



Instructions to complete the Provider Self-Assessment for Day Training and Habilitation (DT&H) and Prevocational Services

General instructions

1. A separate assessment must be submitted for each:
 - a. Facility-based service site, including each satellite for which licensure is required under MN Chapter 245D.27; and
 - b. Program (s) for which there is no facility based service site
2. Staff completing the survey should have knowledge of the DT & H and/or Prevocational Services provided within the facility/program.
3. Submit all provider self-assessments electronically on or before May 29, 2015
4. Additional instructions are available. We will update these instructions periodically to reflect questions and comments received.
5. A copy of the questions in this self-assessment are included at the end of these instructions. You may wish to review and/or print them prior to taking the survey electronically.
6. Responses should be as accurate as possible. Immediate compliance with the new federal requirements is not required. The state will offer a transition period for providers who are not yet, but intend to, comply with the new requirements.
7. Address questions to the MHCP Provider Call Center at 651-431-2700 or 800-366-5411.

Purpose of the provider self-assessment

Centers for Medicare and Medicaid Services (CMS) issued a new rule governing home and community-based services (HCBS) waiver services effective March 17, 2014. The rule defines settings in which HCBS services may be delivered, settings that are not HCBS and settings that are presumed not to be HCBS. Minnesota submitted a transition plan to CMS indicating how it will come into compliance with the new rule.

The rule and the Minnesota transition plan require an assessment of all provider-owned and controlled settings to determine the level of compliance with the new requirements. CMS requires states to 1) follow-up with on-site monitoring and 2) assure on-going compliance. Completion of this provider self-assessment is the first step in the process.

The provider self-assessment is designed to:

1. Provide the state with information it will use to develop measurable criteria for settings where HCBS services are delivered.
2. Help providers understand changes they need to make to comply with the rules.
3. Identify sites that may not currently comply with the rules.
4. Identify settings that are presumed not to be HCBS for which additional work with CMS must be done.

Definitions for purposes of this assessment

CSSP addendum: Plans developed by the provider as required in Chapter 245D.

Customized living plan: Plan lead agencies develop.

Person(s): Person receiving services.

Plan refers to plans developed by the lead agency certified assessor or case manager. Any modification of rule requirements must be supported by an assessed need and contain required documentation in the person-centered service plan developed by the county, tribe or health plan.

Modifications of rule requirements must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan developed by the lead agency case manager or certified assessor:

- (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 that have been tried but did not work.
- (4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
- (5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- (6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- (7) Include the informed consent of the individual.
- (8) Include an assurance that interventions and supports will cause no harm to the individual.

Provider Plan: Plan developed by the provider consistent with and required to implement the ISP, CSP, CSSP or other plan developed by a lead agency or to meet any other licensing requirements.

Navigation

A toolbar at the bottom of each page will help you as you complete the assessment.

1. Please disable any pop-up blockers when completing this assessment.
2. To move between pages, use the BACK and NEXT buttons at the bottom of each page. **DO NOT USE THE BACK BUTTON ON YOUR WEB BROWSER!**
3. To reset your responses on a current page, use the RESET button at the bottom of the page.
4. Use the SAVE button to return to the assessment on the same computer later.
5. Use the PRINT button (found on the last page of the assessment) to print the completed responses for the assessment.
6. When you have completed the assessment, click the SUBMIT button at the bottom of the last page to return your completed responses to DHS.

Provider self-assessment questions

Demographic information

Q1 - Provider information

- **Name of enrolled provider:** Name of the licensed home care agency enrolled with Minnesota Health Care Programs to provide customized living services.
- **Provider NPI/UMPI:** Ten (10) digit National Provider Identifier (NPI) or Unique Minnesota Provider Identifier (UMPI) number the provider used to enroll with Minnesota Health Care Programs to provide customized living services.
- **Name of Facility Based Service Site:** Complete if this is a licensed day service facility for which licensure is required under MN Chapter 245D.27
- **Name of day service program:** Complete if there is no licensed facility service site
- **Street address of day service facility site or program business address:** Indicate the street address of the day service facility site or program business address if there are no programs provided in a licensed day service facility.
 - P. O. Box, if any (optional)
 - City
 - State
 - Zip code
- **Taxonomy code:** Indicate if this site/program has a taxonomy code assigned to this specific to this location, if applicable. (Does not apply to providers using an UMPI)
- **Provider FEIN:** This is the federal employer identification number for the enrolled provider.
- **Provider phone number:** Indicate the phone number associated with this NPI or UMPI with Provider Enrollment).
- **Telephone number for the enrolled provider's representative at this day service facility or program business site.**

Q2 and Q3 - The following person provided information for this assessment. This individual has personal knowledge of the DT &H and/or Prevocational services provided in this day service facility site or program due to on-going contact.

- Name
- Title
- How frequently is this person on-site? Click the response that best reflects how often this person is at this site on average.

Q4 - DHS should contact the following person with any follow up questions:

- Name (if different from above) (Optional field)
- Title (if different from above) (Optional field)
- Telephone number (required)
- Email address (required) Please double-check for accuracy

Providers are invited to specify who in their organization they wish DHS to contact with any follow up questions. This often varies within different provider organizations. If the name and title are left blank, DHS will contact the person listed in Q2 & 3 using the telephone and/or email provided in Q4.

Q5- Provision of Waiver services. Check all the waiver services this program provides: Please check all of the waiver services this program provides including Structured Day and Supported Employment services, which are not services that are part of this assessment.

Q6 and Q7 Physical location. Please answer each question about this day service program:

Q6 - Is this day service program in a building that also provides licensed services as a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or institution for mental diseases (IMD)? If hospital, nursing facility (home), ICF/IID or IMD services are provided in the same building, you must check “Yes.”

Is this day service program in a building, on the grounds of or immediately adjacent to a publicly owned and operated hospital, nursing facility, ICF/DD or IMD? For a facility to be “publicly owned and operated” it must be:

- a. Owned by a (federal, state, county, city or other) public entity and also
- b. Be operated by a (federal, state, county, city or other) public entity. This means that the service license holder is a public entity.

Q7 - Location of building. Please answer this question based on average proximity (within 5 blocks, 10 blocks, 2 miles or more than 2 miles) of the day services site to typical community businesses.

Q8 - Additional licenses, certifications or accreditation. All providers of DT & H and Prevocational services provided in a facility must have a day service facility license in addition to a 245D program license.

Please indicate from the options (245D mental health certification, CARF accredited, MDH licenses) additional licenses, certifications or accreditation this site/program holds.

Q9 - People served. Provide an unduplicated count of all people served in this licensed day service facility or licensed program. The intent of this question is to understand the populations you serve in regardless of payer.

- DT & H funded through the DD waiver
- DT & H funded through the county
- Prevocational services funded through the CAC and CADI waivers

Please respond to the questions remainder of the survey based on the total number of people indicated in Q9.

Q10- Disabilities/Conditions of people served. Please indicate by percentage (less than 25 percent, between 25-75 percent and greater than 75 percent), the primary disabilities or conditions of people served at this site/program. If this program does not serve people with a certain type of disability or condition, please indicate, “Do not currently serve” in response to Q10. “Other” is an optional field.

Q11 - Access and unrestricted use. Does each person in have access to and unrestricted use of each of the following unless specified in their plan? Please indicate on the grid if the *feature exists*; is *physically accessible*; and if the *policy supports unrestricted use* by checking the appropriate boxes:

- Common areas inside of day service site
- Common outdoor areas
- Cooking appliance, i.e. microwave oven
- Dining/Break/Lounge area
- Refrigerator with freezer for private food storage

Q12 – Person-centered choices. Please indicate if written policies, documented staff training and performance evaluation systems are or will be in place that cover the following unless specified in a person’s plan. Policies should explicitly address each area to assure consumer choice.

Check “currently implemented” if written policies, documentation of staff training and current performance evaluation systems are currently in place, Check “Will be implemented by Jan. 1 2017, if you intend for ___ to be in compliance by that date, Check “Do not know” if you are unsure as to whether ___ can or will be in compliance by Jan. 1 2017. Answer these questions based on the total number of people indicated in Q9 regardless of payment source.

- Each person is free to come and go from the day service program
- Each person is free to move in and around the day service facility (people are not restricted to one room or designated area)
- Each person is free to move in and around the community
- Each person has choice of:
 - Where they eat
 - With whom they eat or to eat alone

NOTE: These questions relate to the person having freedom of movement within the day service facility and as well as the community. They do not refer to a person having the freedom to move to another place of residence.

Q13- Rights, personal privacy, security and respect. Please indicate if written policies, documented staff training and performance evaluation systems are or will be in place that cover the following *unless specified in a person’s plan*. Policies should explicitly address each area to assure a person’s choice.

Check “currently implemented” if written policies, documentation of staff training and current performance evaluation systems are currently in place, Check “Will be implemented by Jan. 1 2017, if you intend for ___ to be in compliance by that date, Check “Do not know” if you are unsure as to whether ___ can or will be in compliance by Jan. 1 2017. Answers these questions based on the total number of people indicated in Q9 regardless of payment source.

- All incidents of lost or stolen property are documented and investigated
- Appointment schedules, medications lists and all other personal information is private. This means the information is not visible to other program participants or visitors in public areas
- Each person has a place to secure their personal property
- Each person has access to a telephone in a private area
- Staff treat each person with respect in interpersonal communications (i.e. people addressed by their proper or preferred name, staff use respectful tone when speaking to people)
- Type, amount and process for staff sharing information assures the privacy and respect of each person
- When a person needs assistance with person care, it is provided in private

Q14 - Satisfaction with services/supports. Answer yes/no to the following questions:

- Do you have way to get feedback on overall satisfaction at least annually and maintain the documentation?
- Do people know where to go to report dissatisfaction/concerns?
- Do you have a way to document and address concerns or dissatisfaction people report formally or share informally with any of your staff?

Q15- Person-centered choices: Community integration. Please indicate if written policies, documented staff training and performance evaluation systems are or will be in place that cover the following *unless specified in a person's plan*. Policies should explicitly address each area to assure a person's choice.

Check "currently implemented" if written policies, documentation of staff training and current performance evaluation systems are currently in place, Check "Will be implemented by Jan. 1 2017, if you intend for to be in compliance by that date, Check "Do not know" if you are unsure as to whether can or will be in compliance by Jan. 1 2017. Answers these questions based on the total number of people in Q9, regardless of payment source.

- Each person is assessed to identify community integration needs/preferences
- Each person has community integration goals identified in their CSSP Addendum
- Provider supports person in implementing community integration goals in their CSSP Addendum
- Staff resources are allocated for integrating people in the community

Each person has a choice of:

- How often they participate in social/community activities
- Types of community activities
- Types of social activities within the facility

Person-centered choices: No employment goals

Q16. Please indicate the number of people of the total number in Q9, do not have employment goals specified in their CSSP Addendum.

Q17. Please indicate if the people in Q16 made the informed choice not to work by responding "yes" or "no" to the following:

- Information was provided about the benefits of employment
- Visits to community employers have been facilitated
- Person has been offered opportunities to meet with other individuals with disabilities who are working.

If you responded no to any of the items in Q17, briefly (within a limited character count) explain why people are not offered these opportunities.

Q18 - Please indicate for people in Q16, the average frequency people are interacting with community members by type of community interaction (onsite, community-based enrichment or skill development).

If there are other types of community interaction, briefly describe.

Responses should be based on a typical week of service delivery (1 day per week, 2-3 days per week, 4 or more days per week, less than 1 day per week).

If you indicated that people interact with community members less than one day per week, briefly explain why within a limited number of characters.

Person-centered choices: Employment goals.

Q19 - Please indicate if written policies, documented staff training and performance evaluation systems are or will be in place that cover the following *unless specified in a person's plan*. Policies should explicitly address each area to assure a person's choice.

Check "currently implemented" if written policies, documentation of staff training and current performance evaluation systems are currently in place, Check "Will be implemented by Jan. 1 2017, if you intend for ___ to be in compliance by that date, Check "Do not know" if you are unsure as to whether ___ can or will be in compliance by Jan. 1 2017. Answers these questions based on the total number of people indicated in Q9 regardless of payment source.

- Each person's strengths and preferences are assessed to identify jobs of interest
- Each person with employment goals specified in their CSSP Addendum has the opportunity to choose among employment experiences, including competitive employment
- Staff resources are allocated toward individual job placement

Q20 - Number of people with employment goals. Please indicate how many people receiving DT & H and Prevocational Services have employment goals specified in their person-centered plan written by the county based on the total number of people provided in Q9.

Q21 - Supporting employment goals. Please indicate how many people with employment goals spend the majority of their time (may count people more than once):

- Developing job skills on site
- Developing job skills in the community

Please indicated how many people with employment goals are actively seeking the following at frequencies specified in their person-centered plan written by the county of provider plan (may count people more than once):

- Full or part-time work
- Individual work at a community business or organizational setting
- Group work at a community business or organizational setting
- Work that pays at least minimum wage

Please indicate how many people are working full or part time. Should include people working onsite and in the community (may count people more than once).

Q22 - Working full or part time. Please indicate how many people are working in the following employment settings (may count people more than once):

- Individually at a community business or organizational setting
- In groups (paid work crew, job enclaves) at a community business or organizational setting
- At the day service site (include people that are working individually and in groups)

Q23 - Working in the community. Please indicate how many people working at a community business or organizational Setting:

- Earn at least minimum wage
- Are or have had the option to receive benefits (i.e. health/fringe) paid by the employer at a level of benefits paid by the employer for the same or similar work performed by workers without a disability

Q2 - Working on site. Please indicate how many people working on site:

- Earn at least minimum wage
- Are or have had the option to receive benefits (i.e. health/fringe) at a level of benefits paid by an employer for the same or similar work performed by people without disabilities

Q25 - Please indicate for people in Q20, the average frequency people are interacting with community members by type of community interaction (onsite, community-based enrichment, skill development, on the job).

- If there are other types of community interaction, briefly describe.
- Responses should be based on a typical week of service delivery (1 day per week, 2-3 days per week, 4 or more days per week or less than 1 day per week).
- If you indicated that people interact with community members less than one day per week, briefly explain why within a limited number of characters.

Final steps

Please click the **PRINT** button to print your responses before you submit your assessment. You are unable to print your responses after you submit them.

Please remember to click the **SUBMIT** button to submit your assessment.

Thank you for your participation in this assessment.