INTERAGENCY COUNCIL
of Developmental Disabilities Agencies, Inc.

Guidance, Considerations and Recommendations for the Safe Return to Engaging Adult Day Programs

(A complement to the guidance previously issued by OPWDD and DOH)

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Table of contents

Overview & Executive Summary

Over the last few months we have had to rethink old ways and maximize creativity to support the people in our residences and day programs. It has been necessary to implement virtual services and reassess practices that limited our flexibility. We are grateful for the accommodations afforded us by OPWDD and while we are still adjusting to the strain and restrictions imposed by the COVID-19 pandemic, we have learned a great deal and have developed new and effective ways to provide support.

These recommendations, developed by providers, families and self-advocates, is a set of suggestions for maintaining day services in the short term, incorporating the best of what we have learned to weather the current storm and get us through to the next steps, where we can incorporate our vision for the future.

This document is the beginning – we'll follow up with suggestions that we hope will be the foundation of a new future for I/DD supports and services. We have faith that together we can emerge stronger, better and smarter. This document contains specific suggestions in the following areas:

Infection Control

Our suggestions cover the areas of testing and tracing, face coverings, assessing individuals' risk in returning to in-person day services, surface and air disinfecting strategies, staff training, and daily health screening.

Supporting Individuals Returning to Programs

We suggest that providers conduct program participant surveys and have on-going conversations with the people supported to make sure that services are beneficial. Assess each person's need for re-entry support, provide program duration options, provide training in mask wearing, infection control and on new, required behaviors for community activities.

Transportation

Explore and make available many options for transportation including traditional contracted busing, family provided transport, paratransit options, ride sharing, enhanced travel training, and agency provided transportation including shared responsibility between residential and day services providers. It is essential to screen people, including temperature checks, prior to boarding vehicles. The increased potential for viral transmission while on the vehicle, risk of infection spread at the program site and issues surrounding transportation back home for sick individuals, dictates this precaution.

Support For Families

Both OPWDD and provider agencies must maintain an interactive dialogue with families. Providers should survey all families prior to opening and be sensitive to their concerns and need to return to their own jobs and activities. Safety plans and infection control policies should be posted on websites and updated regularly, virtual and/or in-person walk-throughs of facilities should be conducted as possible. Families should have a full range of program options available, including virtual and face to face services, Com Hab as needed, traditional site and community based day services with full and part time options. Families should receive support, as needed, to prepare their loved ones for the return to in-person services including support for mask-wearing.

Maintaining Services

We looked at financial and regulatory support for maintaining programs and services, including the restoration of retainer payments, reimbursement for a multitude of additional expenses including transportation, staffing, PPE, staff training, testing and infection control equipment and supplies. The paper covers recommendations for a new methodology for reimbursement of property costs, reduced utilization and the effect on re-basing, permanently reimbursing the ½ hour unpaid lunch period, flexibilities in hourly reimbursement add-ons and unit limits, plus the temporary suspension of rules regarding services provided in the community and more.

Program Modifications

We include suggestions for accommodations for fewer community opportunities, transportation limitations, innovative approaches to get supported employees back to work, the recognition that site capacity is severely limited, suggestions to ensure social distancing including managing restrooms, and more.

Staffing and Staff Training

We strongly urge that staff also be surveyed to ascertain and address concerns, to incorporate their knowledge in planning and to foster buy-in for new policies and procedures. Staff testing can be considered as long as there is adequate funding for this purpose. We anticipate staff shortages for a variety of reasons including required isolation and quarantine, child care issues, and more. Staff need training and support to develop new skill sets including activity planning and conducting virtual sessions.

Entry Services

We recommend collaboration in entry activities between providers, CCOs and DDROs and to streamline approvals for Day Hab services by eliminating the distinction between with walls and without walls programs. Until a vaccine and viable treatment options are available, we suggest provisional acceptance of program participants.

Blending Virtual and Face to Face Services

We have suggested a variety of ideas, platforms, equipment and collaborations, and emphasize that blended services should be maintained even after the pandemic to provide a variety of options for program participants and families.

We hope these suggestions provide a starting point for an ongoing collaboration among providers, associations and New York State government that will maintain and strengthen services for people with I/DD, now and for the future.

1. Infection Control

In addition to compliance with all OPWDD, DOH and other infection control guidance required, we recommend:

a. **Testing & Tracing**: Now that the infection rate has been brought under control, we suggest the State provide assistance for rapid testing for the presence of infection as indicated by symptoms, exposure, travel to restricted states, etc. We suggest the State provide assistance with antibody testing which could be conducted more widely in hopes that this will predict immunity and reduction in transmission of the virus. Testing should not be mandatory without a system in place to facilitate and pay for the requirement. Tracing information should be supplied by the Day Services provider and conducted by governmental entities.

b. **Face Coverings**: Providers should make a variety of types of face coverings available to increase comfort and compliance with mask wearing. Face shields are not as effective in preventing the spread of the virus but should be available for those unable to tolerate a mask or unable to tolerate full time mask wearing. N95 masks should be worn only when performing tasks that may increase the risk of infection due to the aerosolizing of viral particles and must be fit tested. N95 masks with breathing ports are unacceptable as they do not comply with required guidelines.

c. **Entry and re-entry** into the program should be based on objective criteria, considering each program participant's health status, ability to comply with infection control guidelines, the health status of housemates if the person lives in a congregate care setting and other risk/benefit factors.

d. **Buildings** should employ air disinfecting strategies wherever possible. Examples include UV lights installed inside HVAC ductwork, HEPA filtration of HVAC systems, ionizing units and foggers for air and surface disinfection. Providers should be reimbursed for expenses associated with equipment purchase, installation and maintenance.

e. **Provide staff training** on all CDC, OSHA, OPWDD, DOH and local health and mental hygiene department requirements including the proper use of PPE, hand hygiene and disinfecting high touch surfaces.

f. **Employ a multi-pronged approach to prevention:**
    i. Ask families and residences to screen each morning and attest that the program participant doesn't have a fever, hasn't been exposed to someone who tested positive, hasn't travelled to one of the restricted states in the last 14 days, and all the other questions that staff and others will be asked prior to program entry.
    ii. Programs may require families to provide a daily attestation or can include in the return/entry attestation, that they will update the program if any new risk factors are present.

iii. At a minimum, families and residences should take each person's temperature prior to them leaving the house.
iv. Bus or other staff should take each person's temperature prior to boarding the vehicle.
v. Program staff must take each person's temperature upon arrival to the program prior to entering, but a "cooling off area" should be provided, to allow time for program participants' temperatures to return to normal after hot bus rides, etc., prior to temperature taking.

2. Support for Individuals Returning to Programs

a. Survey individuals regarding their expectations, concerns and preferences about returning to services
b. Programs should maintain an interactive dialogue with individuals they support.
c. Assess each person's need for support regarding reentry. Anticipate anxiety, social/emotional and other needs.
d. Provide a shortened day for those who need to resume services slowly.
e. Train participants on how to wear a mask, remove a mask, maintain social distancing, hand hygiene, covering coughs, disinfecting high touch surfaces (as appropriate for the individual).
f. Practice infection control procedures during virtual sessions. Use various teaching strategies and include the support team, if applicable, to increase exposure and tolerance for wearing a mask.
g. To facilitate the community acceptance of those who are unable to tolerate wearing a mask, create a wallet card for program participants: "I have a disability that exempts me from wearing a mask"
h. Engage in activities to personalize a paper or cloth mask. Hold a "make your own mask" contest in person or via virtual means.
i. Discuss the importance of learning these new skills so individuals can get back to meaningful activities in the community.
j. Create a mini "certificate course" for these critical skills. Program participants who successfully complete the course can show the certificate to document they are ready to resume participation at volunteer and work sites in the community.
k. Provide a "cooling area" for program participants who are just arriving to the program and are overheated due to the trip, prior to temperature taking.
l. Staff should assess potential program participant skills regression during program closure.

3. Transportation

a. Transportation is one of the biggest barriers and finding solutions will require collaboration and creativity. We must work with each family to assess individuals' needs. The following are suggested transportation options:
    i. Traditional contracted bus transportation capacity is limited, however bus companies are working to ramp up services gradually. Reduced vehicle capacity will greatly increase the cost of bus transportation.
    ii. Share responsibility for transportation between day programs and residential providers.
    iii. Programs that have their own vehicles will incur new expenses including installing polycarbonate dividers, reduced vehicle capacity and infection control procedures and supplies. These additional costs must be reimbursed.
    iv. Investigate Access-A-Ride, SCAT, ABLE Ride
    v. Explore partnering with a ride sharing company like Uber or Lyft to provide transportation for both individuals and staff
    vi. If deemed safe and acceptable, travel training, including new infection prevention strategies could be offered to participants/families
b. Temperatures should be taken before individuals board the vehicle. No one with a temperature of 100.0 or higher should be permitted to board.
c. Explore the use of a spray coating (e.g. Bioshield) for vehicles that kills viruses and bacteria for 90 days.
d. Disinfect vehicles between each use. Ensure time between uses for disinfection.
e. Minimize contact between riders including loading the vehicle from back to front and exiting the vehicle from front to back

4. Support for Families

a. OPWDD should maintain an interactive dialogue with families.
b. Providers should maintain an interactive dialogue with families.
c. Surveys should be conducted with all families.
d. Providers should consider that parents have concerns over their own return to work and the need for day services for their children.
e. Families who's loved ones are exhibiting increased behaviors have more urgent needs for support and may be given priority for return to in-person services.
f. Program Readiness Considerations – work with families either in person or remotely to prepare program participants for return
g. To facilitate mask wearing, send masks to families with instructions, to teach program participants how to use masks prior to resuming in-person services.

h. Assure families that all infection control guidance is being followed, share safety plans, do virtual walk-throughs of the program space or in person walk-throughs after program hours if the provider can accommodate. Post all information on websites and update frequently.
i. Families should be fully briefed on reopening plans and time frames.
j. Assess each program participant's risks/benefits for returning, in collaboration with families– those with lower risk factors should be considered first.
k. On testing Individuals/staff – the value of testing is not clear, provide education to families on types of testing and the benefits of each.
l. Families should have options:
    i. Face to face and virtual day services in residential programs and family homes
    ii. Com Hab
    iii. Traditional site and community based day services
    iv. Full time services
    v. Part time services
m. As program capacity becomes maximized, we must insure that there are viable options for other available supports. Not everyone who wants to return to face to face day services may be able to, due to limits on program capacity.
n. Include care managers in discussions on transitioning back to program, reviewing agency provider plans, making informed decisions, changing programs, etc.
o. Agencies must be financially supported so they can assure families that delaying the return to in person services won't jeopardize their eventual acceptance back to programs.

5. Maintaining Services

a. Financial Considerations

i. The loss of Retainer Day payments presents a huge financial hurdle. The retainer program was a lifeline for agencies to keep programs running. We hope that a solution for the CMS 90 day restriction is found, and, if not, that a state-only supplement can replace some of the original retainer payments. In addition, we suggest that a series of flexibilities be implemented to maximize providers' ability to draw down enough funding to survive until a solution to COVID-19 is found:
    1. Social distancing regulations limit transportation and program site capacity making it nearly impossible to bill enough in person services for providers to meet their costs.
    2. Other variables, like a resurgence in infection rates of COVID-19 and families' potential reluctance of their loved ones returning

to day programs, make it hard to predict how many participants can or will attend in person.

3. There should be freedom to combine any retainer payments and service provision in each of the services (DH, CH, PV), and the allowance of new services and/or additional units available. This would give agencies the flexibility to bill up to 100% of previous revenues and remain financially solvent.
4. The loss of the retainer program has resulted in competition rather than collaboration between residential and day services providers. For the best outcomes, providers need to work together to support the shared people in our programs and state guidance should support this. *There should be a combination of Group CH-R for residential providers and payments for day services that makes sense and supports necessary staffing in both programs. This issue requires immediate attention to prevent the loss of services for people who live in certified IRAs and attend a different provider's day program.*

ii. Providers need to be reimbursed for increased costs including but not limited to:

1. Transportation, related to additional buses and runs needed to maintain social distancing, modifications needed on buses including anti-viral protective coatings, additional staff and installation of barriers, etc.
2. Additional staff hours for increased staffing ratios in programs to ensure participant safety and overtime for extended hours, additional time needed for disinfection including of vehicles between trips and coverage of staff on mandatory quarantine or isolation
3. PPE
4. Staff training
5. Testing
6. Equipment needed including thermometers, infrared scanners, devices to sanitize air and surfaces, etc.
7. Equipment, software and technology needed to provide Virtual services

iii. Property costs must be reimbursed separately from rates due to the reduction of possible billable units

iv. Providers must be held harmless for reduced transportation and program unit utilization – these reductions are a necessary component of infection control and must not be considered as a factor in future re-basing calculations

v. Economies of scale have been removed due to social distancing requirements that limit capacity. Transportation restrictions compound

this problem. Alternate locations may provide more opportunities for individuals to return but the restriction to cohorts of 15 also limits operations.

b. Regulatory Changes

i. The ½ hour non- paid lunch should be discontinued permanently:
    1. Staff have always supervised individuals during lunch – providing safeguards and supports – monitoring food consistency, pacing, swallowing, monitoring for choking, assisting people in eating, encouraging socialization etc.
    2. This extra billable time would also assist providers in increasing program capacity making it possible to incorporate split shifts & transportation for multiple groups.
    3. Meal/lunch time is not backed out of Community Pre Voc, Com Hab, Pathway, or SEMP in recognition of support needs that continue the entire day.

ii. Provide complete flexibility on hours and days, allowing providers to freely combine services; DH, Supplemental DH, PV, CH and Respite, as long as billing doesn't exceed 100% of the average monthly rate as calculated using the July through December 2019 billing. Remove the current restrictions on combining DH & PV

iii. The following services should be billable as an add-on to traditional DH billing as an hourly service in 15 minute increments:
    1. Indirect service provision for prep time needed for lesson/activity planning for virtual sessions, etc.
    2. staff travel with or on behalf of a program participant
    3. virtual DH services since it is difficult and sometimes contraindicated to deliver 1, 2 or more hours of virtual services

iv. Since community partners may not be accepting our participation at the pre-COVID level, requirements for community engagement for participants of both with and without walls programs will need to be relaxed. Program participants must have the flexibility to spend time in with walls settings, as needed,

v. Maintain the Appendix K flexibility on providing services in various locations.

vi. The property reimbursement methodology should be changed from the current per unit method to a 1/12 per month payment to properly reimburse providers with the current lower participation rate in programs

vii. Virtual services and the limited hours and capacity of in-person services available right now, make the program experience very different from what it may be once there is a vaccine and successful

treatments for COVID-19. Therefore, we suggest allowing provisional acceptance of new program participants through the return to typical service provision.

viii. Relax group size restrictions for CH -should be up to 6 people (currently 4)
ix. All the flexibility for billable services in the SEMP ADM should be extended to all fee-based programs (CH, Respite, CPV)
x. Allow providers to furlough staff, if needed, to prevent program closures
xi. Virtual service delivery should become a permanent addition to the menu of service options for all day services. This will address the needs of certain populations who miss face to face services from time to time due to medical or behavioral concerns and allow those who would be safer at home for various reasons to participate and receive support
xii. It is important to note that some providers support particular segments of the I/DD population including cultural and disability specific specialties. The specific groups these providers support would be underserved or unserved, if not for the culturally sensitive and disability-specific and technical supports they provide. Many are "Day Services Only" providers which are particularly vulnerable to the economic hardships presented by the COVID-19 pandemic.

6. Program Modifications

a. Currently many locations in the community are closed or have limited capacity. Businesses are starting to open but many locations may be harder to engage with due to infection control restrictions.
b. Programs will need to develop new locations for smaller groups to participate in the community, with access to restrooms.
c. Since businesses also have to limit their capacity they may not be willing to have groups of people from our programs if it limits the number of customers they will be allowed to accommodate.
d. There will be concern over which sites will be "safe" or feasible in the short and long term.
e. Programs will need to consider the site's requirements, the staff and agency's comfort level and the comfort level of the individual and their family as we move back into community opportunities.
f. Programs must work with each site to see what their reopening plan is, what their PPE requirements are and any other requirements they may have, such as testing.
g. Many sites like nursing homes and assisted living programs will not be accessible anytime soon

h. Programs should create resource guides for community options with logistical information and requirements for staff and program participants. If the setting is indoors, ask for copies of safety plans.
i. Look for new volunteer sites, establish new partnerships and modify existing ones. For example office work, such as preparing a mailing, can be done at your site instead of at a doctor's office.
j. To enable SEMP programs to support individuals who lost their jobs, Intensive SEMP and ETP should be available as needed. ETP can be used as a bridge back to employment to compensate for a difficult and more competitive job market for job seekers in the SEMP program.
k. Participants of both with and without walls programs will need the flexibility to spend time in with walls settings as needed since community partners may not be accepting outside participation at the pre-COVID level, as referenced in section 5.b.iv.
l. Employ strategies to assist those with significant behaviors that affect their ability to conform with social distancing.
m. There should be clear guidance and uniform handling of documentation and procedural requirements to reflect current service needs and facilitate coordination between CCO's, providers and families. Updates must be clearly communicated to all parties.
n. Regional differences must be taken into account (up/downstate).
o. We recommend obtaining letters of agreement or attestations from families/guardians for each person, including health screening as per OPWDD/DOH guidance, at least once, prior to re-entry.

Modifications Specific to Programs With Walls

p. Programs must modify operations to accommodate far fewer program participants due to social distancing requirements. Transportation restrictions compound this problem. Alternate locations and split shifts may provide more opportunities for individuals to return but the restriction to cohorts of 15 also limits operations. These factors present both fiscal and operational challenges for providers that must be monitored.
q. Placement of decals on floors will assist in social distancing
r. Bathroom protocols should be enforced to ensure social distancing including closing off every other sink and/or stall in communal bathrooms. Limit capacity in bathrooms to maintain social distancing, consider purchasing toilet seats with lids.
s. Each program participant should have their own program supplies and keep them separately.

7. Staffing & Staff Training

a. All staff should be surveyed on their wants, needs, concerns, suggestions, etc.
b. Staff testing can be considered if there is a rapid turnaround for results and funding is available to cover the cost. Pending further scientific support regarding reinfection and contagion, staff testing for antibodies would provide comfort to them, families and program participants.
c. Providers should anticipate staffing issues:
    i. Staff on FMLA and Paid Family Leave may not be willing or able to return to work
    ii. Some staff have resigned during the pandemic
    iii. Staff with children may not be available if programs reopen prior to school/ camp/ child care being open.
    iv. Day services staff may still be needed in residential services while all/ some residents are still home during the day

Training

d. All staff should have CDC, OSHA, OPWDD, DOH and local health and mental hygiene department COVID-19 training, updated as new guidance becomes available.
e. Staff need additional training in how to create engaging virtual meetings and groups.

8. Entry Services

a. There should be consistency and clear communication regarding procedures for approving new services and accepting people into programs.
b. Students transitioning this year should be fast tracked into day services if they are not approved for additional school services.
c. Entry into services would be facilitated through collaboration between providers and CCO staff completing SARFs and other required documentation.
d. We recommend provisional acceptance into programs until regular services resume – it's difficult, at best, to ascertain the fit between a program and a participant virtually, and still hard to determine even after the person begins to attend in person services when the program temporarily consists of smaller groups, shorter program hours and less time spent in the community.
e. Consider eliminating the distinction between with and without walls in the approval process through an agency's provisional acceptance period, allowing the agency and individual time to determine which type of program can best support the person's needs.

9. Blending Virtual and Face to Face Services

a. We recommend the permanent continuation of virtual alternatives to face to face service provision. Providers have been creative and found success using Zoom, Google Meets, Google Classroom and other platforms. A hybrid model for the future that encompasses both direct and distance learning experiences, with center based and remote options is the best configuration for all day services, and can support individuals who have high support needs including for those who are elderly, medically frail, have behavioral challenges and others who frequently miss time from their day programs due to a multitude of unavoidable issues.
b. Programs must assess each individual's access to and ability to use technology:
    i. Equipment available/needed
    ii. Internet access
    iii. Support during engagement: families, residential staff, other staff
c. Provide technical training to parents, caregivers, and individuals. Have staff available to provide in-home instruction. Create a trouble shooting document for program participants, families and staff.
d. Expand provider IT departments to assist with creative programming and access.
e. Create a provider collaborative utilizing I/DD associations for:
    i. Development of technology/programing
        1. Creating a You Tube channel for participants, families and staff to use – provide various topic categories and additional instructional videos to complement the content videos
        2. A virtual learning library of ideas for agencies to share
    ii. Identifying funding to purchase technology for staff and program participants, including Wi-Fi and data plans.
    iii. Making family support money available to agencies to purchase technology for people at home.
    iv. Creating and maintaining a shared technology platform for agencies to utilize for virtual and on-site programing
    v. Hiring a consultant to develop on line programing which will be shared with member agencies.
    vi. Creation and maintenance of a virtual activity website.
    vii. Providing staff training on:
        1. Planning and delivering virtual services- most don't have a "teacher skill set". Training should include how to make the activities presented more meaningful and how to provide person-centered instruction to engage everyone in your virtual group.
        2. Mixing fun activities with skill building activities to achieve valued outcomes.
        3. The specifics of individual vs. group activities
f. Utilize virtual platforms for various training, skill building and preparation for community engagement.
g. Virtual learning ideas include:

i. YouTube videos for meditation and breathing and other calming and crisis intervention supports
ii. Virtual trips
iii. Interactive games
iv. Creation of work place scenarios using Google Expedition
v. Fitness, yoga, Zumba
vi. Music and craft sessions
vii. Themed sessions e.g.: “Spirit Week”
viii. Mad Libs
ix. Scavenger Hunt
x. Meal preparation/cooking shows
xi. Happy Hour
xii. Book Club
xiii. Travel groups
xiv. Gaming groups
xv. Personal Hygiene
xvi. Mask desensitization program
xvii. Skill building groups organized by clinical staff

h. Technology options include:
i. Subscriptions to Zoom, Google Classroom, Go To Meeting etc.
ii. laptops, iPad, headsets, hotspots for Wi-Fi, smart phones
iii. Virtual reality headsets
iv. Voice activated tech
v. Touch screens
vi. Smart Table
vii. Interactive White Boards
viii. Apps like Screencastify and Screenomatic to capture the instructor’s screen and provide step by step instructions to the user.
ix. A Mobile Device Manager to enable agencies to make software and programming available to all participants of an activity on their mobile devices.