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Legislative Report

Adult Day Services Study

Aging and Adult Services Division

January 2019

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I. Executive summary

This report is submitted to the Minnesota Legislature as required by Laws of Minnesota, 2017 1st Special Session, chapter 6, article 3, section 47. The report conveys activities, findings, and recommendations connected with a study of adult day services that took place between April and November 2018. The purpose of the study was to evaluate current and potential adult day service models to support the state's goal of purchasing high-quality services that meet the needs and goals of adult day participants.

The results of the study support the following recommendations:

Update licensing standards for adult day service

The licensing standards for adult day services have been in place for many years. Adult day participants, providers, and the state would benefit from a comprehensive review and update of the licensing standards that govern this service. Updating the licensing standards would provide Minnesota with an opportunity to clearly and directly express the expectation that adult day services are delivered in a person-centered manner, and that participants have opportunities for community engagement. Updated standards would provide better tools and mechanisms for the state to provide oversight and monitoring of the service, related to these expectations. Providers would benefit from clear expectations and regular feedback through licensing monitoring. Participants would benefit from improved service delivery, focused on their individual needs.

DHS recommends that the state develop a proposal for new licensing standards for adult day services. This proposal should be reported to the legislature by January 1, 2021. DHS should convene a stakeholder group to provide input on the development of these proposed standards.

Enhance provider guidance and assistance

As part of implementation of new licensing standards, DHS will develop resources for providers to train them on the new standards and support adoption of the standards. These resources may include, but are not limited to: licensing self-assessment tools, all-provider technical assistance calls, a provider handbook, and standardized templates for required policies or forms. This type of guidance and assistance will support providers to successfully implement new requirements.

II. Legislation

Laws of Minnesota, 2017 1st Special Session, chapter 6, article 3, section 47 requires the Department of Human Services (DHS) to report to the legislature on the results of a study of adult day services in Minnesota. This legislative report addresses the topics of adult day services models and quality assurance. The topics of adult day resident (participant) acuity, staffing and support levels, and projected demand are addressed in the report titled *Evaluation of Rate Methodology for Services Provided under Elderly Waiver and Related Programs*, submitted to the legislature on January 1, 2019.

> Sec. 47 **DIRECTION TO THE COMMISSIONER; ADULT DAY SERVICES STAFFING RATIOS; ELDERLY WAIVER.**
>
> The commissioner of human services shall:
>
> (1) study existing adult day services models, including resident acuity, staffing and support levels, and quality assurance;
>
> (2) project demand for adult day services into the future; and
>
> (3) report to the legislature by January 1, 2019.

III. Introduction

This report is submitted to the Minnesota Legislature as required by Laws of Minnesota, 2017 1st Special Session, chapter 6, article 3, section 47. The report conveys activities, findings, and recommendations connected with a study of adult day services that took place between April and November 2018.

Adult Day Services is an individualized program of activities designed to meet the health and social needs of a person age 18 or older who has a functional limitation and needs supervised care outside of his or her residence during the day. For more information about the service and the regulations surrounding the service can be online in the DHS Community-Based Services Manual (CBSM).

The purpose of the study was to evaluate current and potential adult day service models to support the state's goal of purchasing high-quality services that meet the needs and goals of adult day participants. The study's objectives are below.

- Study the features of adult day service models, nationally and locally, that support providers to comply with the Home and Community Based Settings Rule and deliver person centered services.
- Develop recommendations for potential changes to adult day service definition, in waiver plans and/or statute, to more clearly define the appropriate use of this service.
- Identify and recommend potential data-based measures that can be used to demonstrate the impact of adult day services and outcomes for adult day participants.

This study focused on adult day services delivered in centers rather than Family Adult Day Services, which is delivered in residential homes. It also focused on services provided to older adults, including participants who access the service through Elderly Waiver (EW), Alternative Care (AC), and the Essential Community Supports Program (ECS).

Study process

A request for proposals for an outside firm to conduct the study was released on January 23, 2018. Navigant Consulting (Navigant) was selected through a review process and began work on the evaluation on April 4, 2018. DHS formed a stakeholder group to support the study. The stakeholder group was made up of providers and provider associations connected to the service. The complete list of stakeholders is included in this report as Appendix A. Between April 4 and the submission of this report, the full stakeholder group met on five occasions. The stakeholder group provided input at each step in the evaluation process. Summarized below are the key steps in the study process:

- Review and approval of a research plan,
- Review and analyze existing adult day service documents,
- Solicit stakeholder input on Minnesota's adult day delivery system, including challenges and barriers to success and best practices,
- Conduct a national scan of adult day standards and service definitions in other states,

- Identify criteria to assess final recommendations, and
- Identify recommendations and develop interim and final reports.

More information about the study process is provided in Navigant's report, which is included in this report as Appendix B.

Report overview

Section IV of this legislative report will summarize key findings from the study. Section V puts forward recommendations as requested by Laws of Minnesota, 2017 1st Special Session, chapter 6, article 3, section 47. Section VI offers suggested legislative language directing DHS to pursue the report's recommendations further.

IV. Study activities and findings

As requested by the legislature, the study focused on two main areas: adult day service models that support best practices and quality measurement. In conducting the study, DHS pursued the following objectives:

- Study the features of adult day service models, nationally and locally, that support providers to comply with the Home and Community Based Settings Rule and deliver person centered services;
- Develop recommendations for potential changes to adult day service definition, in waiver plans and/or statute, to more clearly define the appropriate use of this service; and
- Identify and recommend potential data-based measures that can be used to demonstrate the impact of adult day services and outcomes for adult day participants.

This section summarizes the study findings connected with each study objective. It also relays additional findings on how the state provides assistance and guidance to adult day providers. More information on the study activities and findings are available in Navigant's study report, provided as Appendix B.

Adult day service models

The study gathered input on best practices in adult day service delivery through roundtable discussions with providers, state staff, and adult day participants. Site visits were also conducted at three adult day programs in the greater Twin Cities area. The following is a summary of key findings from these activities.

Benefits of Participation in Adult Day Services

Stakeholders generally agreed on the purpose and value of the service. When the service is delivered well, participants experience the following benefits:

- Social support and alleviation of isolation and loneliness,
- Engagement in recreational and community activities,
- Support for physical and mental health, including nutritious meals and cognitive stimulation, and
- Oversight and increased support for participants with limited or no informal caregivers.

Informal caregivers also experience benefits, including:

- Respite from their caregiving responsibilities,
- Formal caregiving of a loved one supports continued employment,
- Social support and counsel from adult day program staff, and
- Care recipients with improved physical and mental health.

Characteristics of High-Quality Adult Day Services

A roundtable discussion held with adult day participants and informal family caregivers was a key source of information about quality in adult day service delivery. Providers and state staff agreed that the following characteristics contribute to high-quality adult day services:

- Longevity and stability of direct care staff,
- Program staff that develop an interest in and knowledge of each individual participant,
- Tailoring programming to each participant, and allowing each participant to make their own choices,
- Programming that reflects the cultural and personal preferences of the participants,
- A strong individualized service planning process
- Good quality and readily available food, and food options, to allow for choice
- A program space that is welcoming, safe, and comfortable
- Access to well-coordinated transportation

Changes in the Adult Day Service Participant Population

Providers and state staff shared observations about how the adult day participant population has changed in the past several years. Some perceived shifts in the participant population discussed are:

- Some programs are serving a wider array of age groups, including younger individuals with a brain injury, a primary diagnosis of a mental illness, or early-onset dementia.
- Some providers are serving more participants that require more support/more intensive care needs, or more significant behavioral health needs.
- Some providers report more participants who have only limited support from an informal caregiver outside the program.
- Participants are more diverse, racially and ethnically, and some providers are serving a larger proportion of participants who are refugees or immigrants, some with a primary language other than English.

Service definition and rules

Roundtable discussions with stakeholders, review of Minnesota's current adult day services standards and rules, and a national scan of other states' practices indicated that there is a need to update and revise the standards and rules for the service. Areas for revision fall into three main categories: updating or removing dated standards; strengthening person-centered services practices and alignment with the HCBS Settings Rule;[1] and clarifying the definition and scope of the service.

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[1] Home and Community Based Settings Rule requirements. See: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/hcbs-transition/

Updating or removing dated standards

The Administrative Rule for adult day services was written many years ago and a number of the provisions and standards within the rule are dated or obsolete. The rule refers to outdated technologies or practices. Several examples of outdated rules are provided in Navigant's final report.

Strengthening licensing standards

The adult day study found that the existing Administrative Rule for adult day provides too little guidance to support person-centered service delivery. While the Rule requires an Individualized Service Plan (ISP), it provides insufficient guidance on the use of this important service delivery tool. The Administrative Rule also has a number of one-size-fits-all standards, stating expectations about the type of programming that should occur at adult day centers. A person-centered delivery model requires that the service be tailored to each individual participant. The study indicates that if the licensing standards were modernized, it would replace one-size-fits-all standards with stronger person-centered service delivery standards.

Strengthening the person-centered elements of the licensing standards would also serve to further align the service with new federal rules for this HCBS setting. These new rules affirm that services should respect individual choice and rights in a variety of ways. Expectations for person-centered service delivery are critical to ensuring that these requirements are met and services are delivered in a manner that aligns with the federal rule.

The Settings Rule also requires that adult day programs provide opportunities for participants to engage in community life, beyond the center. While the current Rule does not in any way preclude community engagement, and other expectations of the Rule, modernized licensing standards could more effectively promote and support these expectations.

Clarifying the definition and scope of the service

As part of the study, Navigant performed a scan of service definitions and standards for adult day services around the country. Minnesota's service definitions and standards were found to be quite similar to other states. One area of difference, however, is that some states distinguish between two major models of adult day services: adult day social and adult day health.

In Minnesota, social and health related activities occur in adult day settings and are guided by the same Administrative Rule. In some other states, separate standards are defined to support adult day social and adult day health. Sometimes these separate standards are set forward in separate licenses for each model. At other times one license is used but some standards in the license apply to only one model.

Further study would be needed to understand the benefits and drawbacks if Minnesota were to define two models of adult day.

Quality measurement

The study sought to identify and recommend potential quality measures that could be used to demonstrate the impact of adult day services and outcomes for adult day participants. In reviewing possible measures, Navigant, DHS, and the stakeholder group also discussed measures that could motivate individual providers in their own improvement.

As directed by their contract with DHS, Navigant explored the work of the National Quality Forum which has cataloged many potential measures of home and community based services quality.[2] The adult day study put forward ten measures for consideration. The measures align with five of the quality domains identified by the National Quality Forum:

- Service delivery and effectiveness
- Participant choice and control
- Informal caregiver support
- Workforce
- Holistic health and functioning

Navigant's final report, which is included in this report as Appendix B, provides the specific quality measures. These findings lay the ground for further work in the future.

Provider guidance and assistance

In exploring best practices in service delivery, the study surfaced a number of ideas for how the state might support individual adult day providers in their pursuit of quality. Based on Navigant's review of practices in other states as well as observation made in Minnesota, they recommended the following ideas:

- Develop a licensing self-assessment checklist tool
- Implement a recurring provider conference call to provide technical assistance
- Develop a provider handbook that provides more detailed interpretation of license requirements
- Offer more training opportunities specifically aimed at adult day providers

[2] Quality in Home and Community-Based Services to Support Community Living (2016)

V. Report recommendations

Update licensing standards for adult day service

As noted earlier in this report, the licensing standards for adult day services have been in place for many years. Adult day participants, providers, and the state would benefit from a comprehensive review and update of the licensing standards that govern this service. Updating the licensing standards would provide Minnesota with an opportunity to clearly and directly express the expectation that adult day services are delivered in a person-centered manner, and that participants have opportunities for community engagement. Updated standards would provide better tools and mechanisms for the state to provide oversight and monitoring of the service, related to these expectations. Providers would benefit from clear expectations and regular feedback through licensing monitoring. Participants would benefit from improved service delivery, focused on their individual needs.

DHS recommends that the state develop a proposal for new licensing standards for adult day services. This proposal should be reported to the legislature by January 1, 2021. DHS should convene a stakeholder group to provide input on the development of these proposed standards.

Provider guidance and assistance

As part of implementation of new licensing standards, DHS should develop resources for providers to train them on the new standards and support adoption of the standards. These resources may include, but are not limited to: licensing self-assessment tools, all-provider technical assistance calls, a provider handbook, and standardized templates for required policies or forms. This type of guidance and assistance will support providers to successfully implement new requirements.

VI. Implementation language

Uncodified language

The commissioner of human services shall develop a proposal for new licensing standards for adult day services currently governed under Minnesota Rules, parts 9555.9600 to 9555.9730. The commissioner shall report back to the legislature with this proposal by January 1, 2021. The commissioner shall convene a stakeholder group to provide input on the development of these proposed standards.

VII. Appendix

Appendix A

Adult Day Study Stakeholder Group

Organization	Representative(s)
Aging Services for Communities	Jeff Bostic; Roni Falck
Care Providers of Minnesota	Todd Bergstrom
Eagle's Crossing Adult Day Center	Diane Kramer
Elder Circle Adult Day Care	Rinna Waters
Ebenezer Hastings Adult Day	Nanette Marsh
Pathstone Day Living in Mankato	Marti Titus
Augustana Open Circle – Adult Day Services	Gail Skoglund
Elder Care Day Services	Youa Her
Benedictine Living Community of Duluth	Sarah Dvergsten
Minnesota Chippewa Tribe – Adult Day Services	Alyssa Leecy
Mission Today at The Residence at North Ridge	Lisa Desnick
Heritage of Foley – Adult Day Services	Jessica Pierce

Appendix B

The following pages are the Navigant report. The Navigant report was screened and adapted to meet DHS accessibility standards.

DHS-7849-ENG 01-19

Final Report:

Adult Day Services Quality and Outcomes Study

Prepared for:

Minnesota Department of Human Services, Aging and Adult Services Division

Prepared by:

Navigant Consulting, in partnership with National Association of States United for Aging and Disabilities (NASUAD)

October 15, 2018

navigant.com/healthcare

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Executive Summary

Summary of Engagement

The Minnesota Department of Human Services (DHS) contracted with Navigant Consulting (Navigant) to study current and future adult day service (ADS) models, supporting DHS' goal of purchasing high-quality services that meet the needs and goals of Elderly Waiver (EW) and Alternative Care (AC) program participants. Adult day service is a service offering of both the EW and AC programs, and related programs such as Minnesota's Essential Community Supports program, and provides individualized social opportunities, recreational therapy, and health supports to older adults, adults living with dementia or cognitive impairment, and adults living with disabilities.

This report summarizes the findings of our study and proposed recommendations regarding:

- Changes to the current ADS definition, in waiver applications and/or state regulation, to align service design with intended service objectives and outcomes
- Data-based measures that Minnesota may consider using to monitor the demonstrated impact of ADS and outcomes for adult day participants

Research Plan Process

Navigant studied Minnesota's adult day services system by implementing a multi-step research plan, described below.

Step 1. Review and analyze existing program documents and incorporate information from the evaluation of the Elderly Waiver and related programs

Step 2. Obtain stakeholder input on Minnesota's ADS delivery system, including challenges / barriers to success and best practices

Step 3. Conduct a national scan of adult day standards and service definitions in other states

Step 4. Identify criteria to assess final recommendations

Step 5. Identify recommendations and develop interim and final reports

Minnesota's Department of Human Services will use this report to develop its legislatively-mandated report to the Minnesota State Legislature, due in January 2019.

Key Recommendations

As described above, the main observations and recommendations of this report focus on adjustments to the service definitions and quality measurement. Figure 1 includes a summary of the key recommendations with Sections V and VI providing more detail.

Figure 1. Key Recommendations

Figure 1 includes a summary of the key recommendations.

Topic	Recommendation Description
Licensing Standards/Regulations	Recommendations pertain to elements in Minnesota Statutes and Administrative Rules that govern ADS licensure. Recommendations include, but are not limited to, the following: 1. Update licensure standards to reflect modern ADS operations 2. Consider updated standards regarding physical plant to include features that support participant comfort 3. Update licensure regulations to better reflect person-centered principles and individualized participant service 4. Better articulate expected elements required in an individualized service plan 5. Clarify the role of ADS providers versus case managers as it relates to offering other community-based services to participants to address participants' community-based service needs 6. Consider revising the Positive Supports Rule training requirements for providers who primarily serve the aging population and/or serve a small number of individuals with intellectual or developmental disabilities (I/DD)
Provider Guidance and Assistance	Recommendations pertain to the implementation of regulations and how DHS communicates expectations to providers. Recommendations include, but are not limited to, the following: 1. Develop a licensing self-assessment tool for ADS providers that includes all licensing requirements pertaining to ADS 2. Implement a recurring provider call to provide technical assistance to ADS providers on an ongoing basis 3. Develop an ADS provider handbook separate from licensure regulation that provides guidance and more detailed interpretation for providers to support case-specific considerations and operationalize key requirements 4. Expand opportunities for training/education
Service Definitions	Recommendation pertains to the manner in which ADS are defined in HCBS 1915(c) waivers and applicable statutes, specifically: Conduct study in the future of the need for a definition and/or rate distinction between adult day health models and adult day social models.

Topic	Recommendation Description
Quality Measurement	Recommendations include 10 proposed quality measures that Minnesota may consider using to monitor the demonstrated impact of ADS, based on quality domains outlined in the National Quality Forum's 2016 report: *Quality in Home and Community-Based Services: Addressing Gaps in Performance Measurement* and informed by stakeholder feedback and review of Minnesota ADS standards.[1]

Report Overview

This report contains the following sections:

- ***Section I: Introduction*** describes the purpose and objectives of this ADS study.
- ***Section II: Methodology*** describes the multi-step research process that Navigant implemented to study Minnesota's ADS system, including methods for obtaining stakeholder input and analyzing the national ADS system.
- ***Section III: Background*** provides contextual information on ADS generally, including how ADS is defined and implemented in Minnesota, and key observations from discussions with stakeholders. Section III also provides a national scan of ADS standards and service delivery, along with an overview of quality measurement in the ADS system.
- ***Section IV: Criteria for the Development of Recommendations*** provides proposed evaluation criteria to assess Navigant's recommendations.
- ***Section V: Service Definition Related Recommendations*** includes Navigant's 11 recommendations for potential updates to ADS licensure regulations, potential updates to implementation of regulations, and potential changes to the ADS definition.
- ***Section VI: Quality Measurement Recommendations*** includes 10 proposed quality measures that Minnesota may consider using to monitor the demonstrated impact of ADS.

[1] National Quality Forum, *Quality in Home and Community-Based Services: Addressing Gaps in Performance Measurement,* September 2016, Available online: https://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

Section I Introduction

In response to *Laws of Minnesota, 2017 1st Special Session, Chapter 6, Article 3, Section 47*, the Department of Human Services (DHS) contracted with Navigant Consulting (Navigant) to conduct a study to evaluate current and future ADS models to support the goal of purchasing high-quality services to meet the needs and person-centered goals of Elderly Waiver (EW) and Alternative Care (AC) program participants.

In partnership with Minnesota's Department of Human Services (DHS), the National Association of States United for Aging and Disabilities (NASUAD), and the Adult Day Stakeholder Group established for this project, Navigant studied the current state of Minnesota's ADS system by implementing a multi-step research plan. This report and the associated study focuses on center-based ADS and does not incorporate the family ADS service due to differences in the program model and licensing standards, as well as the relatively low utilization of family ADS compared to center-based ADS.

This report summarizes the observations of our study and proposed recommendations regarding:

- Changes to the current ADS definition, in waiver applications and/or state regulation, to align service design with intended service objectives and outcomes
- Data-based measures that can be used to monitor the demonstrated impact of ADS and outcomes for adult day participants

Section II Methodology

Navigant's research process centered around engagements with the Adult Day Study Stakeholder Workgroup and implementation of a multi-step research plan. Below is an overview of the research process.

Adult Day Study Stakeholder Workgroup

Navigant and DHS initiated an Adult Day Study Stakeholder Workgroup to gather input from key stakeholders for the duration of this study. From May to September 2018, Navigant and DHS conducted monthly meetings to gather input from key stakeholders.

The stakeholder workgroup included several ADS providers and staff from statewide associations that represent ADS providers. Meetings focused on the following topics throughout the study:

- Review of research plan
- Roundtable discussion regarding quality in ADS delivery
- Discussion of study findings
- Discussion of national scan findings and state case studies
- Review of draft evaluation criteria
- Review of interim and final reports

Step 1 – Document Review

Navigant reviewed and analyzed current program documentation to understand the design and dynamics of Minnesota's ADS system. This documentation included:

- Elderly Waiver (MN.0025.R08.00) home and community-based services (HCBS) 1915(c) waiver application[2]
- Minnesota adult day licensing standards (e.g., Minnesota Statutes Chapter 245A, Minnesota Administrative Rules 9555.9600-9730)[3,4]
- Related licensing statutes (e.g., Minnesota Statutes Chapter 245D)[5]

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[2] Centers for Medicare & Medicaid Services, *State Waivers List*, Available online: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8558

[3] The Office of the Revisor of Statutes, *MN Administrative Rules Chapter 9555 – Social Services for Adults*, Available online: https://www.revisor.mn.gov/rules/9555/full#rule.9555.9600

[4] The Office of the Revisor of Statutes, *MN Statutes Chapter 245A – Human Services Licensing Act*, 2017, Available online: https://www.revisor.mn.gov/statutes/cite/245A/full

[5] The Office of the Revisor of Statutes, *MN Statutes Chapter 245D – Home and Community-Based Services Standards,* 2017, Available online: https://www.revisor.mn.gov/statutes/cite/245D/full

- Community-Based Services Manual (CBSM)[6]
- Licensure materials provided by DHS (e.g., survey and monitoring tools)
- Existing quality measures (e.g., National Core Indicators – Aging and Disabilities)[7]
- Positive Supports Rule (Minnesota Administrative Rule 9544)[8]

Step 2 – Stakeholder Engagement

Navigant obtained stakeholder input as a part of its study by engaging with three stakeholder segments, including:

- ADS participants and their caregivers
- ADS providers
- State staff across multiple divisions who contribute to oversight and monitoring of ADS service delivery

Stakeholder engagement helped Navigant understand stakeholder perspectives and expectations for what defines effective, high-quality service delivery. Stakeholders offered first-hand insights and observations on existing best practices and areas of opportunity to advance ADS in Minnesota.

Navigant and DHS collected feedback through stakeholder engagement activities, described in the following Figure 2.

[6] Minnesota Department of Human Services, *Community-Based Services Manual – Adult Day Services*, 2018, Available online: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_002205

[7] NASUAD, *National Core Indicators – Aging and Disability Adult Consumer Survey – Minnesota Results*, April 2018, Available online: https://nci-ad.org/upload/state-reports/NCI-AD_2016-2017_MN_state_report_FINAL_508.pdf

[8] The Office of the Revisor of Statutes, *MN Administrative Rules Chapter 9544 – Positive Support Strategies and Restrictive Interventions*, Available online: https://www.revisor.mn.gov/rules/9544/full

Figure 2. Overview of Stakeholder Engagement Activities

Figure 2 describes the various stakeholder engagement activities through which Navigant obtained stakeholder input.

Activity	Description
Key State Staff Roundtable	On June 26, 2018, Navigant and DHS conducted a roundtable with key state staff, including staff from the following divisions: Aging and Adult Services Division, Disability Services Division, Licensing Division, Surveillance Integrity Review (SIRS), and Office of Inspector General. Discussion themes focused on the following subject matter: • Defining and supporting high-quality ADS • Strengths of current ADS monitoring, compliance, and regulations • Observed areas of improvement among ADS programs
Provider Site Visits	On June 27, 2018, Navigant and DHS visited three "best practice" ADS providers identified by DHS. At each site, we conducted observations/walkthroughs and then interviewed site managers to learn about the sites' promising practices and any challenges they face in service delivery. Our discussions and observations focused on the following subject matter: • Drivers of ADS utilization • Opportunities to improve the current approach to monitoring, compliance, and regulations • Potential quality/performance measures for ADS delivery • Elements that contribute to the success of high-performing providers For further details on the nature of the sites visited, refer to Appendix A.
Adult Day Study Stakeholder Workgroup	On June 28, 2018, Navigant and DHS conducted a roundtable with the ADS Stakeholder workgroup, which served as a group representative of the statewide provider network. The discussion focused on the following subject matter: • Suggested quality measures to evaluate ADS outcomes • Elements that contribute to strong ADS settings • Suggestions for modifying existing ADS licensure regulations and implementation to better drive high-quality service delivery
Participant Experience Roundtable	On July 24, 2018, Navigant and DHS conducted a participant roundtable at an ADS site in the Minneapolis area. The roundtable consisted of eight ADS participants with varying ambulatory and cognitive statuses and three primary caregivers of ADS participants. Discussions focused on the following subject matter: • Benefits of ADS participation • Perceived participant experience

Activity	Description
	• Perceived caregiver experience • Factors contributing to ADS success

Step 3 – National Scan

As part of the study, Navigant partnered with experts from the National Association of States United for Aging and Disabilities (NASUAD), who conducted a national scan of adult day standards and service definitions in other states to identify promising practices among high-performing ADS models and promising quality measurement practices.

Step 4 – Evaluation Criteria

Navigant identified criteria for the assessment of potential recommendations. These criteria are structured to support the alignment of final recommendations with the needs of Minnesota's ADS participants and the ability of providers to meet those needs. Navigant developed these criteria with input from DHS and the Adult Day Study Stakeholder Group.

Step 5 – Identification of Recommendations

Using information gathered throughout the research process, Navigant identified recommendations for data-based measures and ADS definitions and assessed those recommendations using the evaluation criteria. Navigant shared preliminary recommendations and the interim report with the Adult Day Study Stakeholder Workgroup and incorporated resulting feedback into this report. In addition, Navigant has also incorporated feedback from the larger provider community that DHS collected after sharing a recorded DHS webinar statewide that described the preliminary recommendations.

Section III Background

Overview of Adult Day Services

According to the National Adult Day Services Association (NADSA), "adult day services" is a professional care setting in which older adults, adults living with dementia or cognitive impairment, or adults living with other types of physical, developmental or intellectual disabilities receive individualized therapeutic, social, and health services for some part of the day.[9] Adult day services are typically provided in a community-based congregate setting, and are staffed by an array of professionals including: direct care staff, nursing staff, and social work professionals. Some states also require additional professionals including occupational therapists or dieticians. In addition to providing direct services to adults who need supervised care during the day, ADS afford caregivers respite from the responsibilities of caregiving.

Although service delivery varies by state, common ADS elements include the following:

- Social activities (i.e., interaction with other participants in planned activities or outings)
- Meals and snacks
- Therapeutic activities (e.g., exercise, mental or cognitive stimulation)
- Personal care (e.g., assistance with activities of daily living such as grooming, eating, etc.)
- Transportation to and from the ADS site

The types of activities and services offered by ADS providers may vary. There are three generally recognized ADS models[10], with the prevalence of model types varying by state:

- Social model (provides meals, recreation and some health-related services)
- Medical/health model (provides social activities and more intensive health and therapeutic services)
- Specialized model (provides services only to specific participants, such as those with Alzheimer's or other dementias or persons with developmental disabilities)

[9] National Adult Day Services Association, *About Adult Day Services*, Available online: https://www.nadsa.org/learn-more/about-adult-day-services/

[10] U.S. Department of Health and Human Services, *Regulatory Review of Adult Day Services*, 2014, Available online: https://aspe.hhs.gov/basic-report/regulatory-review-adult-day-services-final-report-2014-edition

Minnesota's Adult Day Services System

Defining Adult Day Services in Minnesota

Minnesota's Community-Based Service Manual defines ADS as an "individualized program of activities designed to meet the health and social needs of a person age 18 or older who has a functional limitation and needs supervised care outside of his or her residence during the day."[11]

Minnesota provides and funds ADS through the programs listed below. Please note that other programs in Minnesota offer ADS, but fall outside the scope of Navigant's study, including the Brain Injury (BI), Community Alternative Care (CAC), Community Access for Disabled Disability Inclusion (CADI), and Developmental Disabilities 1915(c) waivers.

- **Elderly Waiver (EW) program:** This Medicaid-funded HCBS 1915(c) waiver program provides HCBS services to individuals aged 65 or older who need the level of care provided in a nursing home but choose to live in the community. The Elderly Waiver program serves individuals who are eligible for Medical Assistance.[12]
- **Alternative Care (AC) program:** This non-Medicaid program provides HCBS to individuals aged 65 or older who need the level of care provided in a nursing home but choose to live in the community. The Alternative Care program serves low-income individuals who do not meet financial qualifications for traditional Medical Assistance.[13]
- **Essential Community Supports (ECS) program:** This non-Medicaid program provides service coordination and select HCBS to individuals aged 65 or older who do not meet nursing facility level of care but would benefit from community services. The ECS program serves individuals who do not meet financial qualifications for traditional Medical Assistance.[14]

Minnesota's licensing regulations require ADS settings to provide individualized and coordinated health services, social services, and nutritional services. We describe ADS requirements and limitations in more detail below.

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[11] Minnesota Department of Human Services, *Community-Based Services Manual – Adult Day Services*, 2018, Available online: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_002205

[12] Minnesota Department of Human Services, *Elderly Waiver*, 2018, Available online: https://mn.gov/dhs/people-we-serve/seniors/services/home-community/programs-and-services/elderly-waiver.jsp

[13] Minnesota Department of Human Services, *Alternative Care*, 2018, Available online: https://mn.gov/dhs/people-we-serve/seniors/services/home-community/programs-and-services/alternative-care.jsp

[14] Minnesota Department of Human Services, *Community-Based Services Manual – Essential Community Supports*, 2018, Available online: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_176053

Licensure Standards

The Minnesota Department of Human Services licenses ADS settings in accordance with Minnesota Administrative Rules, chapter 9555 and Minnesota Statutes, chapter 245A.[15, 16]

Service Requirements

Per Minnesota Administrative Rule 9555.9710, required services include, but are not limited to, the following:

- **Health services:** Adult day service providers must deliver health services in consultation with a registered nurse. Providers must monitor participants' health status, provide health education and counselling, and offer assistance with medication administration.
- **Social services:** Adult day service providers must observe and record participants' psychological, emotional, social, financial, employment, and other living situations and refer participants to community services as needed.
- **Food service and nutrition:** Adult day service providers must provide snacks twice daily, must provide meals for participants who attend for greater than 4.5 hours, and must have a registered dietician approve menus.
- **Assistance with activities of daily living:** Adult day service providers must assist participants with activities of daily living, (e.g., dressing, grooming, and eating) and assist participants in maintaining these skills.
- **Structured activities:** Adult day service providers must offer a daily structured exercise program developed in consultation with a registered physical therapist. Providers must maintain a monthly activity plan with diversified programming that meets the needs and interest of participants, including socialization activities (e.g., group projects, recreational activities), personal interest activities (e.g., arts, crafts, music), and activities designed to increase knowledge and awareness of environment and enhance language and conceptual skills.

Program participants may attend adult day services no longer than twelve hours per day. Payment from DHS is based on 15-minute increments.

In addition to required services, ADS providers may elect to provide transportation or baths. DHS' ADS reimbursement rates include the cost of transportation that occurs during the program day, however, transportation to and from the program may be billed separately as waiver transportation. The ADS with bath cost is an increased rate with a limit of up to two 15-minute units per day.[17]

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[15] The Office of the Revisor of Statutes, *MN Administrative Rules Chapter 9555 – Social Services for Adults*, Available online: https://www.revisor.mn.gov/rules/9555/full#rule.9555.9600

[16] The Office of the Revisor of Statutes, *MN Statutes Chapter 245A – Human Services Licensing Act*, 2017, Available online: https://www.revisor.mn.gov/statutes/cite/245A/full

[17] Minnesota Department of Human Services, *Community-Based Services Manual – Adult Day Services Bath*, March 2018, Available online: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-291135#

Staffing and Training Requirements

Adult day service staff must include the following:

- A site director or a designated staff member in the director's absence
- An individual trained in basic first-aid and CPR
- Other direct-care personnel in accordance with staffing ratios

Staffing ratio requirements vary depending on participants' ability of self-preservation (i.e., ability to ambulate and have the capability to recognize danger and evacuate in case of an emergency). If there is a mixture of participants with varying levels of self-preservation, ADS providers must calculate the ratio in accordance with applicable statutes. The required staff-to-participant ratios are:

- 1:5 – One staff member present for every five participants when participants are not capable of self-preservation
- 1:8 – One staff member present for every eight participants when participants are capable of self-preservation

Adult day service staff must meet the following training requirements:

- Receive 20 hours of orientation within the first 40 hours of employment, including training on safety requirements and procedures and the kinds of functional impairment of current site participants
- Receive four hours of supervised orientation before working directly with participants
- Receive orientation within the first 72 hours of working directly with participants regarding the Maltreatment of Vulnerable Adults Act, including reporting requirements, definitions, the program abuse prevention plan, and internal policies and procedures. Annual training is required in the same areas
- Receive a minimum of eight hours of in-service training annually, including topics related to care of participants and the provision of medication assistance
- Receive additional training for dementia care, if the site promotes services to individuals with Alzheimer's disorder or related disorders
- Receive additional trainings related to person-centered principles and use of positive supports, if the site serves individuals with intellectual or developmental disabilities (I/DD), as required by the Positive Supports Rule

Volume of ADS Providers

As of December 2017, there are 189 Minnesota providers who offer ADS through the Elderly Waiver, Alternative Care, and Essential Community Support (ECS) programs, totaling approximately $57,945,831 in expenditures from 07/01/16 through 12/31/2017. ADS expenditures account for ~12.9 percent of the total EW, AC, and ECS program expenditures.[18]

[18] Claims data provided by Elderly Waiver Rate Evaluation Study. Includes claims from 07/01/16 through 12/31/2017.

Current Quality Measurement of Minnesota Medicaid-Funded ADS

The current Minnesota adult day landscape includes the following quality reporting requirements:

- Providers must report alleged maltreatment of vulnerable adults and incidents.
- Providers must report the death of an ADS participant.
- Providers must maintain documentation of actual attendance.
- Providers who serve individuals with I/DD are also subject to the Positive Supports Rule, which requires providers to "report the emergency use of manual restraint and any procedure identified in a positive support transition plan to the Department of Human Services and the Office of the Ombudsman for Mental Health and Developmental Disabilities."[19]

HCBS Settings Final Rule

The Centers for Medicare & Medicaid Services (CMS) issued the *HCBS Final Rule of 2014* which defines characteristics of settings offering home and community-based services (HCBS). The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and guarantees that individuals receiving services through HCBS programs have full access to the benefits of community living.

The Centers for Medicare & Medicaid Services required states to submit transition plans that evaluate whether their existing HCBS providers comply with the Final Rule's requirements. States must bring any unmet requirements into compliance by March 2022. Minnesota received initial CMS approval for its HCBS Transition Plan on June 2, 2017. As indicated in the plan, Minnesota conducted a site-specific assessment of all settings where services are delivered in provider-controlled settings that group people together, including ADS. Providers of these services were required to submit attestations by December 31, 2017.[20]

Requirements for ADS providers to be able to attest to compliance with the Final Rule include:

- The setting provides opportunities for people to seek employment and work in competitive integrated settings
- The setting provides people opportunities to access and engage in community life
- The setting supports the person's control of personal resources (their money)
- The setting ensures people's right to privacy

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[19] Minnesota Department of Human Services, Community-Based Services Manual – Positive Supports, January 2017, Available online: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_192301

[20] Minnesota Department of Human Services, *Minnesota's Home and Community-Based Services Final Rule Statewide Transition Plan*, December 2016, Available online: https://mn.gov/dhs/assets/12022016-HCBS-statewide-transition-plan_tcm1053-284362.pdf

- The setting ensures people's dignity and respect
- The setting ensures people's freedom from coercion and restraint
- The setting optimizes individual initiative, autonomy, and independence in making life choices, including daily schedule and with whom to interact

Minnesota's Department of Human Services also assessed the setting of each site to determine whether the setting met the definition of a setting that is "presumed not to be HCBS" according to the federal rule. This includes settings that are "in" certain facility types, "adjacent" to certain facility types, and settings that are potentially isolating.

Some ADS sites in Minnesota meet this definition, primarily because they are "in" certain facility types, or "adjacent" to certain facility types. States are responsible for conducting an initial review to assess whether these sites are in fact home and community-based. States submit an evidentiary package to CMS, who then reviews the package and issues a determination on whether the specific setting is considered to have institutional or home and community-based qualities, which determines whether the site can continue as a HCBS service delivery setting.

Minnesota Stakeholder Feedback

As described in Section II, Navigant obtained input from key stakeholders (e.g., ADS providers, participants, and state staff) via roundtables, site visits, and workgroup meetings. We describe key conclusions from our discussions with stakeholders below.

Reasons for Participation in Adult Day Services

Adult day service providers and program participants often agreed that individuals typically attend ADS sites for at least one of the following reasons:

- To alleviate isolation and loneliness through access to social supports
- As an outlet to engage in recreational activities
- To provide caregiver respite for individuals with a primary, informal caregiver
- As a source of oversight and increased support to individuals with limited or no informal caregivers
- To support cognitive stimulation and/or support physical and mental health

ADS Population Changes

Many of the providers we spoke to have worked in the ADS field for several years. Providers indicated that they have witnessed the ADS population shift over time, and have observed some of the following perceived shifts in the participant population:

- Providers perceived they are working with a wider array of age groups within their participant population who have differing needs than they have in the past; for example, providers indicated serving participants with early onset dementia or brain injury at a younger age than providers have seen in the past

- Many participants require more support/more intensive care needs with physical healthcare
- Participants have a higher incidence of significant behavioral health need than in the past
- Informal caregiver networks have become increasingly strained or not available at all
- Participants are more diverse, racially and ethnically, and some providers are serving a larger proportion of participants who are refugees or immigrants, some with a primary language other than English

Changing participant needs have led to a perceived increase in staff demand among even small sites, which some providers highlighted as a challenge. Several ADS sites reported efforts to adapt to shifts in the population by updating their site offerings to better appeal to participants' varied interests (e.g., updating their music library to include a range of preferred artists, including more technologically oriented offerings, etc.), but reported it can be difficult to do so for financial reasons.

High-Performing Adult Day Sites

Stakeholders generally agreed that the following elements often contribute to high-quality ADS:

- Personal connections between staff and participants
- Individualized programming that meets the needs of participants, coupled with a strong individualized service planning process
- Good quality and readily available food
- A diverse activity plan that reflects the wishes and preferences of the participants at the ADS site
- Access to well-coordinated transportation

Challenges

Stakeholders discussed the following challenges in ADS delivery:

- Some providers mentioned the difficulty they face in balancing staffing requirements and resource demands of community outings. If some participants do not wish to attend outings, a staff member must remain at the ADS site, which may place a strain on limited resources.
- Some providers indicated that they were unsure of how to coordinate with case managers, asserting that the boundaries of responsibility between case managers and providers was not clear. These providers mentioned often performing the duties of a case manager. These providers' difficulties in maintaining clear boundaries between their responsibilities and those of the case managers appeared to be heightened by a perceived high case manager turnover.

- Some participants provided anecdotes that suggest difficulty with providing person-centered and individualized care while also adhering to specific regulations. For instance, certain regulations attempt to protect participants while limiting participant choice. One participant described that he was unable to eat anything outside of his required dietary restricted option (e.g., diabetic friendly dessert).

Key ADS Trends

Providers shared trends that impact ADS service delivery, specifically:

- **HCBS Final Rule:** As discussed previously, the HCBS Final Rule provides additional requirements for HCBS providers. Some providers indicated that they more easily complied with the requirements because they were already conducting their programs in alignment with the rules, whereas other providers indicated having to adjust their programs to comply.
- **Positive Supports Rule:** Several providers mentioned that Minnesota's Positive Supports Rule has been difficult to implement because the Rule seems to be more applicable to residential settings and does not readily apply to the ADS setting. Providers noted that the staff training requirements are difficult to fulfill, especially if the site only serves one or two individuals with I/DD, which is the target population of the Rule.

National Scan of Adult Day Standards and Service Delivery

ADS Models Overview

Adult day services encompass several different models of service delivery, which generally reflects the types and levels of clinical supports provided in the sites. Historically, these variations have led to a differentiation between "adult day health" services and "adult day social" services. The underlying support needs of the population served coupled with the drive for integrated, person-centered care has led to challenges with creating clear distinctions between these two types of service models. As a result, one of the defining characteristics of this service model is an intersection of health, rehabilitative, and social supports.[21]

In many cases, ADS also include supplemental unskilled support services, such as meals and nutrition supports, or providing hygiene assistance for an individual's nails and hair. Adult day services may also include ancillary health services such as dental and oral health care.[22]

Adult Day Social and Adult Day Health

Many states make a distinction in their regulations and service definitions between an "adult day health" or "adult day social" model, as demonstrated by the following state examples.

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[21] Metlife Mature Market Institute, *The MetLife National Study of Adult Day Services*, October 2010, Available online: https://www.nadsa.org/metlife-study-2010/

[22] NASUAD, *Medicaid HCBS Settings Regulations and Adult Services*, April 2015. Available online: http://bit.ly/2Bh3d9f.

Adult Day Service Model Differentiation Example: Connecticut

While ADS definitions vary from state to state, one clear example of the service distinction comes from Connecticut, which provides both models of care. The Connecticut Association of Adult Day Services' Standards for Adult Day Care Centers in Connecticut articulates the differences between the social and medical settings.[23] The standards make a clear distinction between the social model of adult day and the health model of care, but jointly regulate the providers under the same section of the code. The standards require that both models meet minimum standards, but adult day health models must meet additional requirements that span above and beyond the requirements of adult day social, as demonstrated in the regulations language in Figure 3.

[23] Connecticut Association of Adult Day Services, *Standards for Adult Day Care Centers in Connecticut*, March 2015.

Figure 3. Connecticut Standards for Adult Day Care Centers[24]

Figure 3 describes the State of Connecticut's standards for ADS sites.

"Adult day care is a community-based group program designed to meet the needs of functionally impaired adults through a structured, comprehensive program that provides a variety of health, social and related support services, including appropriate therapy, rehabilitation and supervision services, in a protective setting during any part of a day[…]

There are two different models of adult day care: the social model and the medical model. The social model is designed for individuals who need supervision and activities but not extensive personal care and medical monitoring[…]

The following additional requirements must be met by centers which offer the medical model of care:

1. A program nurse must be available on site for not less than fifty percent of each operating day.
2. The program nurse shall be a registered nurse or licensed practical nurse, the program nurse may be a licensed practical nurse if the program is located in a hospital or long term care facility licensed by the Department of Health with ready access to a registered nurse from such hospital or long term care facility or the program nurse is supervised by a registered nurse who can be reached by telephone at any time during the operating day and who can be called to the center if needed within one half hour of the request. The program nurse is responsible for administering medications as needed and assuring that the participant's nursing services are coordinated with other services provided in the adult day care center, health and social services currently received at home or provided by existing community health agencies and personal physicians.
3. Additional personal care services shall be available as specified in the individual plan of care including but not limited to bathing (tub or shower facility on site), transferring, and administering and charting medications with a physician's order.
4. Therapeutic and rehabilitation services shall be coordinated by the center as specified in the individual plan of care including but not limited to physical therapy, occupational therapy and speech therapy. The center shall have sufficient space to provide such therapies on site, but the center may arrange to have therapies provided at other locations in order to meet the needs of individual clients.
5. A monthly health screening shall be provided including but not limited to blood pressure, pulse and weight."

[24] Connecticut Association of Adult Day Services, *Standards for Adult Day Care Centers in Connecticut*, March 2015.

Adult Day Service Model Differentiation Example: Washington

Washington State has a similar distinction between "adult day social" and "adult day health". Figure 4 provides a general definition of an adult day center.

Figure 4. Washington Administrative Codes 388-71-0702[25]

Figure 4 includes the State of Washington's definition of an ADS site.

"An adult day center is a community-based program designed to meet the needs of adults with impairments through individualized goal specific plans of care. This type of structured, comprehensive, nonresidential program provides a variety of health, social, and related support services in a protective setting. Adult day centers support families and caregivers with the following goals:

(a) Provide an opportunity for the client to live in his or her community;

(b) Provide the client with clinical and nonclinical services to meet unmet needs;

(c) Assist the client to maintain maximum independence in his or her activities of daily living (ADL); and

(d) Measure the client's progress through individualized interventions, as outlined in his or her negotiated care plan."

The Washington regulations further specify that adult day care (social model) must include a specific array of services, as described in Figure 5.

Figure 5. Washington Administrative Codes 388-71-0704[26]

Figure 5 includes Washington's required services for ADS sites.

"(1) Assistance with activities of daily living:

(a) Locomotion outside of room, locomotion in room, walks in room;

(b) Body care;

(c) Eating;

(d) Repositioning;

(e) Medication management that does not require a licensed nurse;

(f) Transfer;

(g) Toileting;

(h) Personal hygiene at a level that ensures client safety while in attendance at the program; and

(i) Bathing at a level that ensures client safety and comfort while in attendance at the program.

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[25] Washington State Legislature, *Washington Administrative Codes 388-71-0702*, 2017, Available online: https://app.leg.wa.gov/wac/default.aspx?cite=388-71&full=true#388-71-0702

[26] Washington State Legislature, *Washington Administrative Codes 388-71-0704*, 2017, Available online: https://app.leg.wa.gov/wac/default.aspx?cite=388-71&full=true#388-71-0704

(2) Social services on a consultation basis, which may include:

(a) Referrals to other providers for services not within the scope of COPES waiver or RCL reimbursed adult day care services;

(b) Caregiver support and education; or

(c) Assistance with coping skills.

(3) Routine health monitoring with consultation from a registered nurse that a consulting nurse acting within the scope of practice can provide with or without an authorizing practitioner's order. Examples include:

(a) Obtaining baseline and routine monitoring information on client health status, such as vital signs, weight, and dietary needs;

(b) General health education such as providing information about nutrition, illnesses, and preventative care;

(c) Communicating changes in client health status to the client's caregiver;

(d) Annual and as needed updating of the client's medical record; or

(e) Assistance as needed with coordination of health services provided outside of the adult day care program.

(4) General therapeutic activities that an unlicensed person can provide or that a licensed person can provide with or without an authorizing practitioner's order. These services are planned for and provided based on the client's abilities, interests, and goals. Examples include:

(a) Recreational activities;

(b) Diversionary activities;

(c) Relaxation therapy;

(d) Cognitive stimulation; or

(e) Group range of motion or conditioning exercises.

(5) General health education that an unlicensed person can provide or that a licensed person can provide with or without an authorizing practitioner's order, including but not limited to topics such as:

(a) Nutrition;

(b) Stress management;

(c) Disease management skills; or

(d) Preventative care.

(6) A nutritional meal and snacks every four hours, including a modified diet if needed and within the scope of the program, as provided under WAC 388-71-0770;

(7) Supervision and/or protection if needed for client safety;

(8) Assistance with arranging transportation to and from the program; and

(9) First aid and provisions for obtaining or providing care in an emergency. note: If the client requires the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of an authorizing practitioner, consider adult day health services.”

The regulations clearly distinguish the social model of adult day and the health model of adult day. The state requires that adult day health providers must cover all the supports included in the previous adult day care requirements, as well as the supports described in Figure 6.

Figure 6. Washington Administrative Codes 388-71-0704[27]

Figure 6 includes Washington's additional standards for adult day health sites.

> "Skilled nursing services other than routine health monitoring with nurse consultation; or
>
> At least one of the following skilled therapy services: physical therapy, occupational therapy, or speech-language pathology or audiology, as defined under chapters 18.74, 18.59 and 18.35 RCW; and
>
> Psychological or counseling services, including assessing for psycho-social therapy need, dementia, abuse or neglect, and alcohol or drug abuse; making appropriate referrals; and providing brief, intermittent supportive counseling. These services are provided by social services professionals."

Staffing Requirements

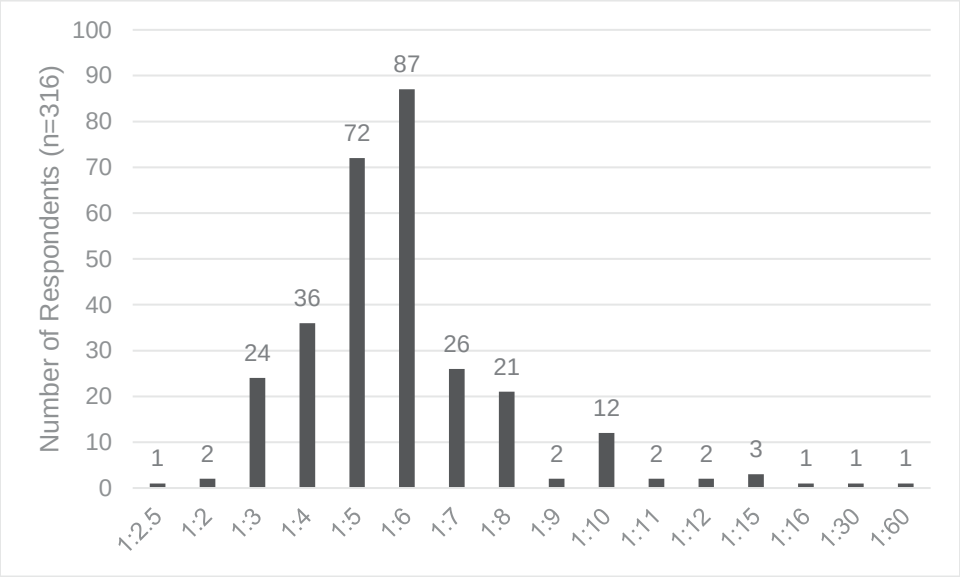
Staffing requirements and reimbursement models often reflect the level of need of ADS participants. For example, in 2017, a NASUAD survey of ADS providers indicated that there is a wide range of staffing ratios between ADS settings across the country. Most of the staffing ratios ranged from one staff for every three participants (1:3) to one staff for every seven participants (1:7). Standards of one to five (1:5) and one to six (1:6) were the most common ratios in ADS settings. A review of state regulations and standards indicates that the minimum requirements are frequently 1:6 or 1:8 (though there is variation across the country), and ADS settings that provide services to individuals with higher levels of need require higher staffing levels.

An example of staffing ratio differentiation occurs in the Arkansas provider regulations, which require "adult day health" providers to maintain a 1:5 staff-to-participant ratio whereas "adult day social" providers have a varied staffing ratio requirement and must have a minimum ratio of two staff when there are more than one and less than sixteen individuals present, and one additional staff for every eight participants above sixteen. Although this does not represent a static 1:8 staffing ratio, it does result in a required ratio of approximately 1:8.

[27] Washington State Legislature, *Washington Administrative Codes 388-71-0706*, 2017, Available online: https://app.leg.wa.gov/wac/default.aspx?cite=388-71&full=true#388-71-0706

Figure 7. Minimum Staffing Ratios Self-Reported by Nationwide ADS Providers[28]

Figure 7 demonstrates the minimum staffing ratios that were self-reported by nationwide ADS providers via a NASUAD survey.



Some states have adopted reimbursement models to differentiate rate reimbursements based on the level of need of ADS participants and varied staffing ratios. For example, Wyoming has differentiated staffing levels based on basic, intermediate, and high levels of need, and the reimbursement rates vary in a similar manner.[29] Colorado also has different rate structures for individuals with higher levels of need. According to the Colorado regulations, there are basic and specialized services. Specialized services apply to centers where 2/3 or more of the participants have a higher level of need, such as a traumatic brain injury, an intellectual or developmental disability, Alzheimer's, or similar types of need.[30]

Approaches to Addressing the 2014 HCBS Settings Final Rule

When studying ADS, it is essential to consider the impact of the HCBS Settings Final Rule as this Rule represents a significant shift in the way states and providers approach delivering HCBS. This Rule requires, for example, that the delivery of ADS facilitates personal choice, community integration, and individualized supports.

In the fall of 2017, NASUAD performed a national survey of state agencies and providers delivering LTSS. NASUAD asked respondents to describe any concerns that they may have regarding the application of the Final Rule to nonresidential services and the impact that it might have on providers, including ADS. Responses to this question varied, with several states

[28] Data provided by NASUAD internal database.
[29] Navigant Consulting, *Report to the Wyoming Department of Health Behavioral Health Division: Comprehensive, Supports and Acquired Brain Injury Waivers SFY 2019 Provider Rate Study*, January 31, 2018.
[30] Code of Colorado Regulations 2505-10 8.491, Available online: https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7555&fileName=10%20CCR%202505-10%208.400

indicating that they did not have any concerns while other states listed multiple areas that they felt were problematic. Some of these concerns include:

- The applicability of certain requirements placed on provider-owned and operated residential providers as they relate to nonresidential supports, including provisions that could impact "daily activities" such as:
    - Access to food at any time
    - Ability for visitors to freely come and go
- Staffing ratios and whether the current Medicaid financing system can support the required changes to meet the Rule
- The ability to retain adequate provider pools, given that several states have experienced provider withdrawal from Medicaid due, at least in part, to the Rule
- The interaction between ADS and other components of the individuals' lifestyle, such as their actual place of residence

As part of its assessment, NASUAD also surveyed providers of ADS across the country to ascertain whether they believed they met the HCBS settings requirements. Most providers responded that they believed they met the integration mandate. Providers included a wide range of rationales in support of their response, such as:

- Robust transportation provided to participants
- Scheduled and, in some cases, individualized outings into the community
- Individualized service plans with supports that respond to participant preferences
- Service centers that are located in the community center and open to outside participants

Potential Barriers for Compliance

One notable challenge with meeting the community integration mandate involves delivering transportation services. For providers in both rural and urban areas, transportation remains a key component to providing individualized supports and services. Some states include delivering transportation as part of the base rate for ADS. Washington State, for example, does not reimburse for transportation under the "adult day social" rate but does reimburse for transportation under the "adult day health" daily rate.[31] Other states, such as Massachusetts, have separate reimbursement for transportation provided by the "adult day health" site. Furthermore, several states and providers are attempting to reach compliance by collaborating with transportation districts – including fixed route and door-to-door options that help facilitate personal autonomy in HCBS settings.

Despite these efforts, the resources required to provide each participant with individualized transportation on an ongoing basis generally exceed the available funding resources.

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[31] Washington State Legislature, *Washington Administrative Codes 388-71-0724*, 2017, Available online: https://app.leg.wa.gov/wac/default.aspx?cite=388-71&full=true#388-71-0724

Therefore, ADS settings continue to struggle with allocating transportation resources in an individualized manner. Providers may mitigate this transportation challenge by offering group transportation services to events that participants elect to attend, and providers can also escort participants to centralized hubs that enable individuals to choose from a range of community activities. NASUAD found via national scan that this type of option is largely unavailable in rural and frontier areas of many states, and that providers must seek other options to deliver services and supports in a personalized manner.

Additionally, ADS providers across the country that reported concerns with meeting the Rule mentioned other issues that present challenges with compliance with the Rule, such as:

- Concerns about the center-based nature of their services and supports
- Belief that their current cost-structure makes it prohibitively expensive to provide the intensive supports required to meet the integration mandate
- Belief that there are challenges with meeting requirements around assuring health and welfare of participants and providing full access to the community
- Apprehensions about the level of need of the populations served and the ability to effectively serve the individuals outside the setting
- Challenges with providing employment supports that are outside the scope of the supports historically provided and, in some cases, not aligned with the populations served (i.e., providers that specialize in dementia care)

Intersection with Case Management and Facilitating Person-Centered Supports

The HCBS Final Rule sets the expectation that providers deliver services in a person-centered manner. There are specific regulatory requirements regarding person-centered planning for individuals who receive Medicaid-funded HCBS. The intention of these requirements is to promote individuals' ability to control their lives, their resources, and their schedules. Ensuring that these person-centered practices exist in ADS settings can help to facilitate compliance with the HCBS settings requirements and also lead to higher quality of care and participant satisfaction.

Provider and Case Manager Coordination Example: Washington

Washington State has implemented processes and procedures to strengthen the person-centered planning delivered to individuals across their HCBS system, but also in nonresidential care facilities. In Washington, the State focuses specifically on whether a setting's design, policies, or practices systemically isolate residents from their greater community. In many cases, the programmatic design and/or the facility structure may not be intrinsically isolated, but individual residents may experience isolation based upon their own circumstances. Washington's plan to bolster person-centered practices includes assessing participants to determine factors contributing to an individual's isolation. This approach is innovative and informative for other states, as it addresses the root cause of isolation in an individual's life. If the assessment finds that the individual's isolation is due to factors that are not related to the provider's physical design and structure, the issues are addressed through person-centered planning. In contrast, if the assessment reveals that the provider's environment is the reason

for isolation, providers must to enact changes to ensure that individuals are not prevented from accessing the community due to the provider's structure, policy, or programming design.

Washington's adult day regulations require coordination between the ADS provider and the case manager and require a negotiated care plan with the ADS setting. The state code includes the specific requirement, "Within ten paid service days from the date the client started attending the ADC center, the ADC center must complete and provide a preliminary service plan to the client or the client and his or her representative and the client's case manager that outlines the client's strengths, deficits, and potential needs."[32] The regulations indicate that the case manager should coordinate care and facilitate connections with other community supports, and this required coordination helps the case manager fulfill required duties.

The negotiated care plan between the ADS setting and the case manager must include (among other things):

- A list of the care and services the ADS setting will provide the participant
- Identification of who will provide the participant's care and services
- When and how the ADS setting will provide the care and services
- The participant's activity preferences and how the ADS setting will meet these preferences
- Other preferences and choices about issues important to the participant, including but not limited to, food, daily routine, grooming, and how the ADS setting will accommodate the client's preferences and choices.[33]

In the course of their assessments for compliance with the HCBS Rule, Washington has identified certain providers as examples of successful models that other entities can emulate and learn from in order to achieve compliance. Follow-up discussions with State staff highlighted one provider in particular that can be used as an example of an ADS provider that is fully compliant with the regulation's integration mandate.

The identified fully-compliant ADS setting website advertises a wide range of supports and services, including:

- Fitness, social and recreational group activities to maintain physical and mental alertness and promote human interaction
- Nutritious, Asian-style lunches including fresh fruits and vegetables
- Transportation coordination
- Registered nurse oversight/coverage

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[32] Washington State Legislature, *Washington Administrative Codes 388-71-0718*, Available online: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-71-0718

[33] Washington State Legislature, *Washington Administrative Codes 388-71-0718*, Available online: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-71-0718

- Rehabilitative, occupational, and physical therapy
- Personal care services
- Respite for caregivers

Participants can easily access partnering service providers located in the same plaza as the ADS setting, including a public library featuring multi-lingual materials, health clinic, mental health care, ESL classes, citizenship classes and the neighborhood community center.

The highlighted ADS site is in Seattle, near shops, restaurants, and other amenities. The site is also nearby accessible public transportation. The site is in a complex that includes housing, such as assisted living, but also has a ground floor that commercial shops available for use to the general public. Although this ADS provider is co-located with other health care services, which some may consider to be isolating, the structure, location, and policies of the entity allow for participants to freely access the community as they choose.

The Washington example highlights how individualized supports and services can promote self-determination and community integration. However, it also implicitly demonstrates some of the inherent challenges with “adult day health” in rural and frontier settings. The example ADS setting identified above is urban, and many of the opportunities it provides for community integration are due to the location and its convenience to fixed-route transportation as well as the nearby availability of robust community options for participants to choose based upon individual preference. Given that transportation is frequently cited as a significant challenge when sites seek to implement community-based options, settings in rural and frontier areas may need to leverage additional resources to address these requirements.

Quality Measurement and Adult Day Services

There is a concerted push for HCBS systems broadly, including ADS, to focus on quality improvement. In HCBS, quality/outcomes measures are often person-based, due to the individualized nature of these supports and services. The measures are generally based upon survey data collected from the individuals receiving services, and include but are not limited to:

- Quality of life measures
- Access to care
- Member satisfaction

Other HCBS quality measures are more quantitative in nature and focus on institutional vs. HCBS placements, timeliness of care plans, and adverse incidents such as falls. One challenge with HCBS quality measurement is that there are several entities at the Federal, state, and local levels working to develop these measures; however, there is not a single federal framework for HCBS quality and outcomes measures. Because there is little standardization and limited Federal guidance, states have the flexibility to establish their own quality measures to accurately reflect and monitor the services they deliver. However, too much flexibility may lead to inconsistencies in approach, resulting in incomparable data sets and limited opportunities for benchmarking on a state and national scale.

National Quality Forum

To address the disparate approaches to HCBS quality measurement, the National Quality Forum (NQF), along with the United States Department of Health and Human Services, conducted a project to support a comprehensive and consistent approach to HCBS quality measurement. The National Quality Forum assembled an expert panel to engage in a two-year HCBS Quality Measurement project with the goal of guiding efforts to develop a broad spectrum of validated quality measures for all populations using HCBS. One goal of the project was to provide consistency and comparability across states and programs and to provide multi-stakeholder guidance on the highest priorities for measuring HCBS that support high-quality community living. The project culminated in a final report published in September 2016, *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*.[34]

The NQF report highlights specific quality measures based on existing state and national measures. However, the purpose of this committee was *not* to endorse specific measures but to instead provide a framework that will lead to measure development.

The NQF report organized the inventory of existing quality measures into eleven specific domains and several sub-domains that encompass the wide range of outcomes associated with HCBS and LTSS. Figure 8 below includes the domains identified in the final report.

[34] National Quality Forum, *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*, September 2016, Available online: https://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

Figure 8. NQF Quality Domains

Figure 8 lists the eleven quality domains identified by the National Quality Forum in a September 2016 report, *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*.

#	Domain Name and Description
1.	**Service Delivery & Effectiveness:** The level to which providers offer services in a manner consistent with a person's needs, goals, and preferences that help the person to achieve desired outcomes
2.	**Person-Centered Service Planning and Coordination:** The processes by which the HCBS system identifies personal goals, preferences, and needs, and coordinates services and supports across providers and systems
3.	**Choice and Control:** The level to which individuals who use HCBS, on their own or with support, make life choices, choose their services, and control delivery of those services
4.	**Community Inclusion:** The level to which people who use HCBS feel integrated into their communities and socially connected, in accordance with personal preferences
5.	**Caregiver Support:** The level of support (e.g., financial, emotional, technical) available to and received by family caregivers or natural supports of individuals who use HCBS
6.	**Workforce:** The adequacy, availability, and appropriateness of the provider network and HCBS workforce
7.	**Human and Legal Rights:** The level to which delivery of HCBS promotes and protects the human and legal rights of individuals
8.	**Equity:** The level to which HCBS are equitably available to all individuals who need long-term services and supports
9.	**Holistic Health & Functioning:** The extent to which service delivery assesses and supports all dimensions of holistic health
10.	**System Performance & Accountability:** The extent to which the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes
11.	**Consumer Leadership in System Development:** The level to which the HCBS system supports individuals to actively participate in the design, implementation, and evaluation of the system at all levels

Additional National Quality Measurement Resources

Several additional entities are currently working to develop and strengthen HCBS quality measures, described in Figure 9 below:

Figure 9. HCBS Quality Measurement Resources

Figure 9 describes several national organizations and associations that have developed HCBS quality measurement frameworks.

Organization and Program	Description of Initiative
Centers for Medicare & Medicaid Services (CMS) - Consumer Assessment of Healthcare Providers and Systems (CAHPS)[35]	The HCBS CAHPS Survey is a questionnaire developed for measuring beneficiary experience with the Medicaid home and community-based services and supports delivered by providers. Core questions cover topics such as: getting needed services, communication with providers, case managers, choice of services, medical transportation, and personal safety, as well as community inclusion and empowerment The questions are generally not targeted to center-based providers, such as Adult Day.
National Association of States United for Aging and Disabilities (NASUAD) – National Core Indicators: Aging and Disabilities (NCI-AD)[36]	The NCI-AD includes a wide range of survey and administrative data that focuses on quality of life, quality of care, and participant experience in LTSS. This project is not specific to ADS but could be helpful to inform participant experience in these settings.
National Association of State Directors of Developmental Disabilities Services (NADDDS) – National Core Indicators (NCI)[37,38]	This initiative is closely related to NCI-AD but focuses on individuals with intellectual/developmental disabilities instead of the NCI-AD focus on older adults and individuals with physical disabilities.
National MLTSS Health Plan Association	The MLTSS Health Plan Association released a report titled *Model LTSS Performance Measurement and Network Adequacy Standards for States*.[39] The report included potential measures for MLTSS plans, including ADS-relevant measures: • HCBS vs. institutional services

[35] Centers for Medicare & Medicaid Services, *Consumer Assessment of Healthcare Providers and Systems*, Available online: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html
[36] NASUAD, *National Core Indicators-Aging and Disabilities*, 2018, Available online: https://nci-ad.org/
[37] Minnesota participates in both NCI and NCI-AD, so there could be opportunities for the state to leverage the information currently collected to inform policymakers on participant experience.
[38] NADDDS, *National Core Indicators*, 2018, Available online: https://www.nationalcoreindicators.org/
[39] National MLTSS Health Plan Association, *Model LTSS Performance Measurement and Network Adequacy Standards for States*, April 2017, Available online: http://mltss.org/wp-content/uploads/2017/05/MLTSS-Association-Quality-Framework-Domains-and-Measures-042117.pdf

Organization and Program	Description of Initiative
	• Overall satisfaction with adult day care provider excellent or above average • Adherence to medication regimen • Percent of members able to see their friends and family when they want, and proportion who are not lonely • Percent of members able to participate in activities outside of home when and with whom they want

Notably, there are specific challenges associated with ADS and quality of care, quality of life, and patient satisfaction outcomes. The intersectionality between social and health services inherent to the ADS model create specific issues with outcome measurement systems that require clinically oriented measures as well as socially oriented measures.

The National Association for Adult Day Services (NADSA) established a workgroup to evaluate potential measures to demonstrate the outcomes and value of services provided. Although the workgroup has not yet finalized their recommendations, examination of the draft report provides insights into the approach and outcomes considered by the providers.[40] Notably, the workgroup recommended outcomes that were sub-divided into various domains for the individual, such as health outcomes (e.g., nutrition risk, falls rate, blood sugar, pain, etc.); emotional and cognitive outcomes (e.g., depression, cognition, quality of life, isolation and loneliness) and person-centered care (e.g., participant satisfaction, ADL/IADL assistance, participant-driven activities). Given the ADS settings' key role in providing supports and services that enable a person's caregiver to keep the participant at home, the NADSA report also suggests measures that focus on caregiver satisfaction and job retention as well as measuring the burden on the caregiver. Lastly, the report provides recommendations related to system-level outcomes, which include items such as emergency room utilization, hospital admissions, and nursing home placements.

The review of these different HCBS, LTSS, and ADS-specific approaches to outcomes measurement highlights the need to consider both the participant experience and health-related outcomes when evaluating quality and outcomes for ADS. There are notable challenges to collecting data to support these measures, including:

- A substantial proportion of the measures are reliant on self-reported data. This can be particularly challenging when individuals have cognitive impairment or other issues that may limit their ability to respond to questionnaires.
- Some of the self-reported measures – particularly those dealing with loneliness, abuse, or self-determination – may be extremely difficult to collect from individuals who have a guardian or other representative assisting with completing the survey.

[40] National Association for Adult Day Services, *NASDA Task Force on Outcomes Levels of Practice and Measures*, September 2016, Available online: http://www.nadsa.org/wp-content/uploads/2016/11/NADSA-Service-Delivery-Outcomes-of-Interest.pdf

- Due to the nature of the supports ADS provide, ADS providers are unlikely to have the ability to fully address all the health care needs of individuals. It may therefore be challenging to hold these providers accountable for certain health-related outcomes of the participants.

Section IV Criteria for the Development of Recommendations

Navigant identified criteria for the assessment of potential recommendations. These criteria were structured to support the alignment of final recommendations with the needs of Minnesota's ADS participants and the ability of providers to meet those needs. Navigant developed these criteria with input from DHS and the Adult Day Study Stakeholder Group.

Figure 10. Evaluation Criteria

Figure 10 includes ten criteria measures developed by the study workgroup to establish whether Navigant's recommendations align with the needs of the ADS system, including ADS participants, providers and state regulators.

#	Proposed Criteria
1.	Recommendations do not conflict with existing federal regulations or requirements
2.	Recommendations are feasible to implement for all ADS provider types (e.g. small capacity site vs. large capacity sites, urban vs. rural, cultural-specific sites, etc.)
3.	Recommendations promote participants' ease of access, limiting potential downstream service restrictions (e.g. participants with higher medical needs are not susceptible to decrease in services)
4.	Recommendations will advance quality of service delivery with the potential to positively impact all participants, regardless of payer type
5.	Recommendations can be implemented consistently with limited gray areas (i.e., not open to interpretation)
6.	Recommendations allow provider flexibility to implement and design their own programs based on their participant population
7.	Recommendations set an appropriate level of expectation with an adequate minimum standard
8.	Recommendations help ADS providers promote participant experience by maximizing person-centered delivery
9.	Recommendations promote ADS provider's potential to holistically support participants with their social, health and day-to-day needs
10.	Recommendations promote coordination of ADS with other parts of the HCBS delivery system

Section V Service Definition Related Recommendations

As part of the study, Navigant recommends changes to the ADS definition, in waiver plans and/or statute, to more clearly define appropriate use of this service. This section describes our recommendations regarding licensure standards, provider guidance and assistance, and service definitions.

For each recommendation, we provide the rationale, primary criteria addressed by the recommendation, and the role of DHS and providers in implementing the recommendation. Note that the examples we include are not an exhaustive depiction of all standards that would require updating. DHS will need to conduct a more intensive review of standards if the recommendations are implemented.

In addition to the primary criteria identified below, all recommendations meet Criteria 1 (below).

Criteria 1: Recommendations do not conflict with existing federal regulations or requirements.

Licensure Standards/Regulations: Recommendations pertain to elements in Minnesota Statutes and Administrative Rules that govern ADS licensure.

Recommendation 1: Update licensure standards to reflect modern ADS operations.

Navigant recommends updating licensure standards, with a focus on eliminating standards that are outdated and do not reflect modern-day realities and/or current use of technology in service delivery. Examples of recommended updates include, but are not limited to:

- Modify MN Administrative Rule 9555.9720 to exclude the requirement that first aid kits contain money for phone calls
- Modify MN Administrative Rule 9555.9730 to change the requirement that sites provide "one television set, AM/FM radio, phonograph, or tape player"
- Modify MN Administrative Rule 9555.9640 or related requirements to allow for written or electronic distribution of policies and program information

Figure 11. Recommendation 1

Figure 11 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	Updated regulations would better reflect the realities of modern adult day operations and would allow providers the opportunity to use modern technologies and strategies without needing to retain outdated processes. This recommendation will also curtail administrative and operational burden that occurs when providers are required to follow standards that do not directly impact the success of service delivery.
Primary Criteria Addressed	• Recommendations are feasible to implement for all ADS provider types (e.g. small capacity site vs. large capacity sites, urban vs. rural, cultural-specific sites, etc.). • Recommendations will advance quality of service delivery with the potential to positively impacts all participants, regardless of payer type. • Recommendations set an appropriate level of expectation with an adequate minimum standard.
DHS Role	• Conduct an exhaustive review of standards to identify outdated requirements that pose administrative burden for providers • Develop and propose changes to licensure regulations for legislative approval • Update related licensure materials
Provider Role	• Provide feedback on which standards offer minimal value based on modern service delivery practices • Adjust operations to align with updated standards

Recommendation 2: Consider updated standards regarding physical plant to include features that support participant comfort.

Navigant recommends adding environmental and physical features to ADS standards that support participant comfort and accessibility. This could include incorporating “homelike” conditions as they are described in the HCBS Final Rule. “Homelike” features could include but are not limited to, having certain types of seating available, having space for participants to walk outdoors or a designated quiet area, and/or other elements that enhance participants’ accessibility and ability to self-navigate in the ADS provider setting.

Figure 12. Recommendation 2

Figure 12 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	Existing regulations could be enhanced to more clearly establish minimum standards for features that enhance comfort and participant experience. Strengthening these standards will allow DHS to hold providers accountable on core expectations and help to bolster a statewide approach to high-quality environments for participants.
Primary Criteria Addressed	• Recommendations set an appropriate level of expectation with an adequate minimum standard. • Recommendations help ADS providers promote participant experience by maximizing person-centered delivery. • Recommendations allow provider flexibility to implement and design their own programs based on their participant population.
DHS Role	• Review standards to identify areas where providers could use additional oversight • Develop and propose changes to licensure regulations for legislative approval • Update related licensure materials
Provider Role	• Adjust physical design elements to enhance participants’ autonomy in the ADS environment and align with updated standards

Recommendation 3: Update licensure regulations to better reflect person-centered principles and individualized participant service.

Adult day service providers serve diverse participants with varied ages, socio-economic backgrounds, and disability types. These differences play a role in shaping a participant's goals, preferences, and targeted outcomes. Acknowledging the complexities of individualizing congregate services to a diverse array of program participants, Navigant recommends orienting monitoring requirements to align with an individual's service plan, to support DHS in monitoring and promoting a service delivery culture where the participant's person-centered plan is a primary source of guidance to govern ADS delivery. For example:

- Rather than requiring sites to provide "age appropriate games, books, crafts, and other materials to implement daily program activities," consider requiring that sites provide "games, books, crafts, and other materials that reflect participants' preferences as identified in participants' service plans."
- Language should clearly balance the existing requirement to have menus approved by registered dietitians and to identify and document participant's dietary restrictions with participant's autonomy and freedom of choice in making nutrition selections, defining expectations when participants select an option that poses health risks.

This adjustment will avoid the potential for a "one-standard-fits-all" approach to monitoring and will instead encourage surveyors to consider the unique dynamics of each ADS site based on the population served. For instance, many of the providers visited as part of this study indicated that coloring in coloring books is a commonly enjoyed and requested activity. While a surveyor may opine that coloring is not an "age-appropriate" activity, if the surveyor reviewed a sample of participant plans that included coloring or art as a preferred activity, they would objectively identify the provider as responding appropriately according to DHS standards.

Figure 13. Recommendation 3

Figure 13 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	According to DHS Licensing staff, surveyors currently attempt to understand if the available activities connect with individuals' interests by informally asking providers whether participants play the games at the site. Updating the regulations to link directly to person-centered principles as documented in the individual's service plan, will formally establish the expectation for individualized services and demonstrate a clear connection between individuals' preferences and offered activities, food choices, or other service features. This will better incorporate consideration of participant's individualized service plan (ISP) as a guide for surveyors when considering the appropriateness of provider practices specific to their participant population.
Primary Criteria Addressed	• Recommendations are feasible to implement for all ADS provider types (e.g. small capacity site vs. large capacity sites, urban vs. rural, cultural-specific sites, etc.).

	• Recommendations help ADS providers promote participant experience by maximizing person-centered delivery. • Recommendations will advance quality of service delivery with the potential to positively impacts all participants, regardless of payer type.
DHS Role	• Review standards to identify areas where providers could use additional oversight • Develop and propose changes to licensure regulations for legislative approval • Update related licensure materials • Develop a process to capture participants' preferences
Provider Role	• Adjust operations to align with updated standards • Implement a process that captures participants' preferences, if a process is not already in place

Recommendation 4: Better articulate expected elements required in an individualized service plan.

The individualized service plan (ISP) is an important document that should be the basis for how ADS are delivered, based on participant-identified needs, wishes, preferences, and goals. Due to the criticality of this tool to service delivery, DHS should clearly articulate the expected minimum standards of person-centered service planning information collected and offer further guidance on expectations for how a provider will document and use this information to drive service goals and objectives. Clarifying expected ISP elements may involve clearly delineating what core domains the ISP must include, how frequently information should be re-assessed or updated, depict example goals and case examples, and include instructions on how the service plan should be used to support individualized service planning and delivery.

Figure 14. Recommendation 4

Figure 14 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	Although the licensing standards dictate basic requirements for service plans and plans of care, DHS Licensing indicated that service planning is an area where providers fluctuate in their strength and compliance. Observed concerns include: some ADS providers may designate the same or similar goals and objectives to all participants with similar diagnoses. Others have goals that are vague and cannot be objectively monitored to consider service impacts. Clarifying expectations and offering targeted guidance for service planning would support providers in capturing appropriate person-centered goals that can be monitored for continued progress and developing service plans that truly represent each individual's needs and preferences.
Primary Criteria Addressed	• Recommendations help ADS providers promote participant experience by maximizing person-centered delivery. • Recommendations set an appropriate level of expectation with an adequate minimum standard. • Recommendations are feasible to implement for all ADS provider types (e.g. small capacity site vs. large capacity sites, urban vs. rural, cultural-specific sites, etc.). • Recommendations will advance quality of service delivery with the potential to positively impacts all participants, regardless of payer type.
DHS Role	• Review standards to identify areas where service plan requirements lack detail • Develop and propose changes to licensure regulations for legislative approval • Update related licensure materials • Develop training opportunities and materials

Provider Role	• Adjust service planning process to align with updated standards

Recommendation 5: Clarify the role of ADS providers versus case managers as it relates to offering other community-based services to participants to address participants' community-based service needs.

Adult day services is a congregate service where participants have access to social networks including fellow participants and provider staff. When a participant attends ADS regularly, they are likely to grow more familiar with ADS staff than they are with their assigned case manager, who participants often see less frequently. This dynamic increases the likelihood that participants will raise issues and questions to ADS staff that are more appropriate for their case manager to address. Multiple ADS providers indicated they respond directly to case management-oriented requests and sometimes struggle to connect a participant to their case manager for follow-up.

Navigant recommends clear delineation of responsibilities between ADS staff and case managers, including issuance of guidance on how to redirect participants to their case managers as appropriate, to preserve a coordinated approach to HCBS delivery that connects participants to the appropriate supports based on their identified needs, while reducing the risk of conflict of interest, duplication of service and other inefficiencies.

Figure 15. Recommendation 5

Figure 15 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	ADS providers indicated that they are prone to execute services that are under the purview of case managers because the ADS setting offers more immediacy, continuity, rapport, trust, and ease of follow-up to participants. However, conflict-free case management requires that case management and direct provision of services be separate and distinct, to avoid potential conflict of interest. Therefore, it would be beneficial to clearly define responsibilities and limitations between ADS providers and case managers, to make clear when an ADS provider is expected to refer a participant back to his or her case manager as opposed to taking provider action. Clearly delineating these roles will help to avoid duplication of services and foster a culture of collaboration and partnership across HCBS providers.
Primary Criteria Addressed	• Recommendations promote coordination of ADS with other parts of the HCBS delivery system. • Recommendations promote ADS providers' potential to holistically support participants with their social, health and day-to-day needs.
DHS Role	• Review standards and provider communications to determine current level of explanation on this topic • Develop and propose changes to licensure regulations for legislative approval and/or release provider communications on this topic
Provider Role	• If applicable, adjust daily processes and staff training to align with provider's responsibilities rather than case manager responsibilities

Recommendation 6: Consider revising the Positive Supports Rule training requirements for providers who primarily serve the aging population and/or serve a small number of individuals with intellectual or developmental disabilities (I/DD).

The Positive Supports Rule serves a key purpose, requiring that service providers delivering DHS-licensed services to individuals with I/DD use person-centered principles and positive support strategies. As part of our review of this Rule, we identified a focus on participant employment and other rule elements that may not be well suited to serving the older adult participant population, which is prominently represented in ADS. While providers in Minnesota can select which waiver populations they will serve, some providers may operate in areas where limited options exist, which creates a different pressure to serve multiple disability populations. In many cases, an ADS provider may serve a limited number of participants with intellectual or developmental disabilities.

We recommend that DHS consider potential modification of the Positive Supports Rule for ADS providers by modifying training requirements to better target ADS providers' older adult populations, for example:

- Adding cultural competency training to successfully serve aging and physically disabled populations
- Reducing training hours for sites only serving a small percentage of applicable participants
- Continuing to require the site director to complete all hours of mandated training and requiring all other ADS support staff to complete selected 1-2 hours of trainings annually

Solutions should focus on balancing limited staff time and resources, with the necessity of training activities to promote positive service outcomes for participants of all disability types.

Figure 16. Recommendation 6

Figure 16 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	The Positive Supports Rule includes multiple person-centered training requirements for select providers who serve participants with I/DD, including ADS settings serving the I/DD population. Although the Rule is well intended and encourages tailoring services to meet the needs of the I/DD population, the downstream impacts of the Rule on ADS providers who serve primarily older and physically disabled participants require further consideration. Modifications to the training requirements may lessen the strain placed on sites with limited staff who only serve a limited number of individuals with I/DD.
Primary Criteria Addressed	• Recommendations are feasible to implement for all ADS provider types (e.g. small capacity site vs. large capacity sites, urban vs. rural, cultural-specific sites, etc.). • Recommendations promote participants' ease of access, limiting potential downstream service restrictions (e.g. participants with higher medical needs are not susceptible to decrease in services).

	• Recommendations will advance quality of service delivery with the potential to positively impacts all participants, regardless of payer type. • Recommendations allow provider flexibility to implement and design their own programs based on their participant population.
DHS Role	• Review the Positive Supports Rule training requirements and determine which trainings could better serve small-capacity sites • Develop and propose changes to licensure regulations for legislative approval • Update related licensure materials • Communicate updated requirements to providers
Provider Role	• Comply with updated training requirements as applicable

Provider Guidance and Assistance: Recommendations pertain to the implementation of regulations and how DHS communicates expectations to providers

Recommendation 7: Develop a licensing self-assessment tool for ADS providers that includes all licensing requirements pertaining to ADS.

Navigant recommends implementing a user-friendly, easy-to-reference check list or inventory tool to support providers with self-assessment of their compliance with licensure requirements outside of periodic on-site DHS reviews.

Figure 17. Recommendation 7

Figure 17 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	Providing this tool will minimize gray areas, clearly communicate licensing expectations, and allow providers to monitor their compliance with licensing regulations. This tool may prove especially helpful since there are no licensing policies and procedures that interpret the licensing statutes. Self-monitoring checklists are currently available to providers licensed under Minnesota Statutes 245D.
Primary Criteria Addressed	• Recommendations set an appropriate level of expectation with an adequate minimum standard. • Recommendations can be implemented consistently with limited gray areas (i.e., not open to interpretation). • Recommendations are feasible to implement for all ADS provider types (e.g. small capacity site vs. large capacity sites, urban vs. rural, cultural-specific sites, etc.).
DHS Role	• Develop checklists in accordance with current licensing standards • Distribute checklists to all providers • Provide training and/or other forms of assistance to clearly explain the checklist's purpose to providers
Provider Role	• Providers may choose to conduct the checklist to confirm compliance with licensure standards

Recommendation 8: Implement a recurring provider call to provide technical assistance to ADS providers on an ongoing basis.

Navigant observed gaps in DHS provider support including limited ongoing technical assistance and communication of monitoring trends and changes to providers. Navigant recommends implementing additional provider correspondence beyond an annual or bi-annual licensure visit to offer timely provider education on key ADS trends, observed program best practices, and updated DHS interpretations of rules and regulations. Calls could be conducted jointly by DHS licensing and policy teams to share monitoring trends and at minimum should include joint planning between these teams to maximize the productivity of these calls.

Figure 18. Recommendation 8

Figure 18 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	All-ADS provider calls with DHS will also allow providers an opportunity to hear from DHS and ask questions about licensure requirements, operational issues, or other updates outside of periodic site visits. Additionally, providers will be able to receive targeted ADS-specific updates, which would be welcomed by providers who indicated that existing communications are typically broadly applicable to all waiver providers and do not often clearly explain the direct relevance to ADS providers. These communications would support provider compliance and performance improvement.
Primary Criteria Addressed	• Recommendations set an appropriate level of expectation with an adequate minimum standard. • Recommendations can be implemented consistently with limited gray areas (i.e., not open to interpretation). • Recommendations are feasible to implement for all ADS provider types (e.g. small capacity site vs. large capacity sites, urban vs. rural, cultural-specific sites, etc.).
DHS Role	• Tailor communications to ADS providers • Hold regularly-scheduled provider calls • Conduct joint planning between DHS licensing and policy teams to develop agenda and content of calls
Provider Role	• Participate in regular provider calls and communicate any questions to DHS for response

Recommendation 9: Develop an ADS provider handbook separate from licensure regulation that provides guidance and more detailed interpretation for providers to support case-specific considerations and operationalize key requirements.

Currently, the primary source of DHS guidance to ADS providers is housed directly in state regulation. This guidance is somewhat limited and does not address how to operationalize licensure requirements and address common challenges that do not align directly to licensure requirements. Navigant recommends that the State offer additional guidance through handbooks or other tools to offer a user-friendly source of best practices and ADS operational expectations. This level of guidance is currently offered via third party associations and not all ADS providers access the guidance and/or are association members. Additionally, third party guides may not directly align with DHS interpretation or best practice advice.

Figure 19. Recommendation 9

Figure 19 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	Provider associations, namely LeadingAge of Minnesota, currently offer substantial technical support to ADS providers across the state via a published ADS handbook that interprets existing state regulations. Interpretation of regulations should ideally come from DHS directly to ensure that provider education and technical assistance aligns directly with department expectations, as DHS is ultimately accountable for program performance and regulatory oversight. Additionally, by including guidance in a provider handbook versus increasing the information provided in current licensing regulations, DHS would have the flexibility to make updates in real time. To maximize providers' understanding of required documentation, the handbook may include additional guidance on the minimum standards and required contents of forms, including provision of a sample template or best practice examples.
Primary Criteria Addressed	• Recommendations can be implemented consistently with limited gray areas (i.e., not open to interpretation). • Recommendations are feasible to implement for all ADS provider types (e.g. small capacity site vs. large capacity sites, urban vs. rural, cultural-specific sites, etc.). • Recommendations will advance quality of service delivery with the potential to positively impacts all participants, regardless of payer type.
DHS Role	• Develop handbooks and make them available to the broad network of ADS providers • Leverage the handbooks ongoingly for provision of technical assistance and provider education

Provider Role	• Escalate questions and subject areas that are not clearly articulated in regulation or licensure requirements, and/or merit DHS interpretation and operational guidance

Recommendation 10: Expand opportunities for training/education.

Throughout the study, stakeholders discussed a variety of topic areas that pose specific and unique challenges to ADS providers, many of which were population or case-specific. Expanded training opportunities could include access to *on-demand* training webinars, which offer a time and resource-efficient method for providers to access education and training on an array of diverse topics.

For example, one potential training topic could include guidance specific to serving individuals with chronic, persistent mental illness or who have a specific diagnosis like post-traumatic stress disorder. While not all providers will need this training, it would be an important resource for those that do. Training formats do not have to be lengthy but can offer a go-to source of easily accessible information and assistance for providers as they need it.

Figure 20. Recommendation 10

Figure 20 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation and the role of DHS and ADS providers in implementing the recommendation.

Rationale	Expanded training opportunities will better prepare providers to deliver high quality services and will enable providers to understand expectations more clearly. For example, some providers indicated that trainings are often general to all waiver providers but would be more useful if they provided targeted information that is specific to ADS.
Primary Criteria Addressed	• Recommendations set an appropriate level of expectation with an adequate minimum standard. • Recommendations are feasible to implement for all ADS provider types (e.g. small capacity site vs. large capacity sites, urban vs. rural, cultural-specific sites, etc.) • Recommendations will advance quality of service delivery with the potential to positively impacts all participants, regardless of payer type
DHS Role	• Gauge providers' training needs and preferences • Develop and provide trainings
Provider Role	• Utilize the updated training materials • Request training and topic areas and share best practices for incorporation as case studies into future training

Service Definitions: Recommendation pertains to the manner in which ADS are defined in HCBS 1915(c) waivers and applicable statutes.

Recommendation 11: Conduct study in the future of the need for a definition and/or rate distinction between adult day health models and adult day social models.

Currently Minnesota does not distinguish between "adult day health" and "adult day social" models but based on ADS sites' characteristics and service offerings, it appears that both the "adult day health" and "adult day social" models are present in Minnesota, with "adult day social" being the slightly more prevalent service offering. However, there is a lack of information on the need and projected demand of distinct ADS models in Minnesota. A targeted study would need to:

- Assess the ability of the ADS provider network to offer more intensive medical supports
- Seek to understand if the lack of access to skilled nursing services impedes ADS access for individuals with those care needs
- Consider how differentiating models may drive future rebalancing efforts for individuals who require intermittent nursing support throughout the day
- Project financial impacts, including rate development for a new service and estimated budget impact(s)

Figure 21. Recommendation 11

Figure 21 elaborates on the recommendation above, including a rationale, the primary criteria addressed by the recommendation, and the role of DHS and ADS providers in implementing the recommendation.

Rationale	Distinguishing between the two ADS models may better define expectations of providers.
Primary Criteria Addressed	• Recommendations set an appropriate level of expectation with an adequate minimum standard. • Recommendations promote ADS providers' potential to holistically support participants with their social, health and day-to-day needs.
DHS Role	• Conduct additional research on other states' structure of "adult day health" vs. "adult day social" service models • Conduct analyses to assess the benefits and challenges of differentiating these models, including financial implications for DHS and providers
Provider Role	• Participate in study and provide feedback

Section VI Quality Measurement Recommendations

As part of the study, Navigant identified data-based measures that Minnesota may consider using to demonstrate the impact of adult day services (ADS) and outcomes for adult day participants in Minnesota. Figures 22 and 23 below describe our quality measure recommendations based on select domains from National Quality Forum's 2016 report: *Quality in Home and Community-Based Services: Addressing Gaps in Performance Measurement* and informed by stakeholder feedback and review of Minnesota ADS standards. Most of the measures below are part of a broader HCBS quality framework used to measure outcomes in a breadth of services beyond just ADS. However, each measure has the potential to specifically target the intended outcomes of ADS as a single service. Given the nature of ADS, recommended measures incorporate both the participant experience and health-related outcomes.

Note that these measures are not fully operationalized and serve as a starting point for DHS to begin to consider methods for measuring ADS quality. The measures are not intended to capture providers' compliance but are instead to be used as a key component of a larger continuous quality improvement process for HCBS.

If DHS chooses to implement these measures, it may be necessary to obtain additional data through participant surveys coupled with health assessments and administrative data. Extensive collaboration between the provider community and DHS would also be critical for successful implementation.

We selected these measures based on their ability to clearly demonstrate value in ADS settings. The selected measures address the evaluation criteria described in Section IV of this report, with one exception. The quality measures do not currently address Criteria 7 (below) due to the absence of existing quality measurement in adult day services that would establish baselines and then minimum thresholds. Should DHS choose to implement these measures, DHS would need to consider baselines and performance thresholds.

> *Criteria 7: Recommendations set an appropriate level of expectation with an adequate minimum standard.*

Figure 22. Quality Measurement Recommendations Overview

Figure 22 includes an overview of Navigant's quality measurement recommendations.

Note: Stakeholders either directly or indirectly proposed measures with an asterisk (*). See Figure 23 for more details on each measure.

National Quality Forum Domain	Recommended Quality Measure
Service Delivery and Effectiveness	1. Percent of service plans reviewed in which services are delivered in accordance with the service plan (e.g., scheduled days, transportation arrangements, nutritional needs, role of caregiver, etc.)
	2. Average length of stay across all participants *
Choice and Control	3. Percent of participants responding "yes" to: "Can you see your friends when you want to?"
	4. Percent of participants responding "true" to: "I have control over what I do and how I spend my time in ADS."
Caregiver Support	5. Percent of caregivers responding "disagree" or "strongly disagree" to: "During the past 12 months, my overall health suffered because of my caregiving responsibilities."
	6. Percent of caregivers responding "rarely" or "never" to: "In your experience as a caregiver, how often do you feel that caregiving causes you stress?"
Workforce	7. Average staff retention rate *
Holistic Health and Functioning	8. Percent of participants rating overall health as good or better
	9. Percent of participants reporting that they feel lonely, sad, or depressed "not often," "almost never," or "never"
	10. Percent of participants responding "yes" to: "Do you have access to learning opportunities and/or continuing education activities when/if you want them?"

Figure 23. Quality Measurement Recommendations Details

Figure 23 includes Navigant's quality measurement recommendations. Each measure includes a rationale, the source of the measure, whether the measure is a current reporting requirement in Minnesota, and a summary of stakeholder feedback Navigant and DHS received regarding the measure.

Note: Stakeholders either directly or indirectly proposed measures with an asterisk (*).

Recommended Quality Measure	Rationale	Source	Current MN ADS Reporting Requirement?	Stakeholder Feedback Summary
NQF Domain: Service Delivery and Effectiveness				
1. Percent of service plans reviewed in which services are delivered in accordance with the service plan (e.g., scheduled days, transportation arrangements, nutritional needs, role of caregiver, etc.)	Demonstrates that ADS providers are delivering services that meet participants' needs as identified in their assessments and service plans.	National Quality Forum (MLTSS NY, HI)	No	N/A
2. Average length of stay across all participants*	Demonstrates participants' satisfaction with the service and delays in residential placement.	N/A	Unknown	Some stakeholders indicated the length of stay may not be a helpful indicator because some participants use ADS as a temporary, transitional service
NQF Domain: Choice and Control				
3. Percent of participants responding "yes" to: "Can you see your	Demonstrates participants' ability to control their social interactions.	National Quality Forum (National Core Indicators Adult Consumer Survey)	Yes, DHS participates in the NCI survey and collects data for this	Some stakeholders mentioned items to keep in mind, such as bringing

Recommended Quality Measure	Rationale	Source	Current MN ADS Reporting Requirement?	Stakeholder Feedback Summary
friends when you want to?"			question. However, current NCI data collection does not specifically measure participants of ADS as a specific group. However, the sampling method could be aligned to compare ADS participants to other NCI or NCI-AD respondents	in friends may impact confidentiality and staff coverage, or families with children coming to visit may cause disruption for some individuals with dementia. Some stakeholders suggested to clarify this question by asking participants to respond to the question with the additional phrase, "while at the adult day program." We preserved the measure as-is to consider the impact on a participant's perception of social accessibility holistically. However, this measure could be modified to be specific to social accessibility relative to ADS participation.
4. Percent of participants responding "true" to: "I have control over what I do and how I spend my time in ADS."	Demonstrates participants' level of independence.	National Quality Forum (Participation Assessment with Recombined Tools-Enfranchisement)	No	Per stakeholders' suggestion, this measure is specific to the participant's experience while at the adult day program.

Recommended Quality Measure	Rationale	Source	Current MN ADS Reporting Requirement?	Stakeholder Feedback Summary
NQF Domain: Caregiver Support				
5. Percent of caregivers responding "disagree" or "strongly disagree" to: "During the past 12 months, my overall health suffered because of my caregiving responsibilities."	Demonstrates the impact of caregiving on the caregiver's health.	National Quality Forum (Canada's General Social Survey - Caregiving and Care Receiving)	No	Stakeholders mentioned the complexity of capturing caregivers' perspectives and suggested using measures on a scale to show incremental changes (see considerations at the end of this figure).
6. Percent of caregivers responding "rarely" or "never" to: "In your experience as a caregiver, how often do you feel that caregiving causes you stress?"	Demonstrates the impact of caregiving on the caregiver's stress level.	National Quality Forum (Performance Outcome Measurement Project Caregiver Services Survey)	No	N/A
NQF Domain: Workforce				
7. Average staff retention rate *	Demonstrates the site's ability to retain staff. High staff retention may indicate a higher-quality work environment.	N/A	Unknown	N/A

Recommended Quality Measure	Rationale	Source	Current MN ADS Reporting Requirement?	Stakeholder Feedback Summary
NQF Domain: Holistic Health and Functioning				
8. Percent of participants rating overall health as good or better	Demonstrates the impact of services on participants' health.	National Quality Forum (HCBS Experience of Care Survey)	No	Any health measures may need to be risk-adjusted to account for underlying health of the participants which may vary by population
9. Percent of participants reporting that they feel lonely, sad, or depressed "not often," "almost never," or "never"	Demonstrates the impact of services on participants' emotional states.	National Quality Forum (National Core Indictors - Aging and Disabilities)	Yes, DHS participates in the NCI survey and collects data for this question. However, current NCI data collection does not specifically measure participants of ADS as a specific group. However, the sampling method could be aligned to compare ADS participants to other NCI or NCI-AD respondents	Some stakeholders indicated that this measure could be expanded to capture isolation. We preserved the measure as-is because it was pulled from the NCI-AD survey, and quality measures #3 and #9 both indirectly measure isolation. Some stakeholders expressed concern about underlying diagnoses, and this could be accounted for by risk-adjusting the measures. Some stakeholders suggested to clarify this question by asking participants to respond to

Recommended Quality Measure	Rationale	Source	Current MN ADS Reporting Requirement?	Stakeholder Feedback Summary
				the question with the additional phrase, "while at the adult day program." We preserved the measure as-is to assess the impact on a participant's perception of emotional state holistically. However, this measure could be modified to be specific to emotional state relative to ADS participation.
10. Percent of participants responding "yes" to: "Do you have access to learning opportunities and/or continuing education activities when/if you want them?"	Demonstrates participants' ability to continue to learn if that is something that they desire.	N/A[41]	No	N/A

Additional Considerations for Caregiver Support Measurement

To measure the level of support available to caregivers, DHS may consider leveraging a comprehensive caregiver assessment, such as the Zarit Burden Interview, in lieu of recommended measures #5 and #6.[42] The Zarit Burden Interview is a 22-item caregiver self-report questionnaire that evaluates the burden of providing care to individuals. Using a caregiver assessment would allow for more nuanced and actionable information.

[41] Note that this measure could be included in Minnesota's NCI-AD survey at the state's request.
[42] Zarit Burden Interview, Available online: http://dementiapathways.ie/_filecache/edd/c3c/89-zarit_burden_interview.pdf

Appendix A Provider Profiles

On June 27, 2018, Navigant and DHS visited three “best practice” ADS providers identified by DHS. Department of Human Services staff who frequently visit ADS providers for certification and monitoring activities recommended these select providers for their reputation of excellent service delivery. At each site, we conducted observations/walkthroughs and then interviewed site managers to learn about the sites’ promising practices and any challenges they face in service delivery. The three sites represented varying population groups, economic levels, and geographic areas. Common characteristics of all three sites included:

- **Physical Space:** Sites typically had a large common area where most activities took place, but also areas that included couches, recliners, and more comfortable seating options where participants could engage in activities alone or in a small group. Each site contained accessibility features, including ramps and guardrails.
- **Nutrition:** Some sites had an “open kitchen” with snacks available to participants all day, whereas other sites provided multiple structured snack periods throughout the day. All sites demonstrated some degree of variety and choice of meal options in their dietary menus.
- **Activities:** Each site maintained an activity calendar that included physical activities, crafts, games, etc. All sites allowed participants the option to participate in group activities or partake in independent activities, such as coloring. Sites also host monthly community outings.

Figure 24 below describes additional characteristics of each provider site.

Figure 24. ADS Provider Profiles

Figure 24 describes characteristics of the three provider sites that Navigant and DHS visited as part of the study.

Topic	Site 1	Site 2	Site 3
Location Type	Urban area of Saint Paul	Urban area of Minneapolis	Semi-rural, exurban area approximately 35 miles outside of Minneapolis
Population Served	**Number of Participants Served:** Served 50-60 participants daily, on average **Observed Demographics:** Primarily south-east Asian population, with range in age disability types	**Number of Participants Served:** Served 10 clients participants, on average **Observed Demographics:** Mostly female participants, ranging in age and disability types	**Number of Participants Served:** Served 20 participants daily, on average **Observed Demographics:** Heavily male participant population; primarily over the age of 80 mostly with physical and cognitive disabilities
Funding Information	Nearly all participants reportedly use Medicaid waiver funding to attend	Nearly all participants reportedly use Medicaid waiver funding to attend	Frequent payors included Medicaid waivers, private pay and veteran's administration funding
Physical Space	**Site Layout:** The site operated within a large building and maintained an adjoining outdoor area. The main activity area was a large banquet hall style space; half of the room contained tables and chairs and the other half of the room included recreational areas. Additional areas included a craft room and a quiet room.	**Site Layout:** The site operated within the same building as a skilled nursing center, but the ADS setting was on the basement level. The ADS site included a large common room and a smaller "den" area. **Features:** The site included accessibility features, such as guardrails in the restrooms.	**Site Layout:** The site included a large common area with tables and chairs, another area with recliners, and an outside patio area. **Features:** The site included accessibility features, such as guardrails in the restrooms.

Topic	Site 1	Site 2	Site 3
	Features: The site included accessibility features, such as ramps to the stage and spacious restrooms.		
Nutrition	**Kitchen area:** The site had an open kitchen area where participants could freely help themselves to snacks throughout the day. **Food selection:** The menu integrated food types representative of the Asian cultures that the site serves.	**Kitchen area:** The site had a kitchen area where participants could store any food they brought from home. There were not snacks out at all times, but sites offered snacks to participants multiple times each day. **Food selection:** The site's menu included a variety of meals representing different food groups. The site rotated its menu seasonally, and substitutions were available for participants with specific dietary needs and preferences.	**Kitchen area:** The kitchen area included extra frozen meals as backup in case more participants join than anticipated (because Meals on Wheels selections must be made several days in advance). Snacks did not appear to be available at all times, but sites provided snacks during a structured snack time. **Food selection:** The site partnered with Meals on Wheels for food provision.
Activities	**Activity Schedule:** The site maintained an activity schedule that consisted of exercise, crafts, gardening, holiday celebrations, and other activities. **Independent Activities:** Participants could either partake in the scheduled activity or participate in independent activities. Independent activities included playing games, playing pool, coloring, or watching videos/documentaries.	**Activity Schedule:** The site followed an activity schedule that included writing, music, crafts, baking, Bible study, etc. **Independent Activities:** Participants could either partake in the scheduled activity or participate in independent activities, such as puzzles or coloring. **Community Outings:** Outings included visits to dance performances, museums, or the Arboretum.	**Activity Schedule:** The site followed an activity schedule that included educational presentations, exercise, movies, game tournaments, and monthly visits from elementary school students. **Independent Activities:** Participants could either partake in the scheduled activity or participate in independent activities, such as puzzles, coloring, and board games. **Community Outings:** Outings included visits to picnics or parks.

Topic	Site 1	Site 2	Site 3
	Community Outings: Scheduled outings included visits to picnics or parks, for example.		
Individualized Service Plan Elements	**Service Plan Elements:** The site's service plan contained the following elements: • Participant's needs/strengths • Participant's goals • Approach to work toward goals • Responsible party • Reasons goals were not met, continued, or revised	**Service Plan Elements:** The site's *preliminary* service plan contained the following elements: • Participant information (e.g., address, transportation arrangements, living arrangements, marital status) • Responsible party and role in service plan • Needs assessment (included psychosocial status, functional status, physical status)	**Service Plan Elements:** The site's service plan contained the following elements: • Participant information (e.g., transportation arrangements, dietary needs, medication needs) • Long-term goals, needs, and preferences • Short-term measurable outcomes • Ideas to support reaching goal • Area for progress notes each quarter