



Provider Forum

April 14, 2015

1:00 PM

Agenda

Welcome and Updates

Beth Lackey, Provider Network Director

NC START

Michelle Klutz, NC START

Short Term Goals

Charity Bridges, Utilization Management
Joel McClung, Utilization Management

Home and Community
Services Update
Registry of Unmet Needs/Waitlists
SIS
Local Stakeholder Group
ABLE
Ongoing IDD Service Gaps

Doug Gallion, IDD Clinical Director

State Workgroup

Tammy Wellman, Roteakka Cuthrell,
Stephanie Norman, IDD Care Coordinator
Supervisors
Charity Bridges

Monitoring Pilot

Tammy Wellman

Questions

Doug Gallion

New Services

Regina Moody, Holy Angels

Closing

Beth Lackey

Announcement:

Required NC Innovations Service Definition Training

When: July 14-15, 2015 (In lieu of Provider Forum)

Time: 1:00 – 5:00 pm

Go-to-Meeting will be available

Target Audience: QPs, admin staff can attend

Video Conference all three locations

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Compliance with Statewide Transition Plan Alignment with CMS HCB Setting Regulation Requirements
(42 CFR Sections 441.301 (c) (4) - (6); Section 441.302 and 441.530)

Companion Guide for Provider Self-Assessment
Document does not require public comment per CMS, however DHHS requests input.

LME/MCO or Local Lead Agency (Case Management Entity): *Designated Home LME-MCO*

Provider Name (as appears on license, if applicable, or legal name): *Denote name.* **NPI#:** *Reference NC Tracks*

MHL License # (if applicable) *official # is on license issued by DHSR*

- Before completing self-assessment, indicate the intent to comply with all HCBS Setting Rule Requirements: Yes ___ No ___ *Answer only Yes or No*
- If Yes, continue. If No, enter the number of individuals through Medicaid HCBS that will need to be transitioned: *Enter a number only if there is not intent to comply with HCBS Setting Rule Requirements.*
- Self-Assessment must be completed for each site providing HCBS Service(s), submitting one for an organization will not be accepted. *Innovations: Residential: Complete one per physical site; Day Supports: Complete one per physical site; SE – Complete one per corporate site and a minimum of 10 assessments or 10% whichever is greater; CAP/DA/CAP Choice – Adult Day Health one per physical site.*

Section I: Settings That Are Not Home And Community Based:

NOTE: Do NOT proceed past question 1 if any of the items are checked yes.

1. Is the facility one of the following? • <i>Nursing facility</i> • <i>Institution for Mental Diseases</i> • <i>Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)</i> • <i>Hospital</i> If any of these are checked yes, the facility cannot meet HCBS Criteria for community based settings.	<i>If there is a specific question, contact assigned LME-MCO Network Department or Local Lead Agency (Case Management Entity)</i> <i>Nursing Facility – a Medicaid Nursing Facility – (42 CFR 488.301)</i> <i>IMD Facility - defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services</i>
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	<i>ICF/IID – Institution for the mentally retarded or persons with related conditions means an institution (or distinct part of an institution) that— (a) Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and (b) Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability. Based on changes made in Rosa’s Law in 2010, Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) will now reflect nationwide changes and be referred to as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).</i> <i>Hospital - hospital is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;</i> <i>—42 C.F.R. § 441.301(c)(5) (about HCBS waivers); § 441.530(a)(2) (about Community First Choice programs); § 441.710(a)(2); 10A NCAC 27D .0301 Social Integration; 42 C.F.R. §435.1010; Sec 1919 SSA 42 U.S.C. 1395i-3; http://www.gpo.gov/fdsys/pkg/USCODE-2008-title42/html/USCODE-2008-title42-chap7-subchapXVIII-partA-sec1395i-3.htm; Social Security Act Sec. 1861. [42 U.S.C. 1395x]; CFR 483.400 – 483.480; CFR 488.301</i>
2. Is the facility in one of the following locations? <i>a building that is also a publicly or privately operated facility that provides inpatient institutional treatment</i> <i>a building on the grounds of, or immediately adjacent to, a public institution</i> <i>a setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.</i>	Examples include: State Developmental Centers, Nursing Homes, etc. Settings that are located on the same or contiguous property to an institution or are sharing space with an institution. Consideration must also be given to any applicable ordinances. Other examples include: Gated communities, settings that are isolated from the community at large, residential or boarding schools that are disability specific, etc. Any other setting that has the effect of isolating individuals receiving HCBS from the broader community. <i>—42 C.F.R. § 441.301(c)(5) (about HCBS waivers); § 441.530(a)(2) (about Community First</i>

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If any of these are checked yes, the setting is presumed to not meet HCBS Criteria for community based settings, and would require approval of the Secretary of the United States Department of Health and Human Services (HHS).	<i>Choice programs); § 441.710(a)(2)</i>
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SPECIAL NOTE FOR SECTION II AND SECTION III:

All elements for each characteristic must be met for the response to be Yes. Evidence of support should be submitted in circumstances where element(s) of a characteristic is/are met. A plan of action/correction is required for any element(s) that is/are not met. This will ensure monitoring only occurs for the area(s) that is/are out of compliance. *(Evidence is specific to the characteristic and is not policy/procedure or standard operating procedure unless otherwise noted, but may include any evidence of implementation.*

Section II: General HCBS Criteria - Non-Italicized language (on the left side of the assessment) reflects the actual characteristic and the italicized bulleted notations provide guidance to evaluate the characteristic. However, the italicized bulleted items are not all inclusive to each element of the characteristic.

**NOTE: This section MUST be completed, in entirety, if the following services are provided:
 Adult Day Health, Day Supports, Supported Employment and Residential.**

1. The setting is integrated) in and supports full access to the greater community (work, live, recreate, and other services). There are opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.	<i>Refer to CMS Steps to Compliance For HCBS Settings and Requirements in a 1915(c) Waiver and 1915 (i) SPA (State Plan Amendment) and Guidance on Settings that have the effect of isolating individuals receiving HCBS from the Broader Community located at:</i> http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-SupportS/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html
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• <i>Are transportation and other supports provided so that people can regularly access services similar to those used by the community at large?</i> • <i>Can people regularly interact directly with other members of the community who are not paid to do so?</i>	<i>Integration can be most readily defined as any situation/circumstance that does not meet the definition of isolated as defined by CMS.</i> • <i>The opportunity and support needed to get a job and work alongside people without disabilities.</i> • <i>Be part of the local community life which must include what is of interest to the person, e.g. faith based activities, volunteer opportunities, local events, but must occur outside of the service setting.</i> • <i>Access to transportation resources (what is available to the general population) within a given community with recognition given to urban and rural barriers, e.g. urban – metropolis and rural – communities, village, hamlets, towns and cities.</i> • <i>Control their own money, possessions and all other resources with appropriate help which may include a financial coach, dual payee responsibility, etc.</i> • <i>Regularly interact with friends, family, co-workers that enhance the quality and security of a person’s life. It represents “not to do for”, but “with” people. If opportunities are always “scheduled” and are only “occasional” this does not meet the intent of “community-based”.</i> —42 C.F.R. § 441.301(c)(4), (c)(4)(i) (about HCBS waivers); § 441.530(a)(1), (a)(1)(i) (about Community First Choice programs); § 441.710(a)(1), (a)(1)(i); 10A NCAC 27D .0301 Social Integration; § 168-2; § 168-3; § 168-8; § 168 A-6
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the individual’s needs, preferences, and, for residential settings, resources available for room and board. • <i>The setting is selected by people from among</i>	• <i>Choice of setting (includes any setting that is of interest to the person) is based on the preference(s) of the person and is the ultimate decision of the individual. Examples of evidence include, but are not limited to: providing information specific to the options presented, or places visited/employment considered, or individuals the person met during the planning process of choosing a place to live, work or engage during one’s day.</i> • <i>To ensure a person’s preferences are being respected, were the</i>

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<i>residential and day options that include generic settings.</i> • <i>Do people choose their rooms (if residence) or the area they work in, etc.?</i>	<i>choices presented in such a way that it was clearly understood by the person, e.g. conversation, picture, written, object format.</i> • <i>A setting that is chosen by an individual, if they are to receive HCBS services, must meet all the requirements of the rule (Final Rule March 2014).</i> • <i>Options provided align with the individual's available financial resources, e.g. SSI, VA, Special Assistance, Social Security, earned income, trusts, etc. (residential only).</i> —42 C.F.R. § 441.301(c)(4)(ii) (about HCBS waivers); § 441.530(a)(1)(ii) (about Community First Choice programs); 42CFR § 441.301 (6) (2) (i)
3. Ensures the rights of privacy, dignity and respect, and freedom from coercion and restraint. • <i>Do people have the space and opportunity to speak on the phone, open and read mail, and visit with others, privately?</i> • <i>Do people have a place and opportunity to be by themselves during the day?</i> • <i>Is informed consent obtained prior to implementation of intrusive medical or behavioral interventions?</i> • <i>For any restrictions imposed on the person, is there a plan for restoring the right/fading the restriction?</i> • <i>For people using psychotropic medications, is the use based on specific psychiatric diagnoses?</i> • <i>Do people receive the fewest psychotropic meds possible, at the lowest dosage possible?</i>	• <i>There must always be the availability of space that ensures the individual can talk privately with family, friends and others of the persons choosing whether in person, over the phone or the internet (if access is available).</i> • <i>Even in shared situations, there must also be availability for a person to have “personal and alone time” as they define it during their day. If an individual is unable to use words to communicate, information should be obtained from others that know the person the best to ensure they have opportunity for what is important to them.</i> • <i>10A NCAC 27D .0303 INFORMED CONSENT - Informed Consent by definition is given by a person who has a clear appreciation and understanding of the facts, implications, and future consequences of action, e.g. a reference reflective of all components of informed consent is the Consent Handbook, H. Rutherford Turnbull and Douglas Biklen.</i> • <i>Plan for right restoration must be included in the person centered plan at the time of restriction.</i> • <i>Behavioral Interventions/Physical Restraint: 10A NCAC 27E</i> • <i>Psychotropic Medication - Psychiatric diagnosis must be</i>

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	<i>established prior to use of psychotropic medication if it be used to treat a mental health disorder. Other uses of psychotropic medication do not apply.</i> —42 C.F.R. § 441.301(c)(4)(iii) (about HCBS waivers); § 441.530(a)(1)(iii) (about Community First Choice programs); 10A NCAC 27G .0208 Client Services (a) (1); 10A NCAC 27G .0209 Medication Requirements (f) (1) (2); 10A NCAC 27d .0303 Informed Consent; 10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions (c) (1) (2), (d) (1) (2) (3), (e) (1) (2) (3), (f) (1), (2) (A) (B) (C) (D), (3); §122C-62 (b) (1)
4. Optimizes, but does not regiment, independent initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. • <i>Do people receive only the level of support needed to make their own decisions?</i> • <i>Do people exercise their rights as citizens to: voice their opinions, vote, and move about the community, associate with others, practice their religion, access their money, make personal decisions, and other rights that are important to them?</i> • <i>Do people choose their daily activities, their schedules, and locations of the activities?</i>	• <i>Individuals must be able to engage and make their daily decisions/choices which includes, at a minimum, people they talk to, what they want to do during the day, where they spend their time, and with whom they have relationships. However, based on one's circumstances there are realistic considerations that must be made, i.e. people we support will experience realistic barriers such as defined work hours, immediate availability of people they choose to help them; transportation schedules – bus may have stopped operating at 10:00 --- however ultimately the final outcome of the choices includes and is determined by the person. For example, if I am employed and only have 30 minutes for lunch and work in downtown Raleigh, I am not able to go Holly Springs for a lunch hour at my favorite restaurant on days that I am working.</i> • <i>There must be flexibility for “last minute plans/changes” on what an individual may or may not want to do, e.g. again consideration must be given to financial resources, and individual choices e.g. - getting up at 3:00 a.m. desiring to walk at a favorite park 30 minutes from home may not be possible – but then what are the possible alternatives, e.g. a walking track around their home, a treadmill or Zumba DVD.</i> • <i>Adherence to ‘typical rules’ like paying rent, utilities, noise control, pets, etc. are expected, but are not arbitrarily imposed</i>

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	<i>rules such as who can visit, established curfews, restrictions on visits with families and others of choice.</i> <i>• Support should only be available as needed and completely dependent upon the person’s needs: e.g. I may need a ride to my appointment, but I can schedule it on my own; I can choose what I want to eat but, I need assistance to prepare it; I can access and utilize various technology, but need IT support when there is a problem.</i> <i>• A person’s need for support should never reduce or eliminate options for the person, e.g. – it becomes an opportunity to “try a different way”. Foster individual and creative solutions. A person’s need for support should never be used as a reason to “take away” or “restrict” options or to only provide those supports when the person makes the choices that coincide with the service schedule/routine.</i> <i>• Rights are not privileges and individuals choose if they want to vote and for whom they will vote, etc. this may involve using a voter’s guide, networking with the Board of Elections; voicing opinions – what are the opportunities for this, and do people understand how to share what they feel and with who when a specific outcome is desired; people choose religious services, and are not required to attend a staff’s church, a family’s “home church”, or any church at all – but may choose to engage through tele media, private mediation, or choose to not engage at all, etc.</i> <i>• Having the choices and freedoms does not mean people who receive HCBS should never have to do certain things at certain times, e.g. if I have a job at Olive Garden, and am provided a work schedule , just as anyone else who works I must report to work at the scheduled times.</i> —42 C.F.R. § 441.301(c)(4)(iv) (about HCBS waivers); § 441.530(a)(1)(iv) (about Community First Choice programs); 10A NCAC 27D .0301 Social Integration; 10A NCAC 27F .0105 Client’s Personal Funds (a) (b) (c) (1) (2) (3) (4) (5) (6) (7) (8) (d) (1) (2) (3) (4); 10A NCAC 27D .0302
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	<i>Client Self-Governance; 42 CFR § 441.301(D) Individuals are able to have visitors of their choosing at any time; §122C-62 (b) (7); §122C-62 (b) (8)</i>
5. Individuals are free and supported to control their own schedules and activities as well as have access to food at all times. • <i>Do people choose their daily activities, their schedules, and the locations of the activities as opposed to being “told” what they are to do?</i> • <i>Do people receive support needed to make choices about the kinds of work and activities they prefer?</i> • <i>Is there evidence of personal preference assessments to identify the kinds of work and activities people want?</i> • <i>Do the individuals have meals at the times and places of their choosing?</i> • <i>Are snacks accessible and available at all times?</i>	• <i>There must be clear evidence that the individual’s schedule is not prescriptive (developed and imposed by support team without any involvement of the person), and is not identical to that of his/her housemates, but may have some similarities, e.g. (can they share/show their schedule; do they make/write their own schedule if one is needed, do they carry a personal copy/have it on their preferred technology device if this is important in their life, is it repeated from day to day with no changes noted?). Is there evidence that schedules are flexible and change as needed based on personal preferences, e.g. if a person chooses to not go to the movies at the last minute this does not present a problem?</i> • <i>There must be evidence that a person is not required to get up, go to bed, take a bath, exercise at the same time every day, unless it is truly their choice. For minors more defined scheduling may be required, e.g. bedtimes, homework, tooth brushing three times a day could be examples – these are not restrictions.</i> • <i>There must be availability and noted use of preferred “things to do”, e.g. television, board games, IPOD, computer, etc. when a person chooses to do them yet lending consideration to the rights of others.</i> —42 C.F.R. § 441.301(c)(4)(iv) (about HCBS waivers); § 441.530(a)(1)(iv) (about Community First Choice programs); 10A NCAC 27G .0208 Client Services (a) (3) (c); 10S NCAC 27D .0301 Social Integration; § 168-8; §441.301 (vi) (C)
6. Facilitates choice regarding services, supports, and who provides them. • <i>Do people select the services/supports that they receive (generic community services e.g., barber, restaurant, etc.)?</i>	• <i>Individuals are provided a choice regarding the services, provider and settings and the opportunity to visit/understand the options available.</i> • <i>Choices of individuals may not align with selected vendors of provider agencies and must be carefully considered, e.g. people using the same barber, pharmacy or for the convenience of being</i>

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Do people select the provider from a choice of providers?	<i>able to charge to a pre-established account.</i> <i>The setting affords individuals the opportunity to update or change their preferences and can demonstrate this as an operating practice, e.g. educational support, house meetings, self-advocacy meetings.</i> <i>The setting must ensure that individuals are supported to make decisions and exercise autonomy to the greatest possible degree.</i> <i>The setting affords the individual with the opportunity to participate in activities that they prefer/like, but that are not work related.</i> <i>The meaningful activities should occur within the person's community specific to their individual needs and preferences.</i> <i>Support staff must be able to demonstrate their understanding and knowledge of a person's capabilities, interests, likes as well as their dislikes.</i> <i>Individuals should be involved if they desire to choose their own support workers, e.g. involved in interview process, meeting applicants when they visit potential work sites.</i> <i>The provider must have a policy and demonstrate implementation of that policy which ensures that the individual has the needed supports to develop his/her plan that is specifically reflects their needs e.g. development of the plan is a joint responsibility of the person, Care Coordination/Case Management and the Provider.</i> <i>The provider must be able to demonstrate how the individual is best supported in making changes in their service array – there is joint responsibility between the provider and care coordination.</i> —42 C.F.R. § 441.301(c)(4)(v) (about HCBS waivers); § 441.530(a)(1)(v) (about Community First Choice programs); § 441.710(a)(1)(v); 10A NCAC 27F .0103 (3); 10A NCAC 27D . 0302
7. The setting is physically accessible to the individual. Have modifications been made to promote maximum access and use of physical environment for the	<i>The setting must ensure that there are no obstructions which include but are not limited to steps, doorway lips, narrow hallways or entrances that limits or prevents a person's ability to access all</i>

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<i>person, if needed and requested?</i>	<i>areas.</i> <i>• Reasonable modifications must be made that addresses an individual's needs specific to ensuring full access to the environment, e.g. grab bars, raised seats in the bathroom, shower chairs, ramps, reasonable height and location of tables/chairs, accessibility of washer and dryers, commensurate with an individual's needs, etc.</i> <i>• This requirement cannot be changed/modified as it meets ADA.</i> <i>10A NCAC 27G .-0205; 10A NCAC 27G .0304 (a), (b) (1) (2) (3) (4) (5); ADA.gov</i>
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Section III: Residential HCBS Criteria – In a provider-owned or controlled residential setting, in addition to the qualities listed above, the following additional conditions must be met:

NOTE: This section MUST be completed only if the following service is provided: Residential.

8. Individuals have privacy in their sleeping or living unit. <i>• Can the individual close and lock their bedroom door?</i> <i>• Is the furniture arranged as the individual prefers and does the arrangement assure privacy and comfort?</i>	<i>• Individuals must be able to close and lock their personal living area (bedroom and bathroom) if they desire.</i> <i>• If they cannot close and lock their personal living area, it must be clearly addressed in the person-centered plan or assessment, e.g. is it a health and safety issue that makes it a rights restriction, is it a training issue, that the person does not have an interest after there has been opportunity for informed choice or is it that the person will never possess the ability based on individual circumstances.</i> <i>• A training plan must be developed to assist in the acquisition of that particular skill unless the person does not possess any ability to do so and that must be noted in the plan, (e.g. a person that may be medically fragile and has no movement and requires total staff assistance).</i> <i>• The furniture must be adequate to meet the person's needs/preferences and must be arranged the way the person</i>
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	<i>desires.</i> • <i>The arrangement must ensure privacy and comfort for the person.</i> • <i>Staff and other housemates must always knock and receive permission prior to entering a person's bedroom, living area, or bathroom.</i> —42 C.F.R. § 441.301(c)(4)(vi)(B) (3) (about HCBS waivers); § 441.530(a)(1)(vi)(B) (about Community First Choice programs); § 441.710(a)(1)(vi)(B); 10A NCAC 27F .0102
9. The unit or dwelling can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services and the individual has the same responsibilities and protections from eviction that tenants have under landlord/tenant law. For settings in which landlord tenant laws do not apply, there must be a lease, residency agreement or other form of written agreement in place for each HCBS participant. The document must provide protections that address eviction processes and appeals comparable to those provided under landlord/tenant law. • <i>Do people have the same responsibilities that other tenants have under landlord/tenant laws?</i> • <i>Are people provided the same protections from eviction that other tenants have under landlord/tenant laws?</i>	<i>Additional guidance has been requested:</i> • <i>HCBS Services cannot occur in settings that restrict an individual's choices as well as any aspect of their daily life. Individuals have the same rights and responsibilities under state law as any tenant. This includes no eviction/discharge without cause or proper notice. Health and safety remains paramount. This includes eviction/discharge without proper and justified notice. Individuals must know their rights regarding housing and when they could be required to move and this information included in their ISP or assessment.</i> • <i>Is there a lease, residency agreement, memorandum of agreement or other agreed upon form of documentation between the individual and the landlord?</i> —42 C.F.R. § 441.301(c)(4)(vi)(A) (about HCBS waivers); § 441.530(a)(1)(vi)(A) (about Community First Choice programs); § 441.710(a)(1)(vi)(A) §168-9; 10A NCAC 27 G. 0201; add d/c NCGS.
10. Units have entrance doors lockable by the individual with only appropriate staff having keys to doors. • <i>Each person living in the unit has a key or keys for that unit.</i> • <i>Is there evidence that efforts are being made to teach</i>	• <i>Individuals have access to the entrance, bedroom and bathing areas through whatever key system is utilized by the facility if the individual possesses the required skill set to do so safely and does not place themselves at risk of injury. Training in identified areas</i>

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<i>use of a key to anyone who does not understand how to do this?</i>	<i>of need must be carefully assessed.</i> <i>Support staff does not indiscriminately use master keys to gain access without appropriately knocking and receiving permission prior to entering. In the event of a health and safety concern or the person is at risk this would not be expected.</i> <i>The person-centered plan and/or assessment reflects that the person has the ability gain access/use key system to their home or a training plan is developed to assist in the acquisition of that particular skill unless the person does not possess any ability or desire to do so and that must be noted in the plan. This is a joint collaborative between, the person, their Care Coordinator and their provider.</i> —42 C.F.R. § 441.301(c)(3)(vi)(B) (1) (about HCBS waivers); § 441.530(a)(1)(vi)(B) (about Community First Choice programs); § 441.710(a)(1)(vi)(B);
11. Individuals sharing units have a choice of roommates in the setting. <i>Do people choose their roommates?</i>	<i>The home has a process to assist the individual to choose a roommate/housemate regardless of whether the person does or does not use words to share their opinions/desires.</i> <i>Married couples are afforded a choice of sharing a room.</i> <i>The home has a process for the individual to request a roommate change should they desire one, but this not guaranteed a change will occur based on what may be available – but that the person is afforded the opportunity to explore.</i> <i>The individual expresses that they are satisfied with their roommate through contacts with their Care Coordinator, to their support staff and during their person-centered planning meeting.</i> —42 C.F.R. § 441.301(c)(4)(vi)(B) (2) (about HCBS waivers); § 441.530(a)(1)(vi)(B) (about Community First Choice programs); § 441.710(a)(1); (vi)(B)
12. Individuals are free to furnish and decorate sleeping and living units.	<i>Individuals are free and encouraged to choose items of their preference for their specific room/living area.</i>

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• Does each person pick the decorative items in their own private bedroom? • Do people living in the same unit participate in the choices of decorative items in the shared living areas of the unit?	• <i>This is not a choice of one or two items, but an opportunity to visit stores of choice, on line shopping, seeking assistance from people of their choosing to accompany or assist them. Consideration must be given to an individual's financial resources.</i> —42 C.F.R. § 441.301(c)(4)(vi)(B) (3) (about HCBS waivers); § 441.530(a)(1)(vi)(B) (about Community First Choice programs); § 441.710(a)(1)(vi)(B); § 168-8; 10 A NCAC 27F.0102
13. Individuals are free to have visitors of their choosing at any time. • Are people supported in having visitors of their own choosing and to visit others frequently? • Are people satisfied with the amount of contact they have with their friends?	• <i>Individuals are supported to have visitors of their choosing in their home , e.g. is the person assisted to make a phone call, coordinate time that works for both the visitor/friend and the individual;</i> • <i>Help the individual understand what are acceptable social practices;</i> • <i>Visitors cannot infringe on the rights/space of an individual's house or roommates.</i> —42 C.F.R. § 441.301(c)(4)(vi)(D) (about HCBS waivers); § 441.530(a)(1)(vi)(D) (about Community First Choice programs); § 441.710(a)(1)(vi)(D); 10A NCAC 27D .0301; 10A NCAC 26B .0108; APSM 45-1 10A NCAC 26B .0108 (a) (b) (1) (2) (3) (4) (5); 122C-62 (b) (1)
14. Any modification of the additional conditions (1-13 in this document) for provider owned or controlled residential setting must be supported by a specific assessed need and justified in the person-centered plan. The following requirements must be documented in the person-centered plan. 1. Identify a specific and individualized assessed need. 2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan. 3. Document less intrusive methods of meeting the need	<i>If any modifications are needed to any of the items listed in 1-13 of this document, assist the person to contact their responsible Care Coordination/Case Manager to schedule a meeting. The meeting will be for the sole purpose to discuss, address and modify the person's individual plan. The information in the person-centered plan must reflect all elements listed in number 14 (#'s 1 – 8).</i> 10A NCAC 27G .0206 Client Records; APSM 45-2 Chapter 4-10; Review and Annual Rewrite of Person-Centered Plan; APSM 45-2 Chapter 4-6 The Crisis Plan As A Required Component Of The Person Centered Plan

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<i>that have been tried but did not work.</i> 4. <i>Include a clear description of the condition that is directly proportionate to the specific assessed need.</i> 5. <i>Include regular collection and review of data to measure the ongoing effectiveness of the modification.</i> 6. <i>Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.</i> 7. <i>Include the informed consent of the individual.</i> 8. <i>Include an assurance that interventions and supports will cause no harm to the individual.</i>	
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Sources: CFR, NCAC, NCGS, Med.Gov; ASAN,

Additional Comments:

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider

Printed Name/Title

Signature

Date

Contact Number: _____

The signature, by LME-MCO representative, below certifies review and acceptance of the above Self-Assessment information.

Printed Name/Title

Signature

Date

Intellectual Disability and Crisis

William R. McCuller, Ph.D.

Licensed Psychologist

Health Services Provider-Psychologist

NC START WEST Clinical Director

Intellectual Disability

- Significantly sub-average intellectual functioning determined by standardized testing.
- Significantly sub-average adaptive functioning determined by standardized measures.
- Occurs during developmental period.



Levels of Intellectual functioning.

- Mild
- Moderate
- Severe
- Profound



Challenging Behavior in Persons with Intellectual Disability

- The challenging behavior present and found in persons with intellectual disabilities presents in a variety of manners, forms, typographies, intensities, durations.

- 
- In some cases such behavior presents as an occasional issue that will result in minimal problem. In some other cases the behavior may represent a clinically significant danger to the individual demonstrating the problem or to those around him or her.

Types of behavior

- Refusing to cooperate with needed activities
- Verbal disruption-screaming, crying, yelling
- Verbal threats-statements including threats to hurt self or others
- Property destruction
- Activity disruption
- Physical aggression
- Self injury
- Eating inedible items
- Food rumination
- Intentional vomiting
- Food refusal
- Running away; running into the street; laying in the street
- Inappropriate sexual behavior (public masturbation; touching others inappropriately; sexual assault to others-adults, children, intellectually disabled persons)
- Taking objects belonging to others
- Telling untruths
- Hallucinations
- Delusions
- Pseudo-hallucination/delusions
- Pseudo-seizures

The Function of Challenging Behavior

Generally challenging behavior serves a purpose in the individual's life.

For the individual involved, we may think of this behavior as describing an issue, a concern, a need, a biological problem, a social or emotional need. He or she engages in challenging behavior as a product of something that is going on in his or her life that is not tolerable.

The issue is not acceptable as evidenced by his or her inability to adapt; or, the system's inability to support his adaptation to the issue.



There can be great variety in the functions related to challenging-aberrant behavior.

Listed below are categories and examples of functional issues related to aberrant behavior.

These have been drawn from the scientific literature and from clinical experience:

Organic-biological issues related to challenging behavior:

- Any source of pain or discomfort
- Infection
- Loss of appetite
- Seizures
- Dental problems can be common and underestimated
- Hypothyroidism
- Diabetes
- Kidney stones
- Urinary retention
- Sleep apnea
- Sleeplessness
- Bladder or urinary tract infections
- Headaches-migraines
- Earaches
- Constipation; change in bowel pattern, or habits
- Increase in falls
- Loss of orientation to place, time or routine pattern
- Vision or hearing loss
- Vision, hearing, or sense of touch experiences not shared by others
- Loss of mobility
- Change in pattern of movement, speed of movement, tremors, tics, inability to sit still
- Loss of functional skills needed for adaptive functioning
- Change in any medication (anticonvulsants, behavioral, or health related)
- Any health related source of change or suspected cause of discomfort.

Psycho-social issues related to challenging behavior:

- Fear of failure
- Anxiety-fearfulness-history of trauma (relative for all forms of mental illness)
- History of abuse-neglect, or physical conflict
- Currently happening abuse or neglect
- Task demands that exceed the individual's abilities
- Inability to cope with parental demands
- Attempts to escape or avoid interaction
- Change in routine
- Change in care providers, staff
- Change in extent of available support
- Failure to develop functional skills necessary for independent functioning
- Demands for attention, interaction or active engagement
- Loss of contact with family; loss of a loved one; grief
- Death of peer, or other one in his immediate contact
- Change in living environment
- Excessive stimulation-demanding to be alone
- Preference for self-stimulation-self reinforcement
- Job change or loss
- Inability to cope with peers
- Inability to get a job, a home, a girl or boy friend (as appropriate); inability to be "normal"

Crisis Issues for Individuals with Intellectual Disability



Crisis Prevention and Management

The START model proposes that “Crisis is a problem without the tools to address it.”

If you are dealing with an individual who has challenging behavior that is progressively escalating and there is not appropriate tools to deal with it then he or she is already in crisis.

Dealing with an Emergency Situation- Crisis Supports

1. First attempt to connect with the individuals system of supports and informants. Identify who may provide accurate information. Learn about the individual, his functioning level, communication skills, and diagnostic considerations. Autism and anxiety disorders from previous trauma are high frequency issues with persons with IDD in crisis.

- 
2. Get information concerning the current incident/presenting problem and any events that led up to the incident. What are the challenging behaviors that have been presented by the individual? What degree of danger is involved and who is in danger?
 3. How was the individual functioning before this incident.
 4. It is critically important to listen to the individual and to the informant who he or she seems to trust. As you try to talk to the individual ask his permission and ask him if he would like someone in particular to stay with him while he talks to you.

- 
5. To the extent possible connect with the individual and do what is possible to help him relax, feel safe, and avoid on-going conflict.
 - a. If another person is presenting conflict or may escalate the situation attempt to encourage that person to withdraw.
 - b. Talk slowly in a reassuring manner; speak softly so that the individual has to lower his voice to hear what you are saying.
 - c. Use short statements and allow him time to process what you have said; look for an acceptance response.
 - d. Use gestures if necessary to help him understand.

- 
6. Assure safety of the individual, those around him or her and your self. Work with informants to determine what needs to occur to assure safety.
 7. Determine what options are available to assure safety for the individual.
 - a. Discuss and review the options available with informants and supports.
 - i. Is there a safe place he or she would like to go to?
 - ii. Is there another person he or she would like to talk to or be with; can we call that person?
 - iii. Encourage comforters (does he have a preferred item, is it safe, does he like to lay down, rock in a chair? Hold a blanket?)
 - iv. Be sensitive to body language and triggering events or statements. Stop doing things that seem to escalate the individual's anxiety.
 - v. Proceed cautiously with attempted interaction or treatment protocols. Ask the individual before proceeding and get his permission.

- 
- b. Offer and encourage the individual to select one of the available options that seems reasonable to the system of supports.
 - c. Encourage and support the individual in selecting a safety option and continue to assist him in relaxing as he moves into the selected option.
 - d. It seems most desirable to assist the individual to select a safety options alternative to hospitalization if possible.
 - e. If safety cannot be assured then hospitalization may be the most desirable option.

Treatment Strategies and Approaches



Positive supports necessary to enable positive outcomes often requires a combination of effective treatment strategies. Listed to follow are examples of positive treatment methods that may be necessary or used in some combination in an individual's treatment:

- 
1. A structured activity schedule that carries on throughout the individual's entire waking day. Activities presented should be preferred and functional to the individual. Each activity should be constructed to ensure success and build on self-esteem.



2. Adaptive skills training in areas where the individual experiences frustration. Insure success and continued motivation to participate through errorless learning strategies.



3. Structured teaching activities to enable the individual to build behavioral coping strategies that address each area with which he or she has difficulty. For example if she has difficulty interacting with peers you may start with teaching basic greeting skills and progress through taking turns, helping another person learn something he or she knows, etc. This approach attempts to build a repertoire of successful social interaction skills.



4. Supported and structured leisure interaction activities. Support the individual's involvement in fun and engaging leisure activities with others while assuring their success and avoiding any sense of anxiety.



5. Identify the vulnerabilities, and triggers that lead to challenging behavior.

6. Provide support and reassurance when early signs of anxiety occur. Attempt to minimize exposure to upsetting situations (triggers) when the individual is likely to be vulnerable. Allow the individual the self control necessary to escape upsetting events.

- 
- Provision of cognitive behavior therapy targeting the individual's specifically identified needs. In other words, assist the therapist in identifying targeted issues and outcomes for therapy. Don't just refer the client for therapy. A good therapist should seek to know what the individual needs to work on.
 - Assume the individual will need to practice any coping strategies learned in therapy to the point of over learning in order to remember and attempt to use the strategy when the time comes. See to it that he or she gets to practice and role-play over and over his or her coping strategies. Reinforce vigorously his or her efforts at practice. Support his or her practice with all the other members of his or her family or support staff so that every one can assist in the use and remembering of coping strategies when the time comes.

Open for questions and discussion.

Thanks for listening.

North Carolina DHHS HCBS Final Rule Transition Plan
(42 CFR Section 441.301 (c) (4) (5) and Section 441.710(a) (1) (2)

North Carolina Vision

North Carolina supports serving individuals with disabilities in the least restrictive and most integrated settings possible, based on what is clinically appropriate as defined by the individual's person-centered planning process. Through the planning process, the Department believes that individuals with disabilities should have the opportunity to live in community settings that reflect community values and standards. These settings will vary depending upon individual's preferences and supports needed to live in the community.

Our planning process to ensure North Carolina's compliance with Centers for Medicare and Medicaid Services (CMS) Home and Community Based Standard rules will actively engage our beneficiary and provider stakeholders. We will create a plan that supports individuals through a person-centered process that builds upon our already existing system and supports providers to ensure compliance with rules. *

*Adopted July, 2014 by the North Carolina Secretary of the Department of Health and Human Services.

Purpose

In January 2014, the Centers for Medicaid and Medicare Services (CMS) published final Home and Community Based Services rules to ensure that individuals receiving long-term services and supports through (HCBS) programs under the 1915(c), 1925(i) and 1915(k) Medicaid waivers have full access to the benefit of community living and the opportunity to receive services in the most integrated setting appropriate. Furthermore, CMS denotes that the intent of this rule is to enhance the quality of HCBS and provide protections to participants. These rules were effective March 2014.

The purpose of North Carolina's preliminary transition plan, for wavier beneficiaries, is to ensure that individuals have full access to communities of their choosing. At a minimum, this choice will include real opportunities to seek employment and to work competitively within an integrated work force. As a result individuals will have opportunities to engage in life experiences within their own communities while improving personal outcomes. Our State's primary goal is to ensure full compliance with HCBS Final Rule.

Home and Community-Based Setting Requirements:

- The setting is integrated in and supports full access of individuals receiving Medicaid Home and Community-Based Services to the greater community;

- Included are opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources;
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid Home and Community-Based Services;
- The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting (with consideration being given to financial resources);
- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint;
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices;
- Facilitates individual choice regarding services and supports, and who provides them;

Provider Owned or Controlled Residential Setting – Additional Requirements:

- Provides, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the State, county, city or other designated entity;
- Provides privacy in sleeping or living unit;
- Provides freedom and support to control individual schedules and activities and to have access to food at any time;
- Allows visitors of choosing at any time;
- Is physically accessible;
- Requires any modification (of the additional conditions), under 42 CFR 441.301(c) (4) (VI) (A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.

North Carolina DHHS Statement of Progress and On-going Plan of Action

Outreach, Engagement, and Public Notice/Comment (October 1, 2014 – March 17, 2018):

To ensure consistent, clear, streamlined communication with waiver beneficiaries, families, provider organizations and associations, as well as other interested stakeholders, the North Carolina Department of Health and Human Services (DHHS) established a dedicated web portal, and posted information on its website. This source provides information and links focused solely on the implementation of HCBS Final Rule (March 17, 2014) including the rule, the self-assessment and review process, deadlines for compliance, and availability of technical assistance. It will be updated with additional information as it is available, inclusive of any significant changes to the plan following the 30 day public comment period. Other communication will include webinars, meetings, a “person first” version of the transition plan, and Power Point presentations.

Conversations about the HCBS Final Rule began in Spring 2014 and generated valued stakeholder input. The HCBS Stakeholder Committee formed by Medicaid beneficiaries and their family members, as well as providers, provider associations, and representatives from DHHS worked closely together to

advocated and implement a shared approach for crafting North Carolina's Statewide Transition Plan. The Committee's composition is as follows:

STAKEHOLDERS

Anna Cunningham
Jean Anderson
Kelly Beauchamp
Kelly Melage
Sam Miller
Yukiko Puram
Johnathan Ellis
State Consumer Family Advisory Committee (SCFAC)
ABC Human Services (Provider)
Developmental Disabilities Consortium
Enrichment Arc (Provider)
Monarch (Provider)
Easterseals UCP (Provider)
North Carolina Housing Finance Agency
SembraCare (Home Care Software Company)
Disability Rights of North Carolina
Arc of North Carolina

PROVIDER ORGANIZATIONS

NC Provider Council
Benchmarks
North Carolina Adult Day Services Association
The Provider Council
North Carolina Developmental Disabilities Facilities Association

LME-MCOs

East Carolina Behavioral Health
Cardinal Innovations
Smoky Mountain Center
CoastalCare

Local Lead Agencies (Case Management Entities)

RHA Howell
Home Care of Wilson Medical Center
Resources for Seniors

STATE GOVERNMENT

Division of Medical Assistance
Division of Mental Health/Developmental Disabilities/Substance Abuse Services
Division of Health Service Regulation
NC Council on Developmental Disabilities

In addition DHHS established a team of personnel to work in collaboration with the Stakeholder Committee to ensure North Carolina's primary full compliance with the HCBS Final Rule (March 17, 2014). North Carolina also engaged and continues to receive technical assistance from the National Association of State Directors of Developmental Disabilities (NASDDDS) a subject matter expert on best practices that align with HCBS setting requirements.

The initial draft plan and the proposed self-assessment were developed in conjunction with the Stakeholder Committee between October, 2014 and January, 2015. The transition plan and proposed self-assessment was posted for 30 day public comment on January 21, 2015. Notice of the public comment period was announced through the dedicated Department website, LME-MCO/Local Lead Agency (Case Management Entity) collaboratives, provider organizations and the broader stakeholder community. The public comment period proved interactive working opportunities for all vested partners.

Another primary purpose of releasing the plan for comment was to ensure that all stakeholders were fully informed of DHHS's plan for meeting the HCBS Final Rule (effective March 17, 2014). Public comments, as received through email, written correspondence, fax, testimony and through the six listening sessions, were judiciously analyzed and the plan was finalized with appropriate revisions made to the initial draft plan in early March 2015. The final plan, as submitted, is currently posted to the North Carolina DHHS website:

During the public comment period, six listening sessions were held to share information regarding the HCBS Final Rule (March 17, 2014), the proposed transition plan and self-assessment, and to obtain feedback from a broader stakeholder base. These sessions were held in the following locations from February 1 through February 15, 2015. Special consideration was given to determining the specific locales, for each of the sessions, to ensure the best possible access for individuals supported through the HCBS waiver.

Location	Number in Attendance

Common themes from public comment and listening sessions included the following:

Concern/Suggestion	Frequency

DHHS, in conjunction with the LME-MCOs/Local Lead Agencies (Case Management Entities) will continue to solicit feedback to ensure on going waiver compliance, to identify barriers, and to highlight areas of success in preparation for submission of future waiver amendments and/or comprehensive plan. This will occur through multiple frameworks, and feedback will have “no wrong door”.

State Self-Assessment and Remediation (November 25, 2014 - March 16, 2018):

The HCBS Final Rule for Home and Community Based Services will apply to three 1915(c) waivers operated by the State of North Carolina. The waivers and the services that this rule will impact are:

- NC Innovations: Residential Supports, Day Supports, and Supported Employment
- CAP/DA waiver: Adult Day Health
- CAP/C waiver – Currently services are not affected by this rule as they are home based.

The State conducted a comprehensive inventory of services, and reviewed the current LME-MCO/Local Lead Agency (Case Management Entity) contract/agreement to determine if there were any changes/modifications warranted for ensuring transition plan compliance.

The State is strategically vetting the current State system processes and regulations that could impact or be impacted by the implementation of the transition plan. This includes a comprehensive, in depth cross walk of State statutes, existing administrative code, rules, waiver service definitions, provider qualifications and licensing, as well as rate structures to identify areas where changes will be needed to ensure initial and on-going compliance with the CMS HCBS Final Rule (March 17, 2014). Although an integral component of the current waiver, review of the person centered planning and thinking processes are occurring concurrently. In addition, specific timelines and benchmarks for achieving and ensuring full compliance with the rule will occur as a fluid component of this process.

The State, through the Division of Medical Assistance (DMA) will update existing waiver policy to include the HCBS standards as well as the process for ensuring these standards are maintained. The policy will be promulgated through the regular DMA policy process. The changes will be added to the next technical amendment to the waiver and submitted to CMS through the waiver portal.

The State, through the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, will review, revise and adopt policy relative to its vision, outcome measures, and core indicators to ensure full compliance with the rule. Any change in current policy will occur through the established Departmental process.

The State collaborated with stakeholders to develop a self-assessment tool and companion guide for providers to evaluate compliance with HCBS Final Rule. The assessment includes identification of the type of setting and service provided, evidence supporting compliance with HCBS standards, and proposed remediation for standards that are found to be out of compliance.

The State will conduct a pilot of the self-assessment with identified providers to ensure that it captures all of the required waiver elements and is universally understood by families, provider networks, LME-MCOs/Local Lead Agencies (Case Management Entities), DHHS staff, and most importantly individuals who receive waiver supports. The State will make modifications to the tool as indicated by the findings of the pilot group to ensure the tool's conformity to and compliance with HCBS Final Rule. Once the tool has been tested, it will be utilized statewide. Providers will submit completed self-assessments to their assigned LME-MCO/Local Lead Agency (Case Management Entity).

The LME-MCO/Local Lead Agency (Case Management Entity) Quality Management Teams/designated staff will compile the self-assessment data to determine those providers who meet or do not meet the rule requirements. They will also establish the process to ensure that there is continuity of care without interruption of service for those individuals who may reside or receive services from providers who cannot meet the requirements. LME-MCOs/Local Lead Agencies (Case Management Entities) will also determine those providers who could meet the standards with technical assistance. Each LME-MCO/Local Lead Agency (Case Management Entity) will submit its analysis to DHHS.

The State, in partnership with the LME-MCOs/Local Lead Agency (Case Management Entity), will establish a Monitoring Review Process to validate a representative sample of Provider Self-Assessments. This review will ensure overall integrity of the self-assessment process. LME-MCO Care Coordination/Quality Management Departments, Local Lead Agency (Case Management Entities) designees and DHHS/DMA/DMHDDSAS Accountability and Quality Management Sections will validate a State determined percentage of provider self-assessments for validity (initial assessment data in comparison to validation data). Concurrent with the validation process of the representative sample, consideration/assessment will occur specific to the need for an individual assessment. If determined necessary, a tool will be developed and it would be utilized concurrently during the person-centered planning process.

LME-MCO/Local Lead Agency (Case Management Entity) Self-Assessment and Remediation (February 1, 2015 - September 30, 2015):

The LME-MCO/Local Lead Agency (Case Management Entity) will review all policies, procedures and practices, training requirements, contracts, billing practices, person-centered planning requirements and documentation, and information systems to determine their compliance with the HCBS Settings Rule. Each LME-MCO/Local Lead Agency (Case Management Entity) will be required to submit its assessment along with evidence of compliance to the State. Each LME-MCO/Local Lead Agency (Case Management Entity) will be required to identify any modifications needed to achieve compliance with the rule. The State will review each LME-MCO's/Local Lead Agency's (Case Management Entity's) assessment and evidence of compliance to ensure that all aspects of the system are aligned with CMS expectation. Any changes needed to achieve compliance will be incorporated in an amendment to the Transition Plan, including a specific timeline and identified milestones.

All revisions to systems/operations and materials needed to achieve compliance will be submitted to the State for review and approval. Upon approval, final versions will be completed and distributed to providers. Provider education/training will be conducted as appropriate. All education and training materials will be developed or approved by the State.

Provider Self-Assessment and Remediation (March 17, 2015 - March 16, 2018):

The State will conduct statewide provider education and training sessions on completion of the self-assessment. These training sessions will be via webinar and conference call and will be held between March 17, 2015 and May 31, 2015. Providers will receive the self-assessment tool, companion guide, instructions and timelines. Individuals served, family members, advocates, and other stakeholders must be an integral part of this assessment process.

Self-assessments will be submitted, along with the evidence of compliance, to the assigned LME-MCO/Local Lead Agency (Case Management Entity). Additional evidence may be requested or subsequent reviews conducted, as needed, to further assess and validate compliance with these rules.

Providers who self-report or are determined to be non-compliant by the responsible LME-MCO/Local Lead Agency (Case Management Entity) will be required to submit a plan of action to achieve conformity with the rule and must include identified time lines. Any setting that is presumed to have the characteristics of an institutional environment will be subject to heightened scrutiny. Every provider's transition plan will be comprehensively reviewed by the LME-MCO/Local Lead Agency (Case Management Entity) and will be monitored based on approved timeframes with oversight by the State.

Providers requiring technical guidance on how to achieve compliance may request assistance from the State, LME-MCO/Local Lead Agency (Case Management Entity) or another provider (of the same service type to ensure service continuity) that is in full compliance with the rule.

Providers who, following review, are deemed unable or unwilling to comply with the HCBS Final Rule (effective March 17, 2014) will be mandated to fully cooperate with guidance as provided by LME-MCOs/Local Lead Agencies (Case Management Entities) and State officials to:

- 1) Facilitate the seamless transition of individuals supported to an appropriate provider of "like" service to ensure there is no service interruption, or
- 2) Create and implement a plan detailing how individuals who utilize the provider's services at a specific location will be transitioned to a more integrated setting within their service capacity if this is the choice of the individual.

The State, in conjunction with the LME-MCOs/Local Lead Agencies (Case Management Entities) will oversee all necessary transition processes. A minimum of 60 days' notice will be provided to all individuals required to transition to another provider. More notice may be granted in instances when residential services are being secured. To ensure continuity of care and as little disruption to an individual's life as realistically possible, each person will receive a detailed description/notice of the process and a comprehensive listing of providers to consider for continuation of services. The assigned LME-MCO Care Coordinator or Local Lead Agency staff (Case Manager) will schedule a face-to-face visit (with subsequent visits occurring based on the specific needs of the individual) as soon as possible to

discuss the transition process and ensure the individual fully understands any applicable due process rights.

Initial Compliance and Update to Transition Plan:

No later than January 1, 2016, upon completion of provider network self-assessment surveys and in conjunction with the validation of the sample of assessments, the State will submit an amendment to this transition plan with specific remediation activities and milestones for achieving compliance with the HCBS Rule. Upon approval of the amendment by CMS, the State will submit Technical Amendments to its waivers to include the full transition plan.

For providers needing compliance assistance, the State proposes the following strategies from July 1, 2015 through June 30, 2018:

- Facilitate focus groups for providers that are both in and out of compliance with the Rule to ensure there is a peer support, problem solving process.
- Provide technical assistance through the development and scheduling of training regarding waiver compliance, changes and overall effect on individualized services.

Ongoing Compliance:

Once overall compliance has been achieved, ongoing compliance will be ensured through:

- On-going solicitation of feedback from individuals supported through the waiver, providers, provider organizations, and LME-MCOs/Local Lead Agencies (Case Management Entities);
- Annual consumer satisfaction surveys;
- On-going review of contracts with LME-MCOs/Local Lead Agencies (Case Management Entities) to ensure on-going compliance with standards;
- Specified quality assurance/improvement measures that ensure compliance with HCBS Final Rule (effective March 17, 2014);
- If determined necessary, implement an Individual Life Experience Assessment through the Person Centered Planning Process;
- Continuation of Collaborative Monitoring Review Process between the LME-MCOs/Local Lead Agencies (Case Management Entities) and the State;
- Consideration, in conjunction with LME-MCOs/Local Lead Agencies (Case Management Entities) and the broader Stakeholder community, of the creation of a public service announcement to promote the integration of individuals with intellectual and developmental disabilities within their communities;
- Continued partnership with the HCBS Stakeholder Committee.

Conclusion:

North Carolinians who receive Medicaid waiver services and supports must have all the same benefits of living in a community as others do. We, the State of North Carolina, see a new future for Medicaid waiver beneficiaries involving improved community access and quality of life. We will work with those who use home and community based services, their families, allies and others to become the change. Together, we will make this vision real.

NC DHHS HOME AND COMMUNITY BASED SETTINGS (HCBS) SELF-ASSESSMENT

Compliance with Statewide Transition Plan Alignment with CMS HCB Setting Regulation Requirements
(42 CFR Sections 441.301 (c) (4) - (6); Section 441.302 and 441.530)

****NOTE: A Companion Document, for additional guidance, is currently being developed.****

LME/MCO or Local Lead Agency (Case Management Entity) _____

Provider Name: _____ NPI#: _____ MHL License # (if applicable) _____

Site Name/Address _____

HCBS Service Type: Residential ☐ Day Supports/Adult Day Health ☐ Supported Employment ☐

Facility Type: _____ Bed Size/Facility Capacity: _____

Number of Persons Supported Through HCBS Waiver: _____

- *Before completing self-assessment, indicate the intent to comply with all HCBS Setting Rule Requirements: Yes___ No ___*
- *If Yes, continue. If No, enter the number of individuals through Medicaid HCBS that will need to be transitioned: ____*
- *Self-Assessment must be completed for each site providing HCBS Service(s), submitting one for an organization will not be accepted.*

Section I: Settings That Are Not Home And Community Based:

1. Is the facility one of the following? • <i>Nursing facility</i> • <i>Institution for Mental Diseases</i> • <i>Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)</i> • <i>Hospital</i> If any of these are checked yes, the facility cannot meet HCBS Criteria for community based settings.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
2. Is the facility in one of the following locations?	☐ Yes ☐ No

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<i>a building that is also a publicly or privately operated facility that provides inpatient institutional treatment</i> <i>a building on the grounds of, or immediately adjacent to, a public institution</i> <i>a setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS</i> If any of these are checked yes, the setting is presumed to not meet HCBS Criteria for community based settings, and would require approval of the Secretary of the United States Department of Health and Human Services (HHS).	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
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SPECIAL NOTE FOR SECTION II AND SECTION III:

All elements for each characteristic must be met for the response to be Yes. Evidence of support should be submitted in circumstances where element(s) of a characteristic is/are met, but a plan of action/correction is required for any element(s) that is/are not met. This will ensure monitoring only occurs for the area(s) that is/are out of compliance.

Section II: General HCBS Criteria

1. The setting is integrated in and supports full access to the greater community (work, live, recreate, and other services). There are opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.	☐ Yes ☐ No If Yes, provide evidence to support:
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**NC DHHS
HOME AND COMMUNITY BASED SETTINGS (HCBS)
SELF-ASSESSMENT**

• <i>Are transportation and other supports provided so that people can regularly access services similar to those used by the community at large?</i> • <i>Can people regularly interact directly with other members of the community who are not paid to do so?</i>	If No, provide proposed remedial measures/plan of correction:
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. • <i>The setting is selected by people from among residential and day options that include generic settings.</i> • <i>Do people choose their rooms (if residence) or the area they work in, etc.?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:
3. Ensures the rights of privacy, dignity and respect, and freedom from coercion and restraint. • <i>Do people have the space and opportunity to speak on the phone, open and read mail, and visit with others, privately?</i> • <i>Do people have a place and opportunity to be by themselves during the day?</i> • <i>Is informed consent obtained prior to implementation of intrusive medical or behavioral interventions?</i> • <i>For any restrictions imposed on the person, is there a plan for restoring the right/fading the restriction?</i> • <i>For people using psychotropic medications, is the use based on specific psychiatric diagnoses?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:

**NC DHHS
HOME AND COMMUNITY BASED SETTINGS (HCBS)
SELF-ASSESSMENT**

• <i>Do people receive the fewest psychotropic meds possible, at the lowest dosage possible?</i>	
4. Optimizes, but does not regiment, independent initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. • <i>Do people receive only the level of support needed to make their own decisions?</i> • <i>Do people exercise their rights as citizens to: voice their opinions, vote, and move about the community, associate with others, practice their religion, access their money, make personal decisions, and other rights that are important to them?</i> • <i>Do people choose their daily activities, their schedules, and locations of the activities?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:
5. Individuals are free and supported to control their own schedules and activities as well as have access to food at all times. • <i>Do people choose their daily activities, their schedules, and the locations of the activities as opposed to being “told” what they are to do?</i> • <i>Do people receive support needed to make choices about the kinds of work and activities they prefer?</i> • <i>Is there evidence of personal preference assessments to identify the kinds of work and activities people want?</i> • <i>Do the individuals have meals at the times and places of their choosing?</i> • <i>Are snacks accessible and available at all times?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:

**NC DHHS
HOME AND COMMUNITY BASED SETTINGS (HCBS)
SELF-ASSESSMENT**

6. Facilitates choice regarding services, supports, and who provides them. • <i>Do people select the services/supports that they receive (generic community services e.g., barber, restaurant, etc.)?</i> • <i>Do people select the provider from a choice of providers?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:
7. The setting is physically accessible to the individual. • <i>Have modifications been made to promote maximum access and use of physical environment for the person, if needed and requested?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:

Section III: Residential HCBS Criteria – In a provider-owned or controlled residential setting, in addition to the qualities listed above, the following additional conditions must be met:

8. Individuals have privacy in their sleeping or living unit. • <i>Can the individual close and lock their bedroom door?</i> • <i>Is the furniture arranged as the individual prefers</i>	☐ Yes ☐ No If Yes, provide evidence to support:
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SELF-ASSESSMENT**

<i>and does the arrangement assure privacy and comfort?</i>	If No, provide proposed remedial measures/plan of correction:
9. The unit or dwelling can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services and the individual has the same responsibilities and protections from eviction that tenants have under landlord/tenant law. For settings in which landlord tenant laws do not apply, there must be a lease, residency agreement or other form of written agreement in place for each HCBS participant. The document must provide protections that address eviction processes and appeals comparable to those provided under landlord/tenant law. • <i>Do people have the same responsibilities that other tenants have under landlord/tenant laws?</i> • <i>Are people provided the same protections from eviction that other tenants have under landlord/tenant laws?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:
10. Units have entrance doors lockable by the individual with only appropriate staff having keys to doors. • <i>Each person living in the unit has a key or keys for that unit.</i> • <i>Is there evidence that efforts are being made to teach use of a key to anyone who does not understand how to do this?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:

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11. Individuals sharing units have a choice of roommates in the setting. • <i>Do people choose their roommates?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:
12. Individuals are free to furnish and decorate sleeping and living units. • <i>Does each person pick the decorative items in their own private bedroom?</i> • <i>Do people living in the same unit participate in the choices of decorative items in the shared living areas of the unit?</i>	☐ Yes ☐ No If Yes, provide evidence to support: If No, provide proposed remedial measures/plan of correction:
13. Individuals are free to have visitors of their choosing at any time. • <i>Are people supported in having visitors of their own choosing and to visit others frequently?</i> • <i>Are people satisfied with the amount of contact they have with their friends?</i>	☐ Yes ☐ No If Yes, provide evidence to support:

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	If No, provide proposed remedial measures/plan of correction:
14. Any modification of the additional conditions (1-13 in this document) for provider owned or controlled residential setting must be supported by a specific assessed need and justified in the person-centered plan. The following requirements must be documented in the person-centered plan. 1. <i>Identify a specific and individualized assessed need.</i> 2. <i>Document the positive interventions and supports used prior to any modifications to the person-centered service plan.</i> 3. <i>Document less intrusive methods of meeting the need that have been tried but did not work.</i> 4. <i>Include a clear description of the condition that is directly proportionate to the specific assessed need.</i> 5. <i>Include regular collection and review of data to measure the ongoing effectiveness of the modification.</i> 6. <i>Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.</i> 7. <i>Include the informed consent of the individual.</i> 8. <i>Include an assurance that interventions and supports will cause no harm to the individual.</i>	☐ Yes ☐ No Yes confirms that all requirements are met and are contained in the person-centered plan(s). If No, provide proposed remedial measures/plan of correction:

**NC DHHS
HOME AND COMMUNITY BASED SETTINGS (HCBS)
SELF-ASSESSMENT**

Additional Comments:

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider.

Printed Name/Title

Signature

Date

Contact Number: _____

North Carolina DHHS HCBS Final Rule Transition Plan
(42 CFR Section 441.301 (c) (4)(5)and (6); Section 441.302; Section 441.530)

Action Item	Description	Start Date	Target Date	Completion Date	Sources	Key Stakeholders	Intervention/ Outcome
Section 1. Identification							
Purpose.	To ensure compliance with CMS HCBS Final Rule (March 17, 2014), while improving personal outcomes for waiver recipients across the State of North Carolina.	3/17/2014	3/16/2015		Centers for Medicare and Medicaid (CMS)HCBS (Home and Community Based Setting (HCBS) Final Rule (March 17, 2014).	Department of Health and Human Services (DHHS) /Division of Medical Assistance (DMA); Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS).	CMS Approval of Transitional Plan and Self-Assessment.
Inventory of Settings and Day Services - CAP/DA (Community Alternatives Program - Disabled Adults) and CAP/C (Community Alternatives Program - Children).	State identifies comprehensive HCBS service provider type.	11/25/2014	12/12/2014	12/12/2014	DMA.	DMA, Local Lead Agency (Case Management Entity).	Consolidated and verified HCBS inventory.
Inventory of Settings and Day Services - Innovations.	State identifies comprehensive HCBS service provider type.	11/25/2014	12/12/2014	12/12/2014	DMA.	DMA, LME-MCOs.	Consolidated and verified HCBS inventory.
Finalize specific HCBS Informational Portal for Department Website.	Links dedicated to implementation of HCBS Final Rule (March 17, 2014) - Detail will include Final Rule of HCB Settings, review process, deadlines for compliance, and availability of technical assistance. (On-going Process).	11/25/2014	1/15/2015		CMS Final Rule (March 17, 2014); NCAC (North Carolina Administrative Code); Other Waiver Documents.	DHHS Office of Communications; DHHS/DMA/DMHDDSAS Policy Advisors.	Clear, streamlined, consistent information/communication for individuals, families, other valued stakeholders, LME-MCOs and DHHS Staff.
Evaluate need for LME-MCO contract amendment or Local Lead Agency (Case Management Entity) agreement revision specific to implementation of CMS Final HCBS Rule (March 17, 2014).	Review of current LME-MCO/Local Lead Agency (Case Management Entity) contract/agreement to ensure global language regarding waiver compliance.	12/12/2014	12/19/2014	12/19/2014	Medicaid Contract; Medicaid Agreement.	DMA.	Contractual language required to ensure compliance with HCBS Final Rule (March 17, 2014) between DHHS and LME-MCOs/Local Lead Agencies (Case Management Entities).

**North Carolina DHHS HCBS Final Rule Transition Plan
(42 CFR Section 441.301 (c) (4)(5)and (6); Section 441.302; Section 441.530)**

Action Item	Description	Start Date	Target Date	Completion Date	Sources	Key Stakeholders	Intervention/ Outcome
Section 2. Assessment							
Development of Provider Self-Assessment Tool.	State, with stakeholder input, develops self-assessment tool for providers to evaluate conformity to and compliance with HCBS Rules.	11/25/2014	3/2/2015		HCBS Final Rule (March 17, 2014); Review of selected States' assessment tools.	Individuals supported through Waiver; HCBS Stakeholder Committees; other valued stakeholders; Provider Organizations, LME-MCOs/Local Lead Agencies (Case Management Entities) Staff, and DHHS Staff.	Assessment vetted and endorsed by key stakeholders.
NCAC/Standards/Rules Review.	Assess need for change to applicable rules, NC Administrative Code to ensure compliance with HCBS Final Rule.	11/25/2014	3/16/2018		NCAC and CMS HCBS Final Rule (March 17, 2014)	DHHS/DMA/DMHDDSAS Accountability Section, DHSR, HCBS Stakeholder Committees (External and Internal).	Identify Administrative Code Changes per Legislative Process to ensure compliance with Final HCBS Rule (March 17, 2014). Regular session of NCGS is held biennially convening in January after election - January 14, 2015.
LME-MCOs/Local Lead Agencies (Case Management Entities) complete self-assessment.	Respective entities will complete self-assessment of policies, procedures and practices.	2/1/2015	7/15/2015		Self-Assessment Document.	LME-MCOs/Local Lead Agencies (Case Management Entities) staff as assigned by their respective leadership.	Ensure Compliance with HCBS Final Rule (March 17, 2014).
Test, Pilot and Modify Assessment Tool.	Pilot self-administration of tool to ensure it captures elements and is universally understood by provider networks, LME-MCOs/Local Lead Agencies (Case Management Entities) and DHHS Staff.	3/17/2015	6/1/2015		HCBS Self-Assessment Tool.	LME-MCO Care Coordination Departments; Quality Management Departments; HCBS Stakeholder Committees, Local Lead Agencies (Case Management Entities) staff.	Validated Tool.
Identified Providers Complete Self-Assessment.	HCBS Providers will submit completed provider self-assessment to assigned LME-MCO/Local Lead Agency (Case Management Entity).	6/1/2015	7/15/2015		CMS approved HCBS Self-Assessment Tool.	HCBS Providers; LME-MCO Care Coordination Departments; DHHS/DMA - Clinical Policy Section; DMHDDSAS- I/DD Community Policy Section; Local Lead Agency (Case Management Entity) designated staff.	100% Completion of Self-Assessments by HCBS Providers.

North Carolina DHHS HCBS Final Rule Transition Plan
(42 CFR Section 441.301 (c) (4)(5)and (6); Section 441.302; Section 441.530)

<i>Action Item</i>	<i>Description</i>	<i>Start Date</i>	<i>Target Date</i>	<i>Completion Date</i>	<i>Sources</i>	<i>Key Stakeholders</i>	<i>Intervention/ Outcome</i>
Provider Self-Assessment Data are Compiled and Analyzed by respective LME-MCOs/Local Lead Agencies (Case Management Entities). Completed Analysis will be provided by the respective entity to DHHS.	LME-MCO Quality Management Teams or Local Lead Agency (Case Management Entity) designated staff compile the self-assessment data to determine those HCBS service providers who meet, do not meet, as well as those who could meet rule with HCBS technical assistance.	8/1/2015	9/30/2015		Self Assessment Tool.	LME-MCO Care Coordination Departments; LME-MCO Network Departments; LME-MCO Quality Management Departments; DHHS/DMA/DMHDDSAS Quality Management Section; Local Lead Agency (Case Management Entity) designated staff.	Comprehensive report of results/findings and inventory reflecting compliance status.
LME-MCO/Local Lead Agency (Case Management Entity) Evaluation/Assessment Data, as compiled by the respective entity, will be provided to DHHS.	Designated entities will complete self-assessment to ensure compliance with HCBS Final Rule (effective March 17, 2014).	8/1/2015	9/30/2015		Self-Assessment Tool.	LME-MCOs/Local Lead Agencies (Case Management Entities) staff as assigned by their respective leadership.	Comprehensive report of results/findings and inventory reflecting compliance status.
Plan of Correction Oversight.	POCS, as submitted by Providers, will be vetted by LME-MCO QM and Network Departments/Local Lead Agency (Case Management Entity) designated staff to capture specific components/elements that will require tracking as part of the remediation process. Data summary will be provided to DHHS.	8/1/2015	10/30/2015		CMS HCBS Final Rule (March 17, 2014); Provider Self-Assessment Information.	DHHS; LME-MCOs QM and Network; Individual Providers who have remedial plans for compliance with HCBS Final Rule (March 17, 2014).	Ensure Providers meet requirements in accordance with Final HCBS Rule (March 17, 2014).
Vet need for an Individual Life Experience Assessment Tool.	Concurrent with validation process of representative sample, evaluate need for individual assessment to occur concurrently with the PCP process acknowledging the individual is "the expert" specific to their support, services and personal outcomes.	10/1/2015	11/1/2015		CMS Final Rule (March 17, 2014) HCBS Self-Assessment Responses.	DHHS; LME-MCO Care Coordination and Quality Management Departments; and Local Lead Agencies (Case Management Entities) designated staff.	Determination of Need for Individualized Self-Assessment.

North Carolina DHHS HCBS Final Rule Transition Plan
(42 CFR Section 441.301 (c) (4)(5)and (6); Section 441.302; Section 441.530)

<i>Action Item</i>	<i>Description</i>	<i>Start Date</i>	<i>Target Date</i>	<i>Completion Date</i>	<i>Sources</i>	<i>Key Stakeholders</i>	<i>Intervention/ Outcome</i>
Establish a Monitoring Review Process to validate representative sample of Provider Self-Assessments.	Process will ensure integrity of the self-assessment process. LME-MCO Care Coordination/Quality Management Departments and DHHS/DMA/DMHDDSAS Accountability and Quality Management Sections and Local Lead Agencies (Case Management Entities) designated staff will validate a state determined percentage of provider self-assessments for validity (initial assessment data in comparison to validation data).	10/1/2015	11/1/2015		HCBS Self-Assessment Information; LME-MCO Care Coordination and Quality Management Departments; DHHS/DMHDDSAS Accountability and Quality Management Sections.	DHHS; LME-MCO Care Coordination and Quality Management Departments; and Local Lead Agencies (Case Management Entities) designated staff.	Validate Provider Self-Assessment. Random Sample - minimum 10%.

Section 3. Remediation

NCAC/Standards/Rules Remediation.	Develop, adopt, and implement a comprehensive plan that will ensure compliance of State Regulatory Authority with CMS HCBS Final Rule.	11/25/2014	3/16/2015		NCAC and CMS HCBS Final Rule (March 17, 2014).	DHHS/DMA/DMHDDSAS Policy Advisors and other designated personnel; Provider Organizations; and LME-MCOs/Local Lead Agencies (Case Management Entities).	Institute Legislative Administrative Code changes and Department Policy (development/modification) to ensure compliance with CMS HCBS Final Rule (March 17, 2014).
Policy Development.	State will develop/revise policies/standard operating procedures relative to vision, outcome measures, National Core Indicators, implementation, and on-going monitoring and compliance with HCBS Final Rule.	12/12/2014	3/16/2018		NCAC; CMS HCBS Final Rule (March 17, 2014); National Core Indicators; Personal Outcome Resources.	DHHS/DMA/DMHDDSAS Policy Advisors*; Office of the Attorney General.	Approved Policy.
Technical Assistance/Advisement to LME-MCOs and Provider Community.	DHHS/DMA - Clinical Policy Section and DMHDDSAS - I/DD Community Policy Section will provide technical assistance to any LME-MCO or provider requesting support to ensure full compliance with the HCBS Final Rule.	12/19/2014	3/16/2018		NCAC; CMS HCBS Final Rule (March 17, 2014); Individual HCBS Self-Assessment Information.	DHHS; LME-MCO Care Coordination Departments, Quality Management and Network Departments; and Local Lead Agencies (Case Management Entities) designated staff.	Ensure providers are implementing necessary steps to obtain full compliance with CMS HCBS Final Rule (March 17, 2014).

North Carolina DHHS HCBS Final Rule Transition Plan
(42 CFR Section 441.301 (c) (4)(5)and (6); Section 441.302; Section 441.530)

<i>Action Item</i>	<i>Description</i>	<i>Start Date</i>	<i>Target Date</i>	<i>Completion Date</i>	<i>Sources</i>	<i>Key Stakeholders</i>	<i>Intervention/ Outcome</i>
Continuation of Monitoring for Compliance with HCBS Final Rule (March 17, 2014).	State will incorporate HCBS requirements into policy/contracts as a mechanism to identify/determine any areas of non-compliance. Specifically the following elements will be included: responsible entity for monitoring; personnel required to complete monitoring functions; required training and process for monitoring staff; and protocol to manage concerns as well as other out of compliance issues.	3/17/2015	3/16/2018		CMS HCBS Final Rule (March 17, 2014); NCAC; Peer Review Data.	DHHS; LME-MCOs Quality Management Departments; and Local Lead Agencies (Case Management Entities) designated staff.	Integrity of the Program; Provider Compliance with CMS HCBS Final Rule (March 17, 2014).; Established Audit Process.
HCBS Technical Amendment - Innovations Waiver.	Submission of Technical Amendment that includes elements from submitted 3/17/2015 Transition Plan. Language will be incorporated into template once approved.	4/1/2015	7/1/2015		HCBS Final Rule (March 17, 2014); Transitional Plan - submitted March 17, 2015.	DHHS/DMA - Clinical Policy Section; DHHS/DMH - IDD Team/Community Policy Section.	Waiver Amendment with encumbered language reflected from Transition Plan.
HCBS Final Rule Transition Plan Update	Upon completion of provider network assessment, DHHS summarizes findings, revises plan, as indicated, to ensure all components of compliance with HCBS rule and appropriately reflects the State's related mission and values. Remedial strategies will be included for providers not in compliance with HCBS Regulations.	10/1/2015	1/1/2016		Assessment Results as submitted by LME-MCOs to DHHS.	DHHS/DMA - Clinical Policy Section; DHHS/DMH - IDD Team/Community Policy Section.	Waiver Update with Revised Remediation Strategy, as warranted.

North Carolina DHHS HCBS Final Rule Transition Plan
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Action Item	Description	Start Date	Target Date	Completion Date	Sources	Key Stakeholders	Intervention/ Outcome
Section 4. Outreach, Engagement and Public Notice/Comment							
Develop Initial Draft Plan	Gather Stakeholders, Division Leadership and LME-MCO/Local Lead Agency (Case Management Entity) input via multiple frameworks. Revisions to occur as warranted. Feedback will occur via face to face opportunities, fax, email, website submission and through Listening Sessions.	1/16/2014	2/25/2015		CMS HCBS Final Rule (March 17, 2014), Input as received from all sources.	HCBS Waiver Participants, Stakeholder Community, Advocacy Groups, LME-MCOs/Local Lead Agencies (Case Management Entities); Provider Organizations, and DHHS Staff.	Completion and Submission of Initial Transition Plan.
Public Notice/Comment Period - Following 30 day period, comments will be compiled and retained.	Public Notice to occur through multiple venues. Transition Plan and proposed self assessment per HCBS Rule will be shared. Such will occur, at a minimum, through DHHS website, LME-MCO/Local Lead Agency (Case Management Entity) collaborative, Provider Organizations and valued Stakeholder Community. This will serve as interactive working opportunities between all vested partners.	1/21/2015	2/19/2015		Proposed Transition Plan and Provider Self-Assessment.	Waiver Participants, Stakeholder Community, Various Community Advocacy Groups, LME-MCOs/Local Lead Agencies (Case Management Entities), Provider Organizations, and DHHS Staff.	Meet CMS HCBS Requirement of Public Notice.
Statewide Listening Sessions.	Department Staff will share information regarding HCBS Final Rule, and will also obtain critical feedback from vested Stakeholders.	2/1/2015	2/25/2015		CMS HCBS Final Rule (March 17, 2014); Draft Transition Plan and Self-Assessment.	DHHS; Individuals, Families, Advocates, LME-MCOs/Local Lead Agencies (Case Management Entities); Provider Organizations; and Other Valued Stakeholders.	Feedback results in consensus and adoption of proposed transition plan.
Training and Education on Final HCBS Rule and Implementation of Transitional Plan and Self Assessment.	Collaborate with LME-MCOs/Local Lead Agencies (Case Management Entities) to develop, schedule and facilitate training opportunities for individual recipients of services, families, provider network and valued stakeholders regarding on-going waiver compliance, changes and overall affect on individualized services.	2/1/2015	6/1/2015		Approved Statewide Transition Plan.	Waiver Recipients, Families, Provider Networks, LME-MCOs/Local Lead Agencies (Case Management Entities); DHHS Staff.	Informed understanding of changes and impact for waiver recipients.

**North Carolina DHHS HCBS Final Rule Transition Plan
(42 CFR Section 441.301 (c) (4)(5)and (6); Section 441.302; Section 441.530)**

<i>Action Item</i>	<i>Description</i>	<i>Start Date</i>	<i>Target Date</i>	<i>Completion Date</i>	<i>Sources</i>	<i>Key Stakeholders</i>	<i>Intervention/ Outcome</i>
Dissemination of Revisions to Transition Plan Draft Initially Posted.	Office of Communications will post any significant change to the plan following public comment.	3/2/2015	3/31/2015		Input/Comments received through Public Comment and other venues.	DHHS Office of Communications	Meet CMS HCBS Requirement of Public Notice.
Continued Input/Comment.	DHHS in conjunction with LME-MCOs/Local Lead Agencies (Case Management Entities) will solicit feedback periodically to ensure on-going waiver compliance, identify barriers, and areas of success and concern in preparation for submission of future waiver amendments and/or comprehensive plan.	3/17/2015	3/16/2018		Feedback from Individuals Receiving Waiver Services, Valued Stakeholders, Provider Organizations, LME-MCOs/Local Lead Agencies (Case Management Entities), CMS HCBS Final Rule (March 17, 2014).	DHHS; Individuals, Families, Stakeholders, Provider Organizations, and LME-MCOs/Local Lead Agencies (Case Management Entities).	Valued Feedback that will be incorporated into Comprehensive Waiver Plan as well as Department Policy and NCAC as warranted.



PARTNERS
Behavioral Health Management

Development of Short Term Goals

A Utilization Management Perspective
Charity Bridges, Joel McClung

S.M.A.R.T. Goals

Tools for making goals a reality

S.M.A.R.T. Goals are...

- ▶ Specific
- ▶ Measurable
- ▶ Attainable
- ▶ Realistic (Relevant)
- ▶ Timely (Tangible)



Creating specific goals

A specific goal has a much greater chance of being accomplished than a general goal.



So..... How do we come up with
specific treatment goals for our
consumers using the S.M.A.R.T ?



Understanding the foundation and establishing a baseline

- ▶ What do we already know about the individuals strengths, needs, and preferences in employment, education, communication, health and safety, life skills, personal care, medical, fine / gross motor skills, ambulation, independent living skills , self direction, and capacity for independent living ?
- ▶ Where is the participant at currently in these areas?



Understanding the foundation and establishing a baseline

- ▶ What methods and sources will provide the information that is needed?
- ▶ Who will gather the information and what role does each team member plan in the assessment process?
- ▶ When will the progress data be collected and used for planning? (weekly, monthly, yearly, etc)
- ▶ Again, What is the current baseline toward his/her specific goals (training, employment, education, daily living skills, etc.)?
- ▶ This foundation and the established baseline creates what is known as the Present Levels of Performance (PLP).



Present Levels of Performance

The assessment is the on-going process of collecting data on individual's strengths, needs, preferences, progress, and interests as they relate to the demands of the current and future goals.

Assessment data serves as the common thread and forms the basis for defining ISP goals and services.



Present Levels of Performance

- Summation of all available assessment data is used to develop the Summary of Performance.
- Annual goals are developed to address the individual's needs from the present levels of performance.
- There must be a direct relationship between the annual goals and the present levels of performance.
- Annual goals are statements, which emanate from the present levels of performance.



What to Assess ?

- ▶ Learning styles
- ▶ Temperament
- ▶ Personality
- ▶ Social skills
- ▶ Communication
- ▶ Interpersonal
- ▶ Independent living skills
- ▶ Health and Safety
- ▶ Mental Health concerns
- ▶ Aptitudes (academic, work, etc.)
- ▶ Interests and Preferences
- ▶ Self-advocacy skills
- ▶ Vocational and occupational skills
- ▶ Supports and accommodations (including assistive technology)



What to Assess ?

Strengths, Needs, Affinities?
Preferences(Large group vs. small group), Interests?
Parent/Consumer / Provider concerns?
Special Considerations?
Progress in the past year?
Performance compared to standards?
Response to Interventions?
What has worked? What hasn't?
Transition – Post high school, services, providers, etc?



Present Levels of Performance

Details Please 😊

Academic Performance and Learning Characteristics

- ▶ Suzanne has made progress since last year. (No detail)
- ▶ Since last year, Suzanne has increased her decoding skills. Currently, she is able to decode multi-syllable words containing closed and open syllables. (Detail!)

Social-Emotional Performance

- ▶ Maria is disruptive. (No detail)
- ▶ When Maria is confronted by challenging assignments she often reacts by talking loudly, leaving her desk and refusing to complete the assignment. (Detail!)



How to Assess

- ▶ Analysis of background information
- ▶ Interviews (treatment team members, providers)
- ▶ Surveys
- ▶ Checklists
- ▶ Goal Data
- ▶ Rating scales
- ▶ Work samples
- ▶ Interest Inventories
- ▶ Person-centered planning



How to Assess

- ▶ Self-Awareness Inventories and Surveys
- ▶ Curriculum-based assessments
- ▶ Situational Assessment - Observe and record skills and behavior in real-life settings, including the classroom, community, home, and work sites.
- ▶ Formal Assessments
 - Supports Intensity Scale
 - NC SNAP
 - Psychological Testing
 - Adaptive Functioning
 - Medical Assessments
 - Physical / Speech / Occupational



Current Formal Assessments

Supports Intensive Scale (SIS) ®

- ▶ Enhances the person centered planning process but does not replace it
- ▶ Allows the person centered planning process to identify strategies to address the person's needs
- ▶ Focuses on a person's support needs, not on a person's deficits
- ▶ Promotes individuals' personal growth and reflects a positive way of thinking
- ▶ Directly assesses type, frequency, and amount of support/assistance needed
- ▶ Uses a small group interview to engage the person and others
- ▶ Gathers the same information in the same way for each person, no matter the time, place, or level of support needed
- ▶ Allows the person-centered planning process to identify strategies to address the person's needs



Supports Intensity Scale

The **Supports Needs Scale** consists of 49 life activities grouped into six domains:

- *Home Living *Employment *Community Living
- *Health and Safety
- * Lifelong Learning * Social Activities

- ▶ The SIS Supports Needs Index provides a composite score that reflects a person's overall intensity of support needs relative to others with developmental disabilities. The Supports Needs Profile provides a visual graph or pattern of a person's support needs across all six life activity domains.



Supports Intensity Scale

- ▶ Home Living (using the toilet, preparing food, dressing, grooming needs, operating home appliances)
- ▶ Community Living (participating in recreational and leisure activities, shopping and purchasing goods, participating in community activities, accessing public buildings)
- ▶ Lifelong Learning (participating in training and education, using technology for learning, health and physical education skills, functional academics, self management skills)
- ▶ Employment (Job skills, interacting with others, completing assignments, seeking assistance)
- ▶ Health and Safety (taking medications, obtaining health care services, access emergency services, nutritious diet, emotional well being)



Supports Intensity Scale

- ▶ The Supplemental Protection and Advocacy Scale measures 8 activities. These rankings are helpful in developing individualized support plans, but the scores from this section are not used to determine either of the support needs indices mentioned above.
- ▶ Exceptional Medical and Behavioral Supports Needs measures support needs across 15 medical conditions and 12 problem behaviors. An underlying assumption of the SIS is that certain medical conditions and challenging behaviors predict that a person will require increased support over time. The medical and behavioral items identify important considerations for support needs planning and also indicate cases where the SIS Supports Needs Index may underestimate a person's "true" overall level of support needs
- ▶ NC DHHS Website



Supports Intensity Scale

- ▶ Home Living, Community Living , Lifelong Learning, Employment, and Health and Safety
- ▶ Frequency : 0 = None or less monthly, 1= at least once a month but not once per week, 2= at least once a week but not once per day, 3= at least once per day but not once per hour, 4= hourly or more frequently
- ▶ Daily Support Time: 0= none, 1 = less than 30 min, 2= 30 min to less than 2 hrs, 3=2 hrs but less than 4 hrs, 4 =4 or more hrs
- ▶ Type of Support: 0= none, 1= monitoring, 2=verbal / gestural prompting, 3=partial physical assistance, 4= full physical assistance



Current Formal Assessments

NC SNAP

- ▶ The NC-Supports Needs Assessment Profile is a needs assessment tool that, when administered properly, measures an individual's level of intensity of need for developmental disabilities (DD) supports and services.
- ▶ Daily Living : Supervision, Assistance Needed, Age, Structure
 - Self help and daily living skills, amount of assistance needed and type (VP, PP)
- ▶ Health Care : MD, RN, Allied Health Professionals, Equipment
- ▶ Behavior Domain : Mental Health Services, Behavior Severity, and Direct Intervention



Current Formal Assessments

NC SNAP

- ▶ The Overall Level of Eligible Support : Daily Living, Health Care, and Behavior Domains(Highest number)
- ▶ The NC SNAP index is a summation of all the numbers identified in Daily Living, Health Care and Behavior domains multiplied by the highest number
- ▶ The NC SNAP index will also provide an overall reflection to the level of support needed for an individual.



Getting information into the ISP

WHAT OTHERS NEED TO KNOW TO BEST SUPPORT ME.....

Life Situation :

Based on the SIS _____'s greatest areas fall in the area of:

SIS Section 1 : Part A, Home Living

SIS Section 2 : Protection and Advocacy

School / Vocational :

SIS Section Part C Lifelong Learning, Part D Employment



Getting information into the ISP

Social Network:

- ▶ Part B Community Living,
- ▶ Part F Social
- ▶ Section 2 Protection and Advocacy

Medical / Behavioral

SIS Section 1

Part E Health and Safety

Section 3 Exceptional Medical Support Needs

Section 3 Exceptional Behavioral Support Needs

Supplemental questions



Getting information into the ISP

WHAT'S NOT WORKING AND NEEDS TO CHANGE

Consider :

Section 1 : Part E Health and Safety

Section 2 : Protection and Advocacy

Section 3 : Exceptional Medical and Behavioral Supports

Supplemental Questions

Items which have higher rating (4's)

Consider what is important to the person but there are
no current supports or outcomes in place



Getting information into the ISP

Crisis Prevention and Early Intervention Strategies

Consider :

Section 1 : Part E Health and Safety

Section 2 : Protection and Advocacy

Section 3 : Exceptional Medical and Behavioral Supports

Supplemental Questions



S.M.A.R.T. Goals are...

- ▶ Specific
- ▶ Measurable
- ▶ Attainable
- ▶ Realistic (Relevant)
- ▶ Timely (Tangible)



S.M.A.R.T

Specific

- ▶ Specific goals answer the following questions:

Who: Who is involved?

What: What do I want to accomplish?

Where: Identify a location.

When: Establish a time frame.

Which: Identify requirements/constraints.

Why: Specific reasons, purpose or benefits of accomplishing the goal.



S.M.A.R.T

Creating Measurable Goals

To determine if your goal is measurable, ask questions such as:

- How much?
- How many?
- How will I know when it is accomplished?



Creating Measurable Goals

Establish concrete criteria for measuring progress toward the attainment of each goal you set.

We can't measure what we cannot sense (see, hear, smell, feel, taste).



Measurable & Observable Or Not?

Point to

Read orally

Write a paragraph

Realize

Circle

Walk

Illustrate

Be familiar with

Count blocks

Categorize

Enjoy

Spell orally

Know

Remember

Understand

Be familiar with

Grasp the meaning of



Measurable & Observable Or Not?

- ▶ Examples of Measurable and Non-Measurable Treatment Goals

- ▶ Patient's depression will decrease. OR Patient will score 20 or below on the Beck Depression Inventory for 5 consecutive sessions. Target Date: 6/1/2011.
- ▶ Patient will address his alcohol abuse. OR Patient will attend 2 AA meetings per week for 10 consecutive weeks. Target date: 6/1/2011. Patient will verbalize to therapist at least 3 triggers to drinking. Target date: 6/1/2011
- ▶ Patient will learn to control her anger. OR Patient will have no more than 2 angry outbursts per week for 6 consecutive weeks, per self-report. Target date: 6/1/2011.
- ▶ Patient's anxiety will decrease. OR Patient will not experience any panic attacks for 3 consecutive weeks, per self-report. Target date: 6/1/2011.



S.M.A.R.T

Attainable

- ▶ The goal is “do-able”
 - ▶ It is action-oriented
 - ▶ It is “within reach” of mortals!
- ▶ **A** may also stand for Action-oriented and that requires ***action*** verbs in the goal!



Skill / Behaviors Examples

- ▶ Classify
- ▶ Convert
- ▶ Define
- ▶ Estimate
- ▶ Interpret
- ▶ Retell
- ▶ Locate and Use
- ▶ Explain
- ▶ Point to
- ▶ Analyze
- ▶ Illustrate
- ▶ Elaborate
- ▶ Verbally Express

- ▶ Follow Directions
- ▶ Identify
- ▶ Request
- ▶ Calculate
- ▶ Ambulate
- ▶ Cope
- ▶ Exercise
- ▶ Develop

Verb



S.M.A.R.T.

Creating Realistic Goals

To be realistic, a goal must represent an objective toward which you are both *willing* and *able* to work.

To determine if your goal is realistic, ask questions such as:

- ▶ Do I truly believe that it can be accomplished? Again, it must be “do-able”
- ▶ Have I accomplished anything similar in the past?
- ▶ Can I identify the conditions that would have to exist to accomplish this goal?



S.M.A.R.T.

Creating Relevant Goals

- ▶ R – *Relevant*: Does the annual goal reflect individual needs identified in the Present Levels of Performance?
- ▶ How does the annual goal relate to the current performance?



Condition / Criteria Examples

- ▶ Given a request
- ▶ During transition periods
- ▶ During social conversation
- ▶ When using a communication device
- ▶ Content specific: *In Comp Ed class*
- ▶ When provided a writing prompt
- ▶ During class discussion
- ▶ When reading text
- ▶ When given 10 problems, questions....
- ▶ When shown a variety / When given a choice
- ▶ When using a graph
- ▶ When provided a visual schedule



Condition / Criteria Examples

- ▶ Trial based: *on 9 out of 10 trials*
- ▶ Production: *in at least 9 sentences, at least 2 times daily*
- ▶ Percentage: *with at least 75% accuracy, 40 % of trials*
- ▶ Change from baseline: *improve by at least 10%*
- ▶ Behavior change: *no more than 3 times a day*
- ▶ Across sessions: *on 9 consecutive attempts/ sessions*
- ▶ Time based: *for 15 minutes at a time, within 5 minutes*
- ▶ Grade-level: *at the 4th grade level*
- ▶ Condition / Criteria or Performance Criteria can also be used as apart of the assessment and evaluation process.



S.M.A.R.T.

Creating Tangible Goals

T can also stand for Tangible

A goal is tangible when you can experience it with one of the senses, that is, taste, touch, smell, sight or hearing.

When your goal is tangible you have a better chance of making it specific and measurable and thus attainable.



S.M.A.R.T. Creating Timely Goals

A goal should be grounded within a time frame.
With no time frame tied to it, there is no sense of urgency.



EVALUATION SCHEDULE

- ▶ Daily
- ▶ Weekly
- ▶ Bi-weekly
- ▶ Monthly
- ▶ Following summative assessment
- ▶ Every six weeks



S.M.A.R.T.

- ▶ **S – Specific**: What will the individual do one year from now that s/he cannot do today. concrete behavior or skill
- ▶ **M – Measurable**: Describe the criteria that will be used to measure successful achievement of the goal.
- ▶ **A – Achievable**: Based on the current level of performance, what is a reasonable and attainable higher level of performance that can be achieved within one year?
- ▶ **R – Relevant**: Does the annual goal reflect individual needs identified in the Present Levels of Performance?
- ▶ **T – Time Related**: Describe how long the goal will take to achieve, and the evaluation schedule



A well written goal ...

By _____ (date), _____ (the individual)
will _____ (skill/behavior - Verb)
when/at _____ (condition/criteria) as
measured by _____ (Assessment/ Staff
observation/ Evaluation Schedule)

By March 14th, The student will demonstrate skills to transition without physical aggression while exiting and entering the building 80 % of the time as measured monthly by observational logs.



A well written goal ...

▶ *Yasmin has difficulty negotiating situations in which she is in conflict with her peers. Her inability to establish appropriate boundaries, and to respect the boundaries of others causes her to get into frequent verbal disputes with peers. She uses offensive and threatening language during her disputes.*

▶ **S** – Specific, **M** – Measurable, **A** – Achievable, **R** – Relevant, **T** – Time Related

▶ **Goal:** Within one year, given explicit instruction in conflict resolution strategies and the opportunity to role-play in counseling sessions, Yasmin will state verbally to a peer when she feels that she has been disrespected or her personal space has been invaded, using appropriate, inoffensive words, in 4 out of 5 situations as assessed both in class and in unstructured settings by any of her teachers and/or staff members over two consecutive weeks through direct observations.



A well written goal ...

- ▶ Will work cooperatively with peers in small group settings (i.e. Share materials, allow peers to share different thoughts) on ____% of opportunities for ____ consecutive days measured by _____.
- ▶ Will sit and attend to and participate in large/small group activities (remaining seated, imitating actions, making choices, and following directions, attempting/completing tasks) for ____ minutes with no more than ____ prompts on ____% of opportunities as measured by _____.
- ▶ Uses questions to obtain information from others on ____% of opportunities across ____ consecutive days as measured by _____.
- ▶ Will transition between ____ preferred and non-preferred activities appropriately through the use of a visual and verbal cues on ____% of opportunities as measured by _____.



A well written goal ...

- ▶ When presented with questions such as “where is”, “show me”, “touch” will identify objects from a field of 3 with no more than ____ prompts on ____ out of ____ opportunities on ____ consecutive trial days as measured by _____
- ▶ Will produce ____ word length combinations which the following designated relations (e.g. horse jump), attributes (e.g. pretty horse), location (e.g. horse in barn), recurrence (e.g. eat more), possession (e.g. my horse), on 8/10 trials, during structured classroom tasks, with no more ____ verbal or visual prompts as measured by _____.
- ▶ Will communicate yes or no when presented with items and activities by nodding/shaking head or saying yes/no to indicate preferences to ____ preferred items (indicate “yes”) and ____ non-preferred items (indicate “no”) on the first trial per item for ____ consecutive days as measured by _____



Remember that Goals...

- ▶ Must relate directly to the needs from the Present Level of Performance (PLF).
- ▶ Must identify a learning gain that is both *challenging* and *reasonably achievable* in one year, given the instruction and services he/she will receive.
- ▶ A typical initial goal should have a 50-60 % success rate. This will allow for growth while also making the goal challenging.
- ▶ The data sources should be consistent and align with those stated in the Present Level of Performance.
- ▶ Objectives/benchmarks are intermediate steps designed to achieve the annual goal.
- ▶ S.M.A.R.T Goals



Evaluation Procedures

Short Term Objectives vs Benchmarks

SHORT-TERM OBJECTIVES

- One overarching target for the year
- Different short-term objectives (skills) to achieve the goal
- Skill based

BENCHMARKS

- Target tracking to successful completion of annual goal
- Benchmarks are the goals, but with progressive growth each marking period



What does UM see the most ?

- ▶ Goals that are not measurable and vague
- ▶ Goals that do not match the consumers clinical profile or assessment. i.e. IQ to goal matching
- ▶ # of trials are unclear in a given reporting period
- ▶ # of goals do not support the number of hours requested
- ▶ Data : inconsistent progress, no progress
- ▶ Data : Verbal Prompt, Partial Physical Prompt, or Full Physical Prompt, i.e. utilizing of all three for the same goal.
- ▶ Data : incomplete
- ▶ When to reassess ?



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