need: A participant who lived alone became entirely isolated and at risk due to the pandemic. This participant previously handled their health conditions independently.

The managed care plan authorized the participant to receive TAS during the public health emergency because they couldn't safely use public transportation, attend regular medical appointments, or shop for groceries and supplies.

The participant has now deconditioned due to inactivity, however, has regained some independence. As their situation is reviewed, the center may determine that their current need is for in-center therapy and nursing three days a week, rather than the 5 days a week of TAS that was previously essential.

3) **CORE REQUIREMENTS:** While some core CBAS requirements are being waived during this transition period, such as the requirements for monthly therapy hours and the 4-hour minimum program day, Staffing requirements per Title 22 continue to apply:

   a. Sufficient staff must be present at the center to meet the staffing requirements defined in the 1115 Waiver Standards of Participation Attachment W, and based on the number of individual participants **being served in the center at the same time. At all times, however, the core standard is that staffing must be sufficient to meet the health and safety needs of participants.**

   b. Whether described in the ACLs or not, services necessary to the participant during their time in the center must be provided; for example, nursing and personal care assistance when needed.

   c. Nutrition services may be provided in a flexible manner (AFL 20-34) and are not required per se, however **must** be provided to meet participant needs.

      While the modified program day does not have to meet the usual 4-hour minimum ADHC/CBAS standard, if the participant is scheduled to attend the center throughout a period when they would normally eat, provision must be made to meet their needs.

Example: participant is scheduled to leave home at 9:30, attend the center from 10:00 a.m. to 1:00 p.m., and then have a half an hour ride back home. The need of this participant to be provided with a meal in this four-hour period must be appropriately met.

4) **REASSESSMENTS**: Re-assessments must take place on a rolling basis for all participants as necessary to update TAR Authorizations, and should be completed by the MDT per Welfare and Institutions Code §14529, and related Title 22 regulations and shall consist of at least:
    a. Personal physician or a staff physician, or both §54319
    b. Registered Nurse §54323
    c. Social Worker §54329
    d. Activity coordinator §54339
    e. Program director §54211

§**14529.** "At the time of reassessment, if an individual plan of care has been developed by the physical therapist or the occupational therapist, they shall reassess the participant to determine any ongoing or different needs for physical therapy or occupational therapy services.

If it is determined that no further physical therapy or occupational therapy is needed, the physical therapist and the occupational therapist shall not be required to sign the treatment plan. For further reassessments, the nurse or physician shall determine if the physical therapist or occupational therapist is needed.

The assessment team shall:
(1) Determine the medical, psychosocial, and functional status of each participant.
(2) Develop an individualized plan of care, including goals, objectives, and services designed to meet the needs of the person, which shall be signed by each member of the multidisciplinary team, except that the signature of only one physician member of the team shall be required.
(3) At least biannually reassess the participant's individualized plan care and make any necessary adjustments to the plan.
(4) If the initial assessment or any subsequent reassessment shows that restorative therapy is needed, acute rehabilitative treatment shall be provided by the appropriate licensed or certified personnel.
(5) If the initial assessment or any subsequent reassessment shows that restorative therapy is not needed, the multidisciplinary team shall determine whether the participant requires maintenance program services and if the team finds that the participant requires these services, the multidisciplinary team shall develop an individual maintenance program as part of the plan of care."

5) **INITIAL ASSESSMENT**: For the initial assessment, the multidisciplinary health team shall also include a physical therapist and an occupational therapist. In addition, when the need is identified by the MDT, qualified consultants in behavioral health, speech language pathology, or dietary assessment shall serve as team members.

6) **ALL ASSESSMENTS**: If the initial assessment or any subsequent reassessment shows that restorative therapy is needed, acute rehabilitative treatment shall be provided by the appropriate licensed or certified personnel. If the initial assessment or any subsequent reassessment shows that restorative therapy is not needed, the multidisciplinary team shall determine whether the participant requires maintenance program services and if the team finds that the participant requires these services, the multidisciplinary team shall develop an individual maintenance program as part of the plan of care.

7) **ACTIVITIES:** If the participant will be taking part in an in-center activity program, the activities must be based on an evaluation to determine safety.

8) **NUTRITION**: Identification by the RN or dietitian of any nutritional needs that should be addressed during the participant's in-center services, such as diabetic snacks.

9) **IN-CENTER SERVICES:** In-center services should be planned to include clearly identified services to address medical necessity and build the participant's ability to continue attending the center after initiation of full CBAS. These services should address nursing, social work. therapy and other needs, and services may either be provided only in-center, or through a combination of services provided at the Center and through other TAS modes. (Note that, just as during regular CBAS, assessments take place on a continuing basis to ensure appropriate support of the participant.)

10) **PARTICIPANTS WHO ARE *UNABLE* TO BE SERVED IN THIS WAY**, due to their current needs and conditions, *can be approved to continue to receive TAS through October 31, 2021 on the following basis*.

    TAS planning and services for these participants identifies a longer range plan that addresses one or all of the following:

1. If participant wishes to return to the Center and **appears capable of doing so after further help**:
    a. Then services are to be provided, either through the center (TAS) or through referral to another provider, to strengthen the participant, address any barriers, and aid their return to the Center.
    b. TAS can continue to be provided while the Center is addressing these needs and factors to make the participant's return possible.
    c. The IPC will specify how the Center plans to address this.
2. If participant wishes to return, however, **the participant's conditions and current status make it unlikely or impossible** that this can occur:
    a. Services can potentially be approved to be provided longer range through TAS
    b. These services should be clearly described in the IPC, along with the participant's needs
    c. These services should not be available through another resource that could fully meet the participant's needs (such as Hospice)

Phase C – (Additional Guidance to Come)

This is the final phase of the transition to providing a regular CBAS program.

Many questions remain to be answered as to timing of the end of the Public Health Emergency, and the status of participants unable or unwilling to use congregate CBAS at that time.

Further guidance is expected to come from the Department of Aging and the Department of Public Health and will be incorporated in further editions of this paper.