Louisiana 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 who provide services in the following settings must complete one Residential Self-Assessment per region (except Regions 1 & 10). All HCB services provided in those settings must be evaluated when completing the self-assessment.

- **Provider Owned or Leased Residential Settings**
- **Provider Operated/Controlled Residential Settings**
- **Substitute Family Care**
- **Host Home**

Instructions for completing the 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 Residential Self-Assessment must be submitted to your Local Governing Entity (LGE) by September 30, 2015.

ALL PROVIDERS MUST RETURN THIS SELF-ASSESSMENT TO THE LOCAL GOVERNING ENTITY (Regional Office) 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 residential provider agencies who will be asked to submit all supporting documentation and evidence supporting the 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 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 residential self-assessment. Evidence includes, but is not limited to the same documentation requested for the above desk review.

Before beginning your self-assessment process, please select A, B, or C and follow the instructions.

	A	**This agency does NOT operate provider owned, leased, controlled, or operated residential settings for individuals receiving Home and Community Based Services. Additionally, the agency is NOT licensed to provide Host Home or Substitute Family Care services.** **A SELF-ASSESSMENT IS NOT REQUIRED. Proceed to page 14 to provide validation of this choice.**
	B	**This agency does operate provider owned, leased, operated, or controlled residential settings, or Host Home/Substitute Family Care settings but does NOT intend to come into compliance with the CMS HCB settings rule by March 17, 2019.** **NUMBER OF PEOPLE SERVED: _____.** **A SELF-ASSESSMENT IS NOT REQUIRED. Proceed to page 14 to provide validation of this choice.**
	C	**This agency does operate provider owned, leased, operated, or controlled residential settings, or Host Home/Substitute Family Care settings 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 14 to provide validation of information provided.**

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 HCBS Provider type(s)*****	**Circle each that applies:** • **Provider Owned Residential Setting** • **Provider Leased Residential Setting** • **Provider Operated/Controlled Residential Setting** • **Substitute Family Care** • **Host Home**
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(s)*	
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 home setting is located in a building that is NOT also a publically or privately operated facility that provides inpatient institutional treatment (a NF, IMD, ICF/IDD, hospital)?*		
2. The home setting is NOT located in a building on the grounds of, or immediately adjacent to, a public or private institution owned by the provider?*		
3. The provider does NOT own or operate multiple homes located on the same street (excluding duplexes and multiplexes, unless there is more than one on the same street)?*		
4. The home setting is NOT located in a gated/secured "community" for people with disabilities.*		
5. The home setting or dwelling is NOT located in a disability-specific community.*		
6. The home is NOT designed specifically for people with developmental disabilities (exclusive of homes that are built for individuals with physical disabilities)?*		
7. Do individuals who receive services live in an area that is NOT separate from people who are not receiving services?*		
8. Is the setting in the community among other private residences or retail businesses?		

Choice of Setting/Person-Centered	**YES/NO**	**Required Evidence of Compliance with HCBS Rules**
9. Was the individual given a choice of available options regarding where to live/receive services?*		
10. Was the individual given opportunities to visit other settings?		
11. Does the setting reflect the individual's needs and preferences?		

12. Do individuals have an Active Role in Development of Person-Centered Plan?		
13. Is/are the individual/chosen representative(s) aware of how to schedule Person-Centered Planning meetings?		
14. Can the individual explain the process to develop and update his/her plan?		
15. Are routinely held planning meetings held with the individual and his or her planning team?		
Community Integration	**Yes/No**	**Required Evidence of Compliance with HCBS Rules**
16. If the setting offers on site services, such as day habilitation, medical, behavioral, therapeutic, social and or recreational services, are they offered in a manner that complies with the HCBS Setting Rule?*		
17. Does the provider offer options for community integration and utilization of community services in lieu of onsite services?		
18. Are individuals able to regularly access the community and are they able to describe how they access the community, who assists in facilitating the activity and where he or she goes?		
19. Are individuals aware of or have access to materials to become aware of activities occurring outside of the setting?		
20. Do individuals shop, attend religious services, schedule appointments, have lunch with family and friends, etc., in the community, as they choose?		
21. Are individuals able to come and go at any time?		
22. Do individuals in the setting have access to public transportation? (Put N/A ONLY if there are NO public transportation options available in the service setting area)		
23. Do individuals in the setting know how to access and use public transportation? (Put N/A ONLY if there are NO public transportation options available in the service setting area)		
24. Where public transportation is limited, are other resources (wheelchair accessible, private transportation, etc.) provided for the individual to access the broader community for appointments, shopping, etc.?		
25. Do individuals receiving HCBS live/receive services in the same area of the setting as individuals not receiving Medicaid HCBS?		

Recipient Rights	Yes/No	Required Evidence of Compliance with HCBS Rules
26. Do all individuals who do not own their home have a legally enforceable agreement with the setting landlord (dates of lease, amount of rent, etc.)?		
27. Does the setting offer the same responsibilities/protections from eviction for Medicaid recipients as all tenants under the Uniform Residential Landlord and Tenant Act?		
28. In the event the residential setting is not covered by local and/or state tenant laws, is a lease, resident agreement, or other written agreement in place providing protections to address eviction/discharge processes and appeals comparable to those provided under tenant law?		
29. Do individuals know how to relocate and request new housing?		
30. Is health information about individuals kept private?		
31. Are schedules of individuals for PT, OT, medications, restricted diet, etc., posted in a private area and not for all to view?		

Living Arrangements	Yes/No	Required Evidence of Compliance with HCBS Rules
32. Does (each) unit have lockable entrance doors, with the individual and appropriate staff only having keys to doors, as appropriate?*		
33. Can the individual close and lock the bedroom door?		
34. Can the individual close and lock the bathroom door?		
35. Do staff or other individuals always knock and receive permission prior to entering an individual's private space?		
36. Does staff only use a key to enter a living area of privacy space under limited circumstances agreed upon with the individual?		
37. Do individuals have the option for a private unit, as appropriate?		
38. Do the individuals have privacy in their sleeping or living space?		
39. Are individuals permitted to have a private cell phone, computer, or other personal communication device or have access to a telephone or other technology device to use for personal communication in private at any time?		
40. Is the telephone or other technology device in a location that has space around it to ensure privacy?		

41. Are cameras that are present inside the setting only utilized in direct relation to the person-centered plan of care? (Put N/A if no cameras are present in the setting)*		
42. Is the furniture arranged as individuals prefer to assure privacy and comfort?		
43. Is assistance provided in private, as appropriate, when needed?		
44. Do individuals sharing units have a choice of roommates? (Put N/A if your agency ONLY offers private rooms		
45. Do individuals know how he or she can request a roommate change?		
46. Do individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement?		
47. Do individuals have full access to typical facilities in a home such as a kitchen with cooking facilities, dining area, laundry, and comfortable seating in shared areas?		
48. Do individuals help plan the menus for their meals?		
49. Do individuals have access to food anytime, as appropriate?		
50. 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?		
51. Are individuals NOT required to sit at an assigned seat in a dining room?		
52. Are individuals allowed to converse with others during the meal times?		
53. If the individual desires to eat privately, can he or she do so?		
54. Can individuals have visitors at any time?		
55. Do individuals know how and to whom to make a request for new staff?		
56. Is the furniture in shared areas arranged to support small group conversations?		
57. Are individuals moving about inside and outside the setting as opposed to sitting by the front door?		
58. Is there no curfew or other requirement for a scheduled return to the setting?		
59. Is it made clear that an individual is not required to adhere to a set schedule for waking, bathing, eating, exercising, activities, etc.?		
60. Do the individuals' schedules vary from others in the same setting?		

61. Do individuals have access to such things as a television, radio, and leisure activities that interest him or her and can she or he schedule such activities at his or her convenience?		
62. Do individuals have a checking or savings account or other means to control funds?		
63. Do individuals have access to his or her funds?		
64. Is the setting physically accessible and there are no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting individuals' mobility in the setting or, if they are present, are there environment adaptations such as a stair lift or elevator to ameliorate the obstruction?		
65. Is the setting free from gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the setting? Is the setting free from restrictive measures, including isolation, chemical restraints, and physical restrictions?		
66. Are individuals receiving Medicaid HCBS facilitated in accessing amenities such as a pool or gym used by others on-site?		
67. For individuals who need supports to move about the setting as they choose, are supports provided, such as grab bars, seats in the bathroom, ramps for wheelchairs, viable exits for emergencies, etc.?		
68. Are appliances accessible to individuals (e.g., the washer/dryer are front loading for individuals in wheelchairs)?		
69. Are tables and chairs at a convenient height and location so that individual can access and use the furniture comfortably?		
Policy Enforcement	**YES/NO**	**Required Evidence of Compliance with HCBS Rules**
70. Do paid and unpaid staff receive new hire training and continuing education related to individual's rights and member experience as outlined in HCBS rules?		
71. Are provider policies outlining individuals' rights and member experience made available to individuals?		
72. Are provider policies on individuals' rights, member experience, and HCBS rules regularly reassessed for compliance and effectiveness and amended, as necessary?		

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 and B above.

Section A	
Section A Question	**Instruction**
Please select HCBS Provider type	Select all provider types being assessed.
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(s) for services delivered in the settings being assessed (i.e., Host Home, SFC, Individual Family Support, Community Living Supports, etc.).
License Type and license number (if applicable)	Please list the license and license number associated with this agency for the specific provider types (settings or services).
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	
Section B Questions	**Instructions**
Question 1	A "YES" response here means this statement is true for your setting.
Question 2	A "YES" response here means this statement is true for your setting.
Question 3	If "YES", 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 the 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	If "YES", 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 setting grouped together at the 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 5	If "YES", 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 the request of individuals served, were individual 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 6	A "YES" response indicates this statement is true of the service setting(s) 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(s) 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 9	If "YES", your evidence supporting compliance with the HCBS Setting Rule must demonstrate that individuals are able to choose to receive services outside of this service setting.
Question 16	In this question, a "YES" answer means that any other on site services in the home are provided on an individual basis with the setting being chosen by the individual, and the individual's privacy protected from other residents in the home. For example, if physical therapy is required in the setting, it is because the individual has chosen this setting (vs. going to an office), and the visit is held in a manner that protects the individual's privacy from other residents in the home.
Question 32	"Unit" in this question may refer to a home, an apartment or an individual's unit in an Assisted Living Facility. The word "each" is in parenthesis to accommodate each provider type. For example, Residential and Assisted Living Facility providers are completing this for "each" setting. Supported Living providers may be completing this for multiple settings.
Question 41	Uses of cameras for recreational purposes or as assistive technology for appropriate monitoring purposes are acceptable. This question is to assess the use of cameras used for the purpose of surveillance that violate a person's right to privacy.

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 either own or lease their residence, or live in a residence owned or leased by a family member. 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 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 Corrective Action 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 the corrective action plan.**

_____ _____

Signature/Title **Date**