Louisiana Non-Residential Provider Self-Assessment

The Centers for Medicare and Medicaid Services (CMS) announced a requirement for states to review and evaluate current Home and Community-Based Services (HCBS) Settings, including residential and non-residential settings, and to demonstrate compliance with the new federal HCBS Setting rules that went into effect March 17, 2014. CMS developed these rules to ensure that individuals receiving long-term services and supports through HCBS programs under Medicaid waiver authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate. The following self-assessment is designed to measure HCBS non-residential providers' current level of compliance with these HCBS Setting rules and provide a framework for assisting those providers with the necessary steps to compliance.

Providers of the following services must complete ONE Non- Residential Self-Assessment for EACH licensed HCBS SETTING they own, co-own, and/or operate. Only ONE assessment per physical location is required.

- **DAY HABILITATION**
- **PREVOCATIONAL**
- **SUPPORTED EMPLOYMENT- GROUP/MOBILE CREW**

***Individual Supported Employment is presumed to be in compliance with the HCB Settings Rule, and therefore is NOT part of the assessment process.**

Instructions for completing the Non-Residential Self-Assessment:

1. Answer each question with either "**YES OR NO**".
2. For every "**YES"** response you must have evidence to support compliance and document the specific evidence in the **"Required Evidence of Compliance with HCBS rules"** section beside each question.
3. For every "**NO**" response you must address in a "**Provider Transition Plan" which will include timelines for meeting compliance. The Provider Transition Plan format will be provided to you.**

The completed Non-Residential Self-Assessment must be submitted to your Local Governing Entity (LGE) by September 30, 2015.

As part of the Provider Self-Assessment Process:

The Office for Citizens with Developmental Disabilities (OCDD) will choose a random sample of non-residential provider agencies who will be asked to submit all supporting documentation and evidence supporting the non-residential self-assessment answers to the LGE for a **DESK REVIEW**.

Evidence includes, but is not limited to:

- **Provider policies/procedures**
- **Licensure/ certification**
- **Participant handbook**
- **Individual Service Plan (ISP)**
- **Staff training curriculum**
- **Training schedule**
- **Advisory Council/Committee Assessment**
- **Weekly schedules of a sample of participants**

Also, OCDD will choose an additional random sample of non-residential provider agencies who will receive an **ONSITE** compliance review that will be conducted by either the LGE and/or OCDD. Providers must be able to provide evidence at the time of an onsite compliance review to support the answers provided on the non-residential self-assessment.

Evidence includes, but is not limited to:

- **Provider policies/procedures**
- **Licensure/ certification**
- **Participant handbook**
- **Individual Service Plan (ISP)**
- **Staff training curriculum**
- **Training schedule**
- **Advisory Council/Committee Assessment**
- **Weekly schedules of a sample of participants**

Before beginning your self-assessment process, please check the appropriate statement below as it applies to your Agency.

	A	This agency **ONLY** provides the service of **Individual Supported Employment** in the community and therefore does **NOT** operate a service setting that is being assessed. ***A SELF-ASSESSMENT IS NOT REQUIRED.** **Complete Section A (Provider Information) and proceed to page 17 to provide validation of this choice. Forward signed Self-Assessment document to your Local Governing Entity (District and Authority) as soon as possible, but no later than September 30, 2015.**
	B	This agency does operate a setting(s) that provides Day Habilitation, Prevocational and/or Supported Employment-Group services but does **NOT** intend to come into compliance with the CMS HCB settings rule by **March 17, 2019**. ***A SELF-ASSESSMENT IS NOT REQUIRED.** **Complete Section A (Provider Information) and proceed to page 17 to provide validation of this choice. Forward signed Self-Assessment document to your local governing entity (District and Authority) as soon as possible, but no later than September 30, 2015.**
	C	This agency **DOES** operate a setting that provides Day Habilitation, Prevocational and/or Supported Employment-Group services and intends to operate these services in compliance with the HBC Settings Rule. ***A SELF-ASSESSMENT IS REQUIRED.** **Please answer each question for all HCB services provided in the setting(s).** **Upon completion, proceed to page 17 to provide validation of information supplied. Forward signed Self-Assessment document to your local governing entity (District and Authority) as soon as possible, but no later than September 30, 2015.**

NOTE: Questions in this document followed by an asterisk (*) indicate that there are instructions that accompany these questions to provide guidance for completing the self-assessment. Please see Attachment A for instructions for Section A and Section B questions.

Section A - Provider Information	
Please select the service(s) that are provided in the physical setting for which this assessment is being completed. *	**Circle all that apply:** Day Habilitation Prevocational Supported Employment- group/mobile crew Does Not Apply
What Services are provided in a facility- based setting?*	**Circle all that apply:** Day Habilitation Prevocational Supported Employment- group/mobile crew Does Not Apply
What services are provided in a community- based setting?*	**Circle all that apply:** Day Habilitation Prevocational Supported Employment- group/mobile crew Supported Employment- Individual
Number of people served *	
Agency capacity*	
Provider Agency Name*	
Provider Agency Physical Address*	
Name of person responsible for assessment/contact for questions*	
Mailing Address of person above*	
Telephone Number of person above*	
Email of person above*	
Agency Provider Number*	
License type and license number (if applicable)*	
Accreditation (if applicable)*	
Certification and certification number (if applicable)*	

Name and 'Role' of Stakeholder Group*	
Describe Methodology for Completing Self-Assessment*	

Section B *Demonstrate that the setting has access to integrated community living in which individuals' abilities to interact with the broader community are not limited*		
Physical Location	**YES/NO**	**Required Evidence of Compliance with HCBS rules**
1. The service setting location is NOT located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment (a NF, IMD, ICF/IDD, and Hospital).* ***A "YES" response indicates agreement with this statement.***		
2. The service setting location is NOT located in a building that is on the grounds of, or immediately adjacent to, a public institution.* ***A "YES" response indicates agreement with this statement.***		
3. The provider does NOT own or operate multiple locations on the same street.* ***A "YES" response indicates agreement with this statement.***		
4. The service setting location is NOT in a gated/secured 'community' for people with disabilities.* ***A "YES" response indicates agreement with this statement.***		
5. The service setting location is NOT located in the same building as an educational program or school.* ***A "YES" response indicates agreement with this statement.***		
6. The service setting location is NOT designed specifically for people with disabilities.* ***A "YES" response indicates agreement with this statement.***		
7. Individuals who participate in services are NOT primarily or exclusively people with disabilities.* ***A "YES" response indicates agreement with this statement.***		
8. Does the provider provide options for community integration and utilization of community services **in lieu** of onsite services (including medical, behavioral, therapeutic or recreational services that may be offered on site)?*		

Individual Choice	YES/NO	Required Evidence of Compliance with HCBS rules
1. Was the individual provided a choice regarding the services, provider, settings and the opportunity to visit/understand the options available?		
2. Does the setting afford the individual with the opportunity to participate in meaningful **non-work** activities in integrated community settings in a manner consistent with the individual's needs and preferences?		
3. Does the setting afford individuals the opportunity to regularly and periodically update or change their preferences?		
4. Does the setting ensure individuals are supported to make decisions and exercise autonomy to the greatest extent possible?		
5. Does setting ensure the individual is supported in developing plans to support her/his needs and preferences?		
6. Is setting staff knowledgeable about the capabilities, interests, preferences and needs of individuals?		
7. Does the setting post or provide information to individuals about how to make a request for additional Home and Community Based Service (HCBS), or changes to their current HCBS?		

Community Integration	YES/NO	Required Evidence of Compliance with HCBS Rules
1. Does the setting reflect individual needs and preferences and do the policies ensure the informed choice of the individual?		
2. Does the setting afford opportunities for individuals to have knowledge of or access to information regarding age appropriate activities including competitive work, shopping, attending religious services, scheduling appointments, having lunch with family and friends, etc., outside the setting as they choose and who in the setting will facilitate and support access to these activities?		
3. Does the individual regularly access the community and is he or she able to describe how he or she accesses the community, who assists in facilitating the activity and where he or she goes?		

4. Are individuals aware of or do they have access to materials to become aware of activities occurring outside of the setting?		
5. Does the setting options offered include non-disability-specific settings, such as competitive employment in an integrated community setting, volunteering in the community, or engaging in general community activities similar to those who don't receive HCBS services? (i.e. exercising at the YMCA, engaging in sports from the local rec department)		
6. Do the setting options include the opportunity for the individual to choose to combine more than one service delivery setting or type of HCBS in any given day/week (i.e. combine competitive employment with day habilitation)?		
7. Are individuals able to come and go at any time similar to people who do not receive HCB services?		
8. Are individuals able to socialize and discuss activities occurring outside of the setting similar to people who do not receive services? Are they knowledgeable about the community activities?		
9. Does the setting encourage visitors or other people from the greater community (aside from paid staff) to be present, and is there evidence that visitors have been present at regular frequencies? For example, do visitors greet/acknowledge individuals receiving services with familiarity when they encounter them, are visiting hours unrestricted, or does the setting otherwise encourage interaction with the public?		
10. Is the setting in the community/building located among other residential buildings, private businesses, retail businesses, restaurants, doctor's offices, etc. that facilitates integration with the greater community?		
11. Does the setting allow individuals the freedom to move about inside and outside of the setting as opposed to one restricted room or area within the setting? For example, do individuals receive HCBS in an area of the setting that is fully integrated with individuals not receiving Medicaid HCBS?		

Rights and Privacy	YES/NO	Required Evidence of Compliance with HCBS rules
1. Is all information about individuals kept private? For instance, do paid staff/providers follow confidentiality policy/practices and does staff within the setting ensure that, for example, there are no posted schedules of individuals for PT, OT, medications, restricted diet?		
2. Does the setting assure that staff interacts and communicate with individuals respectfully and in a manner in which the person would like to be addressed, while providing assistance during the regular course of daily activities?		
3. Do setting requirements assure that staff does not talk to other staff about an individual(s) in the presence of other persons or in the presence of the individual as if s/he were not present?		
4. Does the setting policy require that the individual and/or representative grant informed consent prior to the use of restraints and/or restrictive interventions and document these interventions in the person-centered plan?		
5. Does the setting policy ensure that each individual's supports and plans to address behavioral needs are specific to the individual and not the same as everyone else in the setting and/or restrictive to the rights of every individual receiving support within the setting?		
6. Does the setting offer a secure place for the individual to store personal belongings?		
7. Does the setting support individuals who need assistance with their personal appearance to appear as they desire, and is personal assistance, provided in private, as appropriate?		

Individual Initiative, Autonomy, and Independence	YES/NO	Required Evidence of Compliance with HCBS rules
1. Is the setting free from gates, Velcro strips, locked doors, fences or other barriers preventing individuals' entrance to or exit from certain areas of the setting?		
2. Is the setting free from restrictive measures, including isolation, chemical restraints and physical restrictions?		
3. Does the setting afford a variety of meaningful non-work activities that are responsive to the goals, interests and needs of individuals? Does the physical environment support a variety of individual goals and needs (for example, does the setting provide indoor and outdoor gathering spaces; does the setting provide for larger group activities as well as solitary activities; does the setting provide for stimulating as well as calming activities)?		
4. Does the setting afford opportunities for individuals to choose with whom to do activities in the setting or outside the setting similar to individuals who do not receive HCBS or are individuals assigned only to be with a certain group of people?		
5. Does the setting allow for individuals to have a meal/ snacks at the time and place of their choosing similar to people who do not receive services? For instance, does the setting afford individuals full access to a dining area with comfortable seating and opportunity to converse with others during break or meal times, afford dignity to the diners (i.e., individuals are treated age-appropriately and not required to wear bibs)? Do individuals' have access to food at any time similar to people who do not receive HCB services?		
6. Does the setting provide for an alternative meal and/or an alternate dining area if requested by the individual similar to people who do not receive services?		
7. Does the setting afford the opportunity for tasks and activities matched to individuals' skills, abilities and desires?		
8. Does the setting post or provide information on individual rights?		

Employment	YES/NO	Required Evidence of Compliance with HCBS Rules
1. Does the setting offer choices for individual schedules that focus on the needs and desires of an individual and an opportunity for individual growth similar to people who do not receive HCB services?		
2. Does the setting afford opportunities for individuals to have knowledge of and access to information regarding competitive work outside of the setting, and does someone in the setting facilitate and support access to this?		
3. Does the setting allow individuals the freedom to move about inside and outside of the setting as opposed to one restricted room or area within the setting similar to people who do not receive HCB services? For example, do individuals receive HCBS in an area of the setting that is fully integrated with individuals not receiving Medicaid HCBS?		
4. Is the setting in the community/building located among other residential buildings, private businesses, retail businesses, restaurants, doctor's offices, etc. that facilitates integration with the greater community?		
5. Does the setting encourage visitors or other people from the greater community (aside from paid staff) to be present, and is there evidence that visitors have been present at regular frequencies? For example, do visitors greet/acknowledge individuals receiving services with familiarity when they encounter them, are visiting hours unrestricted, or does the setting otherwise encourage interaction with the public?		
6. Do employment settings provide individuals with the opportunity to participate in negotiating his/her work schedule, break/lunch times and leave and medical benefits with his/her employer similar to people who do not receive HCB services?		
7. In settings where money management is part of the service, does the setting facilitate the opportunity for individuals to have a checking or savings account or other means to have access to and control his/her funds. For example, is it clear that the individual is not required to sign over his/her paychecks to the provider?		
8. Does the setting provide individuals with contact information and training on how to access and use public transportation, such as buses, taxis, etc., and are these public transportation schedules and telephone numbers available in a convenient location?		

9. Alternatively where public transportation is limited, does the setting provide information about resources for the individual to access the broader community, including accessible transportation for individuals who use wheelchairs?		
10. Does the setting assure that tasks and activities are comparable to tasks and activities for people of similar ages who do not receive HCB services?		
11. Is the setting physically accessible, including access to bathrooms and break rooms, and are appliances, equipment, and tables/desks and chairs at a convenient height and location, with no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting individuals' mobility in the setting? If obstructions are present, are there environmental adaptations such as a stair lift or elevator to ameliorate the obstructions?		
12. Does the setting provide ongoing career planning activities such as facilitating opportunities for the individual to gain knowledge about Social Security benefits planning, volunteering, career exploration, trial work experiences, exploration of employment opportunities in their community and ongoing vocational guidance and counseling to name a few examples?		
13. Do employment outcomes reflect the goals and objective of the individual?		
14. Do individuals receive trial work assessments prior to job placement?		
15. Does the setting offer opportunities to the individual to pursue community employment when the individual chooses?		

Policy Enforcement	**YES/NO**	**Required Evidence of Compliance with HCBS Rules**
1. Does paid and unpaid staff receive new hire training and continuing education related to the rights of individuals receiving services and member experience as outlined in HCBS rules?		
2. Does paid staff receive training related to expectations of people with developmental disabilities, developing employment/career goals, job discovery, and providing support to obtain and maintain competitive integrated employment?		
3. Are provider policies on member experience and HCBS rules regularly reassessed for compliance and effectiveness and amended, as necessary?		
4. Are provider policies outlining rights of individuals receiving services and member experience made available to individuals receiving services?		

ATTACHMENT A

Instructions

The following sections contain instructions to provide guidance for completing the self-assessment. Each instruction is preceded by a short description of the corresponding question from Section A or B above.

Section A - Provider Information	
Section A Question	**Instruction**
Please select the service(s) that are provided in the physical setting for which this assessment is being completed.	More than one service can be selected.
What services are provided in a facility-based setting?	More than one service can be selected.
What services are provided in a community -based setting?	More than one service can be selected.
Number of people served and agency capacity	Enter the total number of people served in the setting that is included in this self-assessment. Include only those for whom you receive Medicaid HCBS reimbursement. Also indicate the number of people that your agency can serve.
Provider Agency Name	Please list the name of your agency
Provider Physical Address	Please list the physical location address of your agency
Name of person responsible for assessment /contact for questions	Please list the person who is responsible for answering any questions related to the completed assessment. We need one person that is responsible for any correspondence regarding the completed assessment and for the Provider Transition Plan if applicable.
Mailing Address of person above	Please list the MAILING address for the person who is responsible for answering any questions related to the completed assessment. The one person that is responsible for any correspondence regarding the completed assessment and for the Provider Transition Plan if applicable.

Telephone Number of person above	Please list the telephone number for the person who is responsible for answering any questions related to the completed assessment. The one person that is responsible for any correspondence regarding the completed assessment and for the Provider Transition Plan if applicable.
Email of person above	Please list the email for the person who is responsible for answering any questions related to the completed assessment. The one person that is responsible for any correspondence regarding the completed assessment and for the Provider Transition Plan if applicable.
Agency Provider Number	Please list the provider number associated with this agency for the specific provider type.
License Type and license number (if applicable)	Please list the license and license number associated with this agency for the specific provider type
Accreditation (if applicable)	Please list the Accreditation number and affiliation associated with this agency for the specific provider type
Certification and certification number (if applicable)	Please list the certification and organization associated with this agency for the specific provider type.
Name and Role of Stakeholder Group	For purposes of this self-assessment, 'Role' is defined as having at least representation from participants, family members, agency staff (including executive staff), support coordinator and community advocate. Each provider is required to conduct self-assessment activities with a stakeholder group that includes but is not limited to participants, family members, agency staff, a support coordinator and an advocate from an advocacy organization not directly affiliated with the provider agency. In this section, enter the first and last names, and role (participant, family member, etc.) of each stakeholder involved in your self-assessment process.
Methodology for Completing Self-Assessment	In this section, please describe your agency's approach to

	completing the self-assessment process. For example, how did you determine the persons selected to represent the required roles of the stakeholder group? Did you convene meetings or conference calls and how many times did you meet? Was each member of the stakeholder group provided with a copy of the self-assessment tool? Who was responsible for which aspects of the self-assessment? How did you get to unanimous agreement on results of the self-assessment before submission?

Section B- Physical Location	
Section B Questions	**Instructions**
Question 1	A YES response indicates this statement is true of the service setting location you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule.
Question 2	A YES response indicates this statement is true of the service setting location you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule.
Question 3	A YES response indicates this statement is true of the service setting location you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were the settings grouped together at request of individuals served, were individuals able to choose to participate in services at this setting from other options made available to them; does participation in services at this setting prohibit individuals from being integrated in their community?

Question 4	A YES response indicates this statement is true of the service setting location you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were individuals able to choose to participate in services at this setting from other options made available to them; does participation in services at this setting prohibit individuals from being integrated in their community?
Question 5	A YES response indicates this statement is true of the service setting location you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule.
Question 6	A YES response indicates this statement is true of the service setting location you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were individuals able to choose to participate in services at this setting from other options made available to them, does participation in services at this setting prohibit individuals from being integrated in their community?
Question 7	A YES response indicates this statement is true of the service setting location you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were individuals able to choose to participate in services at this setting from other options made available to them; does participation in services at this setting prohibit individuals from being integrated in their community?

Question 8	A YES response indicates this statement is true of the service setting location you are assessing. If NO and you need to transition your service into compliance, include action steps and timelines in your Transition Plan. If NO but you believe your operations to be in compliance with the Rule, indicate such in your Transition Plan. Your evidence supporting compliance with the HCBS Setting Rule must demonstrate how such a situation is not in violation of the Rule. For example, were individuals able to choose to participate in services at this setting from other options made available to them; does participation in services at this setting prohibit individuals from being integrated in their community?

Please sign and date the appropriate statement based on the selection made from Page 3.

***ONLY SIGN ONE STATEMENT.**

A. **All individuals served by this agency are ONLY provided the service of Individual Supported Employment in the community. I understand that it is the expectation of CMS and OCDD that individuals receiving HCB services are integrated into the community, have a choice of settings and experiences, have rights that are fully respected and recognized, and make decisions as independently as possible. These expectations are practiced by this agency to the fullest extent possible.**

_____ _____

Signature/Title **Date**

B. **This agency does NOT intend to come into compliance with the CMS settings rule by March 17, 2019. I understand that the individuals served will be given a Freedom of Choice to begin seeking other settings that are in compliance with the HCB settings rule.**

_____ _____

Signature/Title **Date**

C. **The answers to this questionnaire were answered truthfully, and I understand my responsibilities for bringing in to compliance any settings that require a Provider Transition Plan. I also understand that I am required to provide an update to the Local Governing Entity on a quarterly basis on the progress of activities in my transition plan.**

_____ _____

Signature/Title **Date**