Below you will find a summary of the overall trends, best practices, and issues or concerns that DMAS staff observed during the desk reviews of Adult Day Health Care (ADHC) provider self-assessments. This summary is intended to provide guidance to providers to support their full compliance with HCBS settings requirements and person centered planning.

As a reminder, please keep in mind that the DMAS determinations of the compliance status of self-assessments are based on a holistic review of a setting. When making a determination, reviewers take into consideration both the narrative response and evidence submitted. Question responses and evidence/documents submitted are not viewed in isolation but again, holistically across all elements of HCBS compliance.

Questions about this guidance and other aspects of HCBS compliance for ADHC providers should be directed to: HCBSComments@dmas.virginia.gov.

TRENDS

HCBS Rights and Individual Experience in HCBS Settings	DMAS noticed that the majority of providers missed the distinction between the DSS required rights for licensure and the additional HCBS rights. DMAS acknowledges that perhaps the agency was not as clear or as specific as we could have been. To support provider s with coming into compliance, DMAS is in the process of developing a recommended remediation approach for this element for all participating providers. This approach will most likely take the form of a disclosure type statement provided to participants and their families about HCBS rights and experience during person centered service planning. This will be similar to the process for ADHC providers in notifying participants about Medicaid appeal rights. While other aspects of HCBS compliance and remediation will be unique to each setting, DMAS believes this is one area (disclosure of an individual's rights and expectations for experience) that is easily standardized across all settings within the service.
Geographic Locations	For the most part, providers did a good job of submitting photos of: 1) the outside of their buildings, and 2) an aerial or neighborhood map that showed the surrounding neighborhood with key business, residences, and other buildings or landmarks identified. Providers that did not submit something like this (1 and 2) for questions 1-4 of the ADHC provider self-assessment, will probably be asked to do so during the remediation phase and plan.
Field Trips	DMAS noted that some providers identified field trips to demonstrate their compliance with access to the greater community. Field trips are great. They can most definitely be an element of access. However, scheduling field trips weekly, monthly or quarterly, for example, does not alleviate the provider's responsibility to account for how the provider would respond to a participant who expressed interest in community activities beyond or between field trips. In addition, providing details on how participation in field trips is determined is helpful in determining overall compliance. DMAS wants to be careful to emphasize field trips are not required in order to demonstrate access to greater community. Further, having field trips does not alone demonstrate access to the community.

BEST PRACTICES

Access to the Greater Community	Describing how your setting "facilitates access" to the community by providing information and resources can help to demonstrate compliance in this area. For example, some providers provided as evidence pictures of bulletin boards and resource corners with materials that an individual could access any time of day. Resources included: newspapers, calendars, and brochures on a variety community activities, services and resources. Others described and provided policies and procedures on how staff provide support and consultation to individuals and families on a frequent, recurring basis. And others noted how they make computers and the Internet available with support from staff for searches. Some provided a combination of those strategies. DMAS appreciated those that have materials out and available at all times so that participants and their family members can review them when they would like. DMAS note that this element is intended to go beyond medical services to actual community events, activities and other aging services or groups. Simply providing brochures on hospices and home health companies is not sufficient for this HCBS component *to support full access to the greater community.*
Participant and Family Handbooks	DMAS really appreciated the value of participant or family handbooks as a way to share key information with individuals from the start of service delivery. A handbook can serve as 'one-stop-shop' for questions and answers for families well beyond the initial admission to the center, which can often be overwhelming with information to take in. Providers may want to consider how they can develop a participant and family handbook for general purposes; even further, consider building in HCBS elements into the handbook to demonstrate compliance during remediation.
Partnerships with Organizations and Volunteers	Some providers created a chart or table to detail the relationships that the providers has with other organizations and volunteers in the community. A simple listing of organizations does not quite give DMAS a clear picture of how partnerships enhance being a part of the community. In a review, DMAS benefited from having more details about those partnerships, such as: are they new or long standing? One-time experiences or ongoing? Daily, weekly or monthly, etc.? Provider remediation for this element may want to consider how providers can expand on the details of partnerships. Providers may want to include a chart that lists: the partnership organization or volunteer, what role they serve, and how frequently they are engaged with your center.
Policies and Procedures	It was helpful with the process for desk reviews and compliance determinations when providers submitted their policies and procedures for areas that they felt were in compliance. These may have included policies and procedures for topics such as trainings, restraints, admissions, and plan of care development, etc. Particularly helpful was seeing new or updated policies and forms that specifically reflect HCBS requirements. This type of evidence demonstrates a provider's

	greater understanding of the HCBS requirements and the need to make organizational updates to your policies in order to comply. DMAS appreciated when those policies and procedures were presented in a formal and professional manner. This means that they were titled and dated, and they identified who is provided a copy of the policy, when the policy was last updated, who is responsible for updating it, etc. Some self-assessment evidence simply restated the required HCBS element into a Word document, but it was not identified as a formal policy or procedure and did not include key details, such as how staff and others are notified. This did not make it a policy and procedure that was sufficient evidence to demonstrate compliance.
Participant and Family Survey	DMAS appreciated when evidence was included that providers had actually taken the self-assessment questions, adapted them and asked them directly of participants and families. Those that took this approach provided some very convincing evidence that settings were home and community-based in not only eyes of the individuals and families. A major crux of the HCBS rule is based on the individual's experience. A survey directly of participants and their families is a great way to measure that. DMAS recommends that providers consider this approach when more details are requested, and as a remediation approach that works in combination with other approaches, such as updating the provider's policies and procedures.
Interdisciplinary Approach to HCBS Compliance	DMAS noted a significant difference in the submissions that indicated that they were completed by one person and those that were completed in consultation with staff from all levels, community partners, board members, participants, families, and more. Just like there is value in interdisciplinary teams for health care service delivery, having a wide variety of individuals providing input in the process strengthened the case for compliance.
Participant or Family Councils	Some providers also noted and provided evidence for family councils, activity planning councils, or participant councils that inform activity planning, field trips, overall center feedback, and satisfaction with the services. These are great ways to demonstrate that you are being proactive in taking individuals preferences into consideration for center administration and decision making. DMAS encourages providers to consider these. If implemented, providers should document the meetings with minutes and outcomes that reflect and support your compliance with HCBS and that your efforts are participant-driven.

ISSUES OR CONCERNS

Lack of Evidence	Too many providers submitted self-assessments with absolutely no evidence to support an analysis validation of compliance. The self-assessment itself, the guidance document, the instructions, and the webinar all made it very clear that evidence was mandatory and required by DMAS. Providers who did not submit any evidence will be receiving determination letters that they will have to complete a FULL remediation plan for all elements of the HCBS rule.
Non-Emergency Medical Transportation	Taking someone to the doctor or to other medical appointments does not satisfy the element of access to the greater community. This is not what CMS intended or what the agency would look for or would consider sufficient to meet the standard.
Degree of Disability or Impairment	Some self-assessments made statements about the overall participant level of disability or cognitive impairment for all participants served by the provider was a barrier to community integration and as a way to "exempt" providers from community integration requirements. Provider-wide policies that blanket statements that all participants are unable to access the community or that the provider will not offer such access because of significant disability, frailty or cognitive impairment are not allowed. Again, CMS has been very clear in its guidance that this type of thinking is unacceptable under the HCBS rule and standard. If CMS were to see self-assessments that provided such statements, they would be red flags to further scrutinize the provider, the service and setting, and the state on the HCBS rule. DMAS encourages providers to review their self-assessments and prepare remediation plans without such "disclaimers." Further, if this reasoning was the basis that a provider used in a self-assessment, the provider should be prepared to remediate it.
Activity Calendar Layouts	Many providers submitted activity calendars as evidence and these are a great evidence component for many of the HCBS elements. DMAS has a few suggestions for areas that could benefit from a few modifications for remediation. Calendars should more clearly differentiate when activities occur outside of the setting and when partnerships or volunteers from outside the setting are involved. Previous conversations with CMS have indicated that CMS would like to see variety in activity offerings and calendars should clearly state information on how participants can take advantage of alternative activities than the larger or planned group activities. In essence, CMS has noted on calls with Virginia that activities should be broad, numerous, and reflect the interests of the participants. Evidence should demonstrate these aspects of determining and offering activities.
Assessment and Care Plan Tools	Many providers included their assessment and person-centered service plan (PCSP) tools as evidence for the PCSP elements. These are good and definitely worth including and noting, particularly when they provide opportunities to document interests, social history, preferences, dislikes, etc. DMAS notes, however, that these tools should also clearly provide space for detailing an individual's or family's

	feedback or input into the process, and space for documenting when and how often such input occurs. DMAS needs to see that this is a foundational element of your HCBS compliance.
Care Plan Updates	Many providers noted that the care plans are updated every 6 months per DSS requirements. DMAS needs more detail and clarity about how care plans can be updated outside of the required 6 month review by DSS or the DMAS required quarterly reviews. Providers must offer opportunities to update care plans based on an individual's request or a family's request because the individual has developed a new interest or hobby, or they no longer feel able to participate physically in something that was previously included, or any similar reason.
Restraints	DMAS received a variety of responses to the topic of freedom from restraint. Some providers offered broad rights statements that noted a provider-wide policy that prohibited restraints and others provided policies and procedures and training documents for the application of restraints as needed or appropriate. DMAS is conducting further review on this topic and on CMS guidance before it is able to offer any specific feedback.