NYSADSA
New York State Adult Day Services Association Inc.

Overcoming Barriers in Providing Optional SADS Services

Subtitle: Enhancing Support through Case Assistance, Caregiver Services, Transportation Coordination, and More

About NYSADSA

Training Objectives

- Understand the scope of optional SADS services under Title 9 NYCRR §6654.20
- Identify common barriers to providing these services
- Learn strategies to overcome barriers
- Integrate optional services into the Person-Centered Service Plan (PCSP)

NYSADSA
New York State Adult Day Services Association Inc.

Overview of Optional SADS Services

- Case Coordination and Assistance
- Caregiver Support Services
- Transportation Coordination
- Maintenance and Enhancement of Daily Living Skills
- Other participant-specific services per PCSP

NYSADSA
New York State Adult Day Services Association Inc.

Regulatory Foundation

- Title 9 NYCRR §6654.20(d)(1)(iv)(b)
- Optional services must be aligned with participant needs
- Documented in service plans and supported by program policy

What Are Barriers?

- **Definition:**
- Barriers are any **obstacles—internal or external—that interfere with a participant's ability to access services, meet their goals, or participate fully in their Social Adult Day Care (SADC) experience**.
- Barriers may be:
- **Physical**
- **Cognitive**
- **Emotional**
- **Social**
- **Environmental**
- **Systemic or programmatic**

Types of Barriers Common in SADC Settings:

Barrier Type	Description	Examples
Participant-Specific	Related to a person's health, mobility, cognition, or behavior	Memory loss, physical limitations, anxiety
Caregiver-Related	Challenges faced by informal caregivers	Burnout, limited availability, lack of training
Programmatic/Operational	Issues within the SADC program's setup or staffing	No assigned staff for case coordination
Communication/Documentation	Gaps in how services or needs are tracked or shared	Poor file notes, missed service planning
Cultural/Language	Barriers related to culture, language, or literacy	LEP (Limited English Proficiency), misunderstanding of goals

Common Structural Barriers

- Staffing shortages
- Transportation availability
- Budget constraints
- Facility limitations (e.g., space, accessibility)

Procedural Barriers

- Limited service plan documentation
- Lack of inter-agency coordination
- Delays in service updates

Attitudinal and Knowledge Barriers

- Misunderstanding about what's "required"
- Staff discomfort with community resources
- Lack of familiarity with HCBS standards

Aligning Services with PCSPs

- Regular assessment updates
- Document optional services clearly
- Engage caregivers in service planning

Community Partnerships

- Identify local caregiver support programs
- Build transportation vendor lists
- Collaborate with local health and wellness providers

Enhancing Documentation & Policy

- Develop optional services policies
- Maintain logs of services provided
- Train staff to document SMART Goals for optional services
- Use NYSOFA self-monitoring tools (Attachment E)

Staff Training & Development

- Train on optional service protocols
- Use real scenarios in training
- Conduct refresher workshops

Monitoring and Evaluation (DATA, DATA, DATA)

- Track service utilization
- Collect participant satisfaction data
- Adjust services based on feedback

Why Addressing Barriers Matters:

- Promotes **person-centered planning**
- **Ensures Participants receive the services they need**
- Ensures **HCBS compliance** under 42 CFR 441.301
- Supports participant rights and community integration
- Enhances **program quality and outcomes**

Action Planning

- Identify one barrier in your program
- List 3 steps to address it
- Share during staff PCSP meetings for feedback

1. Maintenance and Enhancement of Daily Living Skills

1. Maintenance and Enhancement of Daily Living Skills

- Programs may provide services aimed at maintaining or improving a participant's ability to manage daily tasks. These services include:
- **Instrumental activities of daily living (IADLs)**:
  - Using public or private transportation
  - Doing laundry
  - Shopping
  - Cooking
  - Using a telephone
  - Managing personal finances

🟦 1. Maintenance and Enhancement of Daily Living Skills

- **Self-care skills**:
  - Grooming
  - Washing
  - Dental hygiene
- **Use of equipment**:
  - Supplies
  - Adaptive and assistive devices
- **Other appropriate related skills**

What is Maintenance and Enhancement of Daily Living Skills in SADC?

- Maintenance and enhancement of daily living skills refers to structured activities that support or improve a participant's ability to manage tasks like:
- Cooking, shopping, managing finances (IADLs)
- Grooming, hygiene, self-medication (ADLs)
- Navigating transportation
- Using adaptive/assistive devices
- This is an **optional service** under NYSOFA Title 9, but must be **individualized** and reflected in the **Person-Centered Service Plan (PCSP)** when offered.

SMART Goal Example: Person-Centered + Community Integrated

- **Participant Profile:**
- Maria, age 73, is a retired teacher who enjoys independent shopping and healthy cooking. Due to a mild stroke, she now needs assistance with budgeting and grocery shopping.
  Her **goal** is to return to independently shopping at a local market and preparing her own meals.

SMART Goal for Maria

SMART Element	Goal Statement Component
Specific	Maria will improve her independent grocery shopping skills using a budgeting worksheet provided by SADC staff.
Measurable	She will successfully plan and complete a shopping trip to the local farmers market with minimal verbal cues on at least 3 occasions.
Achievable	SADC staff will provide weekly practice with budgeting and planning during program hours and coordinate transportation with a caregiver.
Relevant	This goal supports Maria’s desire to re-engage with her local community and maintain healthy, independent cooking practices at home.
Time-Bound	Maria’s progress will be reviewed within 90 days during her next PCSP update.

Why This Works for HCBS Final Rule

- This goal:
- **Supports full access to the community** (local market shopping).
- **Is individualized and driven by Maria's personal interests and goals** (healthy cooking).
- **Facilitates meaningful community engagement** (non-staff interaction at the market).
- **Promotes independence** and builds on her existing strengths.
- Is clearly embedded within her **PCSP**, fulfilling documentation and compliance standards.

Potential Barriers to Community-Integrated SMART Goals

1. Participant-Specific Barriers

- **Cognitive or memory issues** that impair budgeting, planning, or navigation.
- **Physical limitations** (e.g., endurance, balance) that make travel or walking through a market difficult.
- **Anxiety or fear** of crowded or unfamiliar environments post-stroke.

Environmental Barriers

- **Lack of accessible transportation** to community locations like farmers markets (especially post-2025 when SADC is responsible for transportation).
- **Unavailability of physically accessible community venues** (e.g., narrow aisles, lack of seating).
- **Unpredictable weather or neighborhood safety concerns** that may affect outing plans.

Programmatic Barriers

- **Insufficient staffing** to accompany or support participants during community outings.
- **Inflexible scheduling** that does not allow time for real-life integration activities during program hours.
- **Limited training** among staff in supporting functional independence in a community setting.

Documentation and Plan Alignment Issues

- **Optional services not included or updated in the PCSP**, which limits staff authority or readiness to support them.
- **Missing documentation** of community integration efforts (non-compliance risk under HCBS Final Rule).
- **Inadequate coordination with MLTC plans** regarding participant transportation or safety supports.

Resource Barriers

- **Resource Barriers**
- **No funding or reimbursement structure** to support optional services like IADL training or escorted community outings.
- **Limited access to low-cost adaptive tools** (e.g., shopping carts with support handles or budgeting aids).

Overcoming These Barriers

- These barriers can often be addressed through:
- **Service coordination** (involving family, caregivers, and MLTC plans),
- **Revising the PCSP** to reflect current goals and necessary supports,
- **Staff training** in community integration and IADL coaching,
- **Creative use of community partnerships** (e.g., local grocers offering senior hours or assistance).

2. Transportation

2. Transportation

- Transportation provided **between the participant's home and the SADC site**.
- Must comply with ADA standards and participant safety protocols.

MLTC Policy 24.01 – SADC Transportation (Effective January 1, 2025)

Background

- Prior to March 1, 2024, non-emergency medical transportation (NEMT) for SADC was typically managed either by MLTC plans, by the SADC directly, or in a hybrid model.
- From **March 1 to December 31, 2024**, the state implemented a **hybrid transitional period** where:
  - Some SADCs continued managing transportation.
  - Others used MAS (Medical Answering Services), the state's transportation broker.

SADC Responsibilities

- SADC sites must:
- **Manage all transportation** to and from their sites.
- Choose one of the following options:
  - **Operate their own vehicles**.
  - **Contract with a transportation provider**.
- Ensure transportation:
  - **Meets ADA standards**.
  - **Is timely and reliable**.
  - **Is safe and appropriate for participants' needs**.
- Must initiate new transportation arrangements for all members currently using MAS or MLTC-coordinated rides.

Support and Resources

- **Support and Resources**
- For a geographic list of approved transportation vendors, SADC programs can email:
   medtrans@health.ny.gov
  Subject: *SADC list of transportation providers*

SMART Goal Example: Person-Centered + Community Integrated

- **Participant Profile: Transportation Support**
- **Name: Robert D.**
- **Age: 73**
- **Living Situation: Lives alone in a senior apartment complex**
- **Diagnosis: Mild cognitive impairment and arthritis**
- **Mobility Aid: Uses a rollator for balance and walking**
- **Transportation Challenge: Relies on others for transportation; experiences anxiety using public transit**
- **Stated Goal (During PCSP Meeting):**
- "I want to come to the center twice a week. I miss being around people, and it helps me stay sharp. But I need a ride that feels safe."

SMART Goal for SADC Transportation

- 12-Month SMART Goal for SADC Transportation
- Participant: Robert D.
- Service Area: Transportation Coordination for Ongoing Program Participation
- Goal Start Date: February 1, 2025
- Goal End Date: January 31, 2026
- Review Intervals: Quarterly (every 3 months)

SMART GOAL Statement

Element	12-Month Goal Description
Specific	Robert will be provided with safe, door-to-door transportation to and from the SADC twice per week through a contracted ADA-compliant vendor, supporting his regular attendance.
Measurable	Transportation will occur at least 8 times per month (2x per week) for 12 months, with no more than 2 missed trips per quarter due to transportation failure.
Achievable	The SADC has secured a reliable transportation vendor, will maintain weekly ride coordination, and will adjust the schedule as needed based on Robert's health or preferences.
Relevant	Continued access to the SADC helps Robert meet his goals of reducing isolation, maintaining routine, and participating in structured social and wellness activities.
Time-Bound	Goal duration is 12 months, with progress reviews at 3, 6, 9, and 12-month intervals during PCSP updates and quarterly care team meetings.

Compliance and Documentation

- Document **ride logs**, missed trip reports, and satisfaction feedback.
- Include transportation support in the **PCSP under community integration**.
- Maintain documentation showing the **goal was developed with participant input**.
- Use **quarterly check-ins** to adjust transportation plans or address emerging needs.

Barriers & Strategies: Transportation SMART Goal for Robert D

- **Barrier 1: Transportation Anxiety**
- **Description:** Robert experiences anxiety using unfamiliar transportation services, especially public transit.
- **Solution:**
  - Use a **consistent transportation vendor** with assigned drivers.
  - Provide Robert with a **visual ride schedule** and introduce him to the driver ahead of time.
  - Offer **staff check-ins** before and after rides during the first month.

Barrier 2: Rollator Use and Physical Accessibility

- **Description:** Robert uses a rollator, requiring vehicles with lifts and extra time for boarding.
- **Solution:**
  - Contract with an **ADA-compliant provider** with lift-equipped vans.
  - Schedule **buffer time** in the pick-up window.
  - Ensure drivers are trained in **safe mobility assistance**.

Barrier 3: Coordination Gaps

- **Description:** Miscommunication between SADC, caregiver, and transportation vendor may result in missed or delayed pickups.
- **Solution:**
  - Assign a **transportation coordinator** at the SADC.
  - Maintain a **weekly ride confirmation log**.
  - Provide **real-time contact info** to Robert and his family for urgent ride issues.

Barrier 4: Cost or Funding Uncertainty

- **Description:** SADC assumes new responsibility for funding transportation under the January 2025 MLTC policy shift.
- **Solution:**
  - **Plan ahead for transportation budgeting** and include these costs in annual program planning.
  - Use **contract templates** that clarify billing, liability, and service scope.
  - Educate staff on **MLTC Policy 24.01** to ensure program compliance.

Documentation & Follow-Up

- Document each barrier and resolution attempt in the **PCSP review log**.
- Include participant feedback on transportation experience in **quarterly reviews**.
- Adjust services and update the goal as needed based on Robert’s needs and satisfaction.

3. Caregiver Assistance

3. Caregiver Assistance

- Designed to support informal caregivers, this may include:
- Educating caregivers on the participant's condition and service plan
- Providing strategies to **maximize participant abilities at home**
- Identifying and connecting caregivers to **support groups, respite services**, and other forms of assistance

SMART Goal Example: Caregiver Assistance

- **SMART Goal Example: Caregiver Assistance**
- **Participant Profile: Ms. Lillian M., Age 80**
- Lives with daughter, who is the primary caregiver
- Diagnosed with moderate dementia
- Daughter reports increased caregiver stress and uncertainty managing Lillian’s care needs at home

Person-Centered Goal Statement

SMART Component	Caregiver Support Goal
Specific	The SADC will provide Lillian's daughter with monthly education and support resources tailored to dementia caregiving, including techniques for behavior management and communication.
Measurable	At least **1 support session** will be offered each month and **documented** in the caregiver communication log.
Achievable	Sessions will be conducted in-person or by phone by the SADC staff , and materials will be provided in the caregiver's preferred language.
Relevant	This goal supports Lillian's care plan to remain at home and maintain stability in her primary caregiving relationship.
Time-Bound	This support will continue for **12 months**, with progress reviewed quarterly and evaluated in the annual PCSP.

Community Integration & HCBS Alignment

- Encourages **in-home stability** through proactive caregiver support.
- Promotes **participant choice** by helping the caregiver better meet Lillian’s expressed goal to remain at home.
- Aligns with **CMS guidance** that services must support the individual’s full access to their community and maximize autonomy.

1. Participant-Specific Barriers

- **Barrier:** Participant with dementia becomes agitated during transitions or when caregiver routines change.
- **Strategy:**
  - Offer **caregiver coaching** on environmental cues and consistent routines.
  - Create a **“transition plan”** with visuals or prompts for the participant.
  - Engage caregivers in **monthly behavior management training** using person-centered strategies.

Caregiver-Related Barriers

- **Barrier:** Caregiver is overwhelmed, working full-time, and unable to attend sessions.
- **Strategy:**
  - Offer **flexible delivery** (e.g., phone consultations, evening Zoom workshops).
  - Provide printed or emailed **educational materials** with follow-up calls.
  - Develop a **caregiver support calendar** they can engage with asynchronously.

3. Programmatic/Operational Barriers

- **Barrier:** No dedicated staff assigned to caregiver engagement or support.
- **Strategy:**
  - Designate a **point person** (trained program coordinator) responsible for caregiver communication.
  - Integrate caregiver support into existing **PCSP development meetings**.
  - Train activity or intake staff to include **caregiver touchpoints** in routine workflows.

4. Communication/Documentation Barriers

- **Barrier:** Caregiver feedback or interactions are undocumented, creating compliance risk.
- **Strategy:**
  - Use a **Caregiver Communication Log** as part of the participant's file.
  - Document all sessions, contacts, and resource referrals clearly in the PCSP and quarterly updates.
  - Include **caregiver signature and feedback forms** post-support sessions.

5. Cultural and Language Barriers

- **Barrier:** Caregiver has limited English proficiency or prefers culturally specific approaches.
- **Strategy:**
  - Provide translated materials and **access to interpreters** for caregiver sessions.
  - Offer **culturally competent training resources** (e.g., dementia education from culturally aligned providers).
  - Build relationships with **local ethnic caregiver organizations** for cross-referrals or co-hosted events.

Tip for Compliance

- Be sure each support session and accommodation is:
- Tied to the **participant's PCSP goals**
- Logged with **date, content, and outcome**
- Evaluated during **quarterly and annual reviews**

4. Case Coordination and Assistance

4. Case Coordination and Assistance

- Although optional, when offered it must include:
- Establishing and maintaining effective linkages with other services
- Coordinating and referring services between providers
- Advising participants and caregivers about benefits, entitlements, and support resources

SMART Goal Example: Case Coordination and Assistance

- **Participant Profile: Mr. Allen S., Age 76**
- Diagnosed with COPD and depression
- Lives alone and struggles to manage multiple service appointments
- Expressed confusion over bills and medication renewals during his PCSP meeting

SMART Goal for Case Coordination

SMART Component	Case Coordination Goal
Specific	Mr. Allen will receive monthly case coordination from the SADC social worker to assist with scheduling health appointments, understanding medication refills, and accessing benefit renewals.
Measurable	Assistance will be documented in a monthly **case coordination log**, including at least 1 completed task per month (e.g., appointment scheduled, form submitted).
Achievable	The social worker will make outreach by phone or in person and use a checklist to track needs and outcomes.
Relevant	The goal supports Mr. Allen's desire to remain independent, manage his health, and reduce stress from missed deadlines.
Time-Bound	The goal will run for 12 months, with **quarterly reviews** and a full reassessment during the annual PCSP update.

1: Participant-Specific Barriers

- **Barrier:**
- Mr. Allen has memory challenges and becomes overwhelmed by forms or long conversations.
- ✅ **Solutions:**
- Break down tasks into small steps using a **visual checklist**.
- Schedule **shorter, more frequent check-ins**.
- Use **reminder cards** or large-print calendars to reinforce plans.

2: Caregiver/Support System Barriers

- **Barrier:**
- Mr. Allen has no formal caregiver and only minimal support from a distant niece.
- **Solutions:**
- Explore **volunteer support services** through community or church networks.
- Encourage participation in peer support groups or **buddy systems** at the SADC.

3: Programmatic/Operational Barriers

- **Barrier:**
- The SADC does not currently allocate staff time to support benefits paperwork or appointment coordination.
- **Solutions:**
- **Designate a staff lead** for case coordination.
- Develop a **monthly workflow** or **case management template** that can be used across participants.
- Incorporate case coordination into **quarterly PCSP check-ins**.

4: Communication/Documentation Barriers

- **Barrier:**
- Notes about support provided to Mr. Allen are written informally or inconsistently, posing a compliance risk.
- **Solutions:**
- Use a standardized **Case Coordination Log** with date, task, and outcome fields.
- Document any support in the **PCSP review record** and share it with MLTC care managers when relevant.
- Train staff on **audit-ready documentation** practices tied to HCBS requirements.

5: Cultural and Language Barriers

- **Barrier:**
- Mr. Allen has difficulty understanding medical or benefits terminology, even in English.
- **Solutions:**
- Use **plain language explanations** and avoid jargon.
- Provide visual aids or **step-by-step how-to handouts**.
- If literacy is a concern, rely more on **verbal reinforcement and demonstration** than written materials.

Resources and Tools

Resources and Tools

- Summary of Title 9 Optional Services
- PCSP Template with Optional Services
- Community Resource Directory Template

Questions & Discussion with NYSADSA Board

- Open floor for Q&A
- Discuss real-life implementation challenges

Thank You

NYSADSA Contact Information