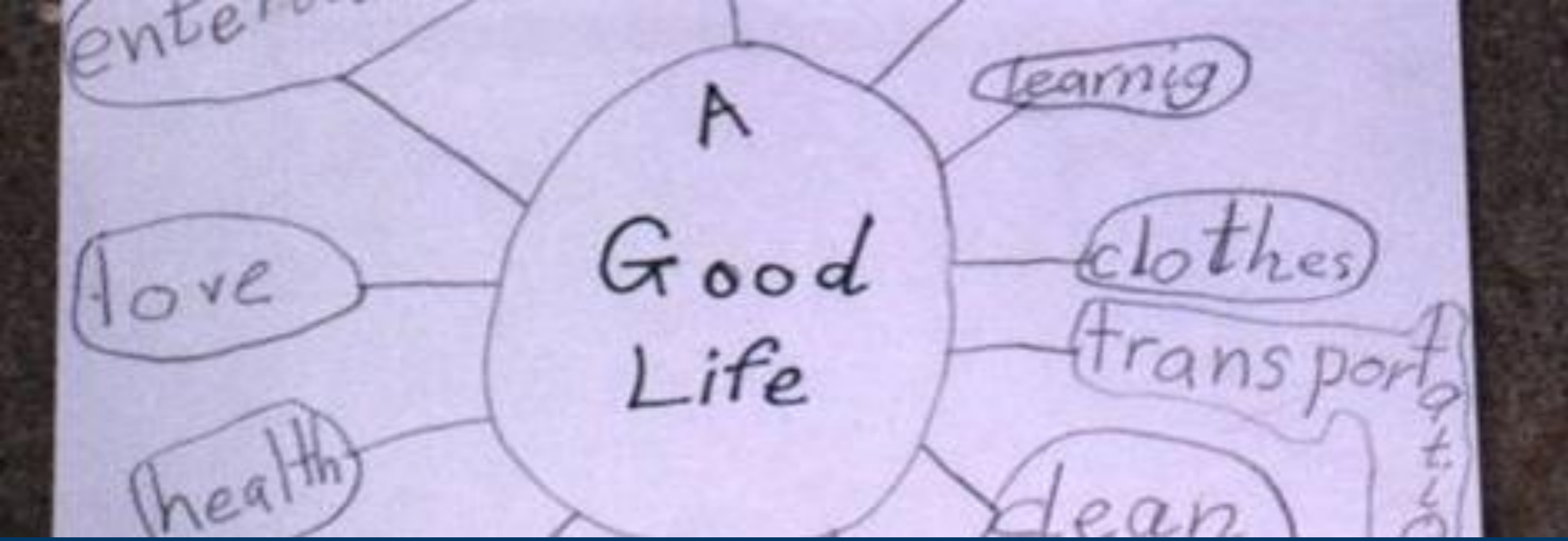

Using EW Participant Evaluation in Person-Centered Planning

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Goals for Today –

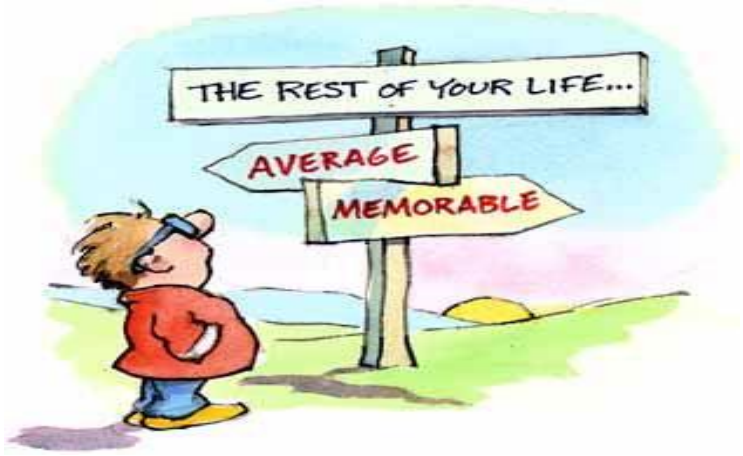
- Review the EW evaluation of residential and adult day services activity.
- Understand how the evaluation can contribute to person-centered planning and service delivery.
- Review methods that care coordinators can use in response to the evaluation to improve service delivery, participant experience.

Why Person-Centered?

- The use of person-centered principles and practices is a way of assuring that people receiving HCBS services:
  - Have the same rights and responsibilities as other people
  - Have control over their lives
  - Make their own choices, and
  - Contribute to the community in a way that makes sense for the person.

Expectations for Person-Centered Services

- People have the opportunity for meaningful choice and self-determination
- Their civil and legal rights are affirmed, respected.
- Is also a requirement in several state and federal authorities.



Sources of Requirements

- The requirements to implement person-centered planning come from multiple sources, including federal rules and requirements, state rules, state statute and a court-settlement agreement.
  - CMS HCBS Rule – *Planning and Services elements*
  - *In particular, the HCBS settings requirements.*
  - *Olmstead*
  - *Jensen Settlement*

Purpose of the CMS HCBS Rule

- Maximize opportunities for people who receive HCBS

- Assure people
  - are able to participate in their communities
  - rights are protected
  - people are not isolated.

CMS Final HCBS Rule

- The Centers for Medicare & Medicaid Services (CMS) issued an HCBS rule in 2014.
  - Includes criteria for person-centered planning processes and individual person-centered plans.
- Applies to people who receive services through all HCBS waivers and other HCBS state-plan services funded through Medical Assistance.
- Includes documentation requirements for process, and focuses more attention in areas of quality of life

HCBS Settings Requirements

- Person-centered planning models reflect these activities, as do federal requirements related to services planning and case manager monitoring of the adequacy of plans over time.
- In addition to person-centered planning requirements, there are also requirements related to participant rights and choices available to them when served in certain settings.
- These requirements are referred to as the “HCBS settings” requirements.

Federal HCBS Rule

- The rule requires that states:
  - Implement a person-centered planning process for all HCBS program participants, and
  - Ensure that HCBS services are only delivered in settings that have characteristics that are home and community-based in nature.
- States submitted transition plans to the Centers for Medicare & Medicaid Services (CMS) to comply with the HCBS settings requirements within established timelines.
  - One part of Minnesota's transition plan specifically addresses steps to ensure compliance in customized living, adult foster care, and adult day services.
  - Specific requirements for residential settings, and other services where people receive center-based services, such as adult day.
  - Minnesota's plan includes participant experience feedback.

Compliance with HCBS Setting Requirements

- The Center for Medicare/Medicaid Services (CMS) requires states to assess all settings that provide HCBS services to people served in groups to determine whether the settings meet the HCBS rule requirements.
- In response to these federal requirements, the department partnered with providers to conduct site-specific assessments.
- DHS developed, tested and launched an online provider attestation process for designated HCBS settings in 2017.
- Providers were required to submit their online attestations by September 1, 2017. The attestations allowed providers to evaluate the settings in which their services were delivered, provide supporting evidence, and allow providers who were not in compliance to devise plans to meet requirements.
- The attestation tools included questions for provider response that are mirrored in the HCBS participant service evaluations.

Provider Attestations- All Providers

- The attestation included the following items:
  - The setting provides opportunities for people to seek employment and work in competitive integrated settings
  - The setting provides people opportunities to access and engage in community life
  - The setting supports the person's control of personal resources (their money)
  - The setting ensure people's right to privacy
  - The setting ensure' s people's dignity and respect
  - The setting ensure' s people's freedom from coercion and restraint
  - The setting optimizes individual initiative, autonomy, and independence in making life choices, including daily schedules and with whom to interact

Additional Attestations for Residential Providers

- Each person at the setting has a written lease or residency agreement in place providing protections to address eviction processes and appeals
- Each person at the setting has privacy in his/her sleeping or living unit, including a lockable door
- The setting facilitates that a person who shares a bedroom is with a roommate of their choice
- The setting provides people with the freedom to furnish and decorate their bedroom or living units within the lease or residency agreement
- The setting provides people with the freedom and support to control their schedule and have access to food any time
- The setting allows people to have visitors at any time
- The setting is physically accessible to the individual

Provider Information

- The attestations were completed using survey tools developed and launched by DHS.
- Required documentation to validate the provider's responses would include, but not be limited to, a blank lease, service plan, provider policies, and staff training content.
- The department will continue to validate provider compliance with HCBS setting requirements over time as part of Provider Enrollment, and as part of licensing application and review.

Information About Provider Attestations

For more information about the provider attestation process and content, see:

- DHS Form 7176E (HCBS Provider Attestation Guidebook for Residential Settings: Customized Living)
- DHS Form 7176D (HCBS Provider Attestation Guidebook for Residential Services: Elderly Waiver Adult Foster Care Services)
- DHS Form 7176C (HCBS Provider Attestation Guidebook for Day Settings: Adult Day Services)

Using Participant Feedback to Improve Quality

- The Department of Human Services (the department, or DHS) has implemented several quality initiatives related to the assessment of, and improvement in, the quality of care and quality of life experienced by home and community-based services (HCBS) program participants.
- These initiatives rely on participant experience feedback as well as other administrative and programmatic information.
- While these initiatives also help meet HCBS requirements, DHS has its own interest in ensuring quality of life and quality of care for participants. And other intiatives, for example:
    - NCI Participant Survey –Biannual for seniors, includes waiver, AC, home care only, stratified sampling to examine equity, etc.

Before We Move On.....Pulling the Pieces Together

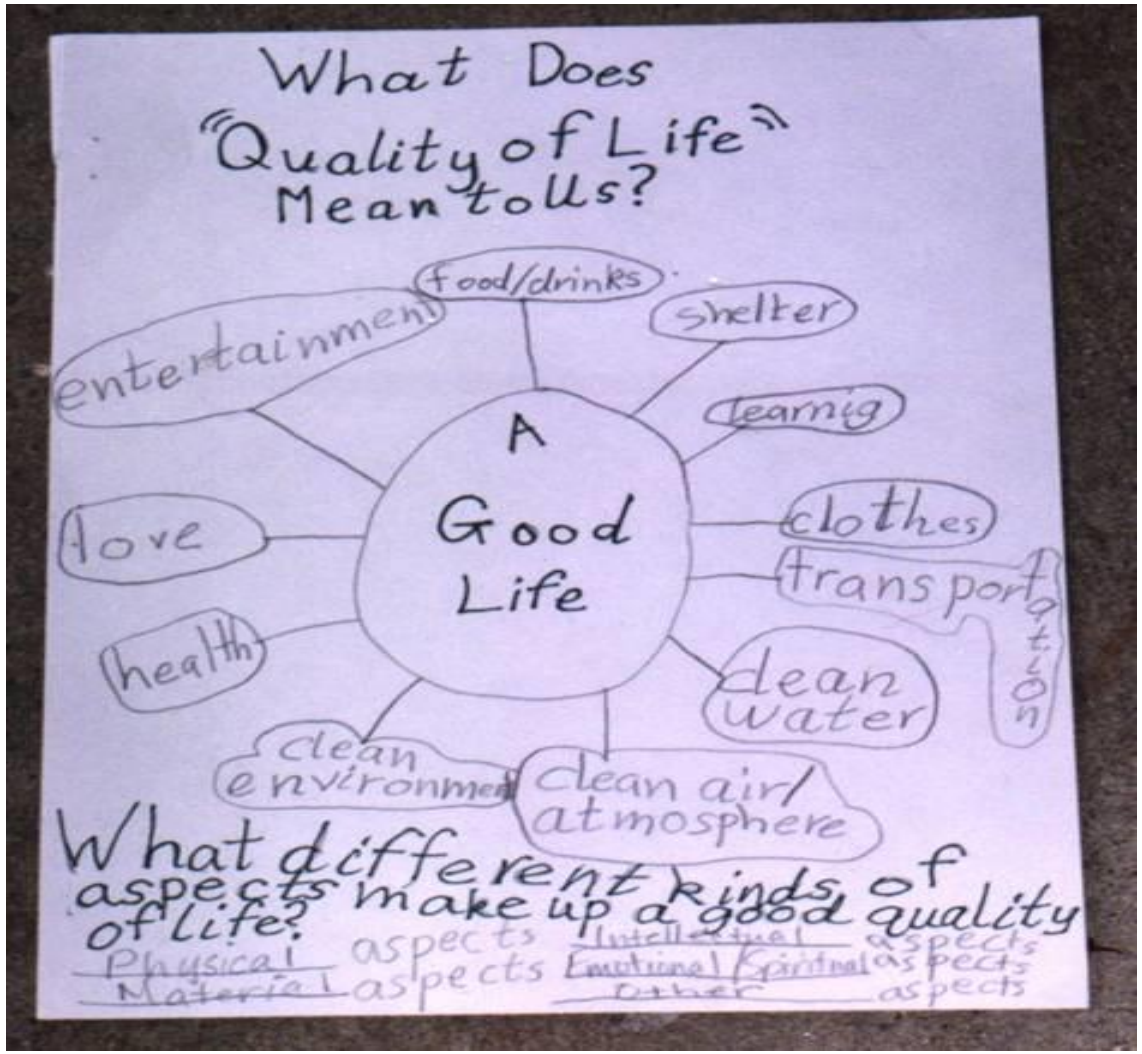
- Assessment is about discovery and learning: who is this person, what's important to them, what kind of life do they want, now and in the future?
- What is needed to help them have that life? Reasonably ensure health and safety?
- Using the assessment, the support plan is developed.
  - All kinds of requirements about the process and product.
- Ongoing case management/care coordination provides the monitoring and feedback piece:
  - How are things going?
  - Are things changing, are service changes needed?

Creating Person-Centered Plans - Discovery and Learning

- Understanding how the person *wants* to live his or her life:
  - Goals, aspirations, future plans
  - Preferred type of living situation
  - Preferences about who they want to live with, socialize with
  - Productive activities the person want to do
  - Social, leisure, recreational, religious activities – participate and/or learn
  - Controlling personal resources
  - Identifying possible barriers to achieving the life the person wants to live

Person-Centered Assessment

- Most assessment tools focus on needs, limitations, etc.
- Revisions to assessment tools to get at more information related to quality of life as well as quality of care.
- This is all about HOME and COMMUNITY.



Person-Centered Planning Implications

- Providers need to know what support, activities they are responsible for.
- Requirements related to communication with providers about the CSSP/CCP.
- Evaluating a person's experience with a provider's service delivery really depends on this communication.
- Requirements in statute requiring provider notification about assessment, sharing of the plan.
- Still honors the person's choice about who to share what with re: their plan.
- Important to have the conversation with the person about how this communication can make sure their experience is positive.

Monitoring the quality of services

- Reviewing services included within a CSSP or CCP has always been part of the lead agency activity completed at reassessment, and during other case manager monitoring contacts.
- This review necessarily includes conversation with the participant about how well providers are delivering services, are helping participants achieve their goals as noted in the CSSP/CCP, and addressing any concerns or issues identified by the person.
- Participants also continue to be offered choice among services and among providers of services, and are required to be provided with sufficient information to make meaningful choices.

Formalizing Participant Feedback

- Questions have been developed to gather EW participant feedback related to adult day, foster care, or customized living service at reassessment. These questions and response choices, as well as instruction for the case manager/care coordinator are included in DHS Form 3428Q, *Person's Evaluation of Foster Care, Customized Living, or Adult Day Service.*
    - Only managed care organizations are required to gather this EW participant experience information as described below, using 328Q. Counties and tribes are gathering this same information using different tools.
- Using standardized questions helps focus the conversation on those person-centered planning and HCBS settings requirements that should be reflected in the person's CSSP.
- Gathering standardized information is also of great value to the department in assessing overall EW participant experience, and in identifying opportunities for systematic improvements.

Using 3428Q

- Briefly, 3428Q is designed to help CC/CM:
  - Determine if a participant is receiving a service included in the evaluation
  - Determine whether a participant or a legally appointed substitute decision maker is able to participate in the evaluation
  - Capture information about the provider
  - Complete the evaluation questions and the responses
  - Remind the CC/CM when follow up might be needed based on response(s)
- See Bulletin 18-25-04 for information about entering evaluation data into MMIS at reassessment.

Using the Evaluation Information

- The primary purpose *for the individual* of including these questions at reassessment is that the case manager/care coordinator use the information to address concerns or issues identified by the person in subsequent service planning.
- This may include requests to change services or providers of service. There is an expectation that the case manager/care coordinator act on information provided by the participant to improve services and/or participant experience.
- While 3428Q doesn't note this, it would also be great to communicate positive experience to a provider, with the person's permission!

CM/CC Follow Up

- If the person's responses indicate they are not satisfied, the case manager/care coordinator may need to take follow-up action for remediation or improvement.
- Follow-up action may include a discussion with the provider to resolve the identified issue, updating the person's CSSP or CCP, or documenting in a case note why no action was needed or taken by the case manager/care coordinator.
- There are reminders for follow-up imbedded in the question response sets.

Participant Reassurance

- That said, the case manager/care coordinator must also reassure the participant that their responses can remain confidential if the person so chooses.
- This may be reflected in notes indicating why no action was taken.
- This reassurance does not change mandated reporter requirements if the person reports provider maltreatment.
- An example is provided here to show how the reminder for follow-up appears in the question set.

Do staff treat you with respect?

1- Almost always

2- Most of the time

3- Some of the time *(Case manager/care coordinator, follow up action needed.)*

4- Rarely *(Case manager/care coordinator, follow up action needed.)*

0- Chose not to answer

Space for follow-up notes is included in the questionnaire; follow-up notes are used to direct any changes in the CSSP or CCP, or other actions identified by the person and case manager/care coordinator.

Follow-Up

- The type and extent of follow up needed will, of course, differ based on a variety of considerations:
  - Whether the person wants follow up to occur (can be related to desired confidentiality).
  - How significant the person thinks the problem is, the extent of impact on their life and choices (e.g.).
  - Whether the changes the person might want in their CSSP/CCP are within the scope and definition of the service.
  - Whether modifications are approved and in place , and how well a person can understand the modification in their CSSP/CCP.

Deciding on Actions to Take

- Similarly, the action taken will vary as well.
- Is it a problem with service delivery or with the plan?
  - Some are clearly service delivery: respect, e.g.
- Does the plan need to be revised to improve the person's experience, quality of life?
  - Start by reviewing the plan with the person.
    - Are the provider's duties, tasks clear regarding what the person thinks the provider will deliver?
    - Are the person's goals consistent with the provider service delivery plan? For example, if the person is unsatisfied with the amount or type of support the provider delivers to help the person participate in the community, is this expectation reflected in goals, service description (i.e. how a provider is supposed to support this, how often, etc.)

Thinking Bigger

- (Re)assessment refocuses on what is important to as well as important for the person.
- Review goals, preferences which will be reflected in the HCBS community support plan.
- Revise the service delivery plan reflects the provider's role, support provided, in ways that help achieve goals, reflect preferences and choice.

Everyone's Goal in the Past

- Stay out of the NF.
- Stay independent.
- Maintain my health.
- Ask me WHY, I'll tell you about my **real** life.

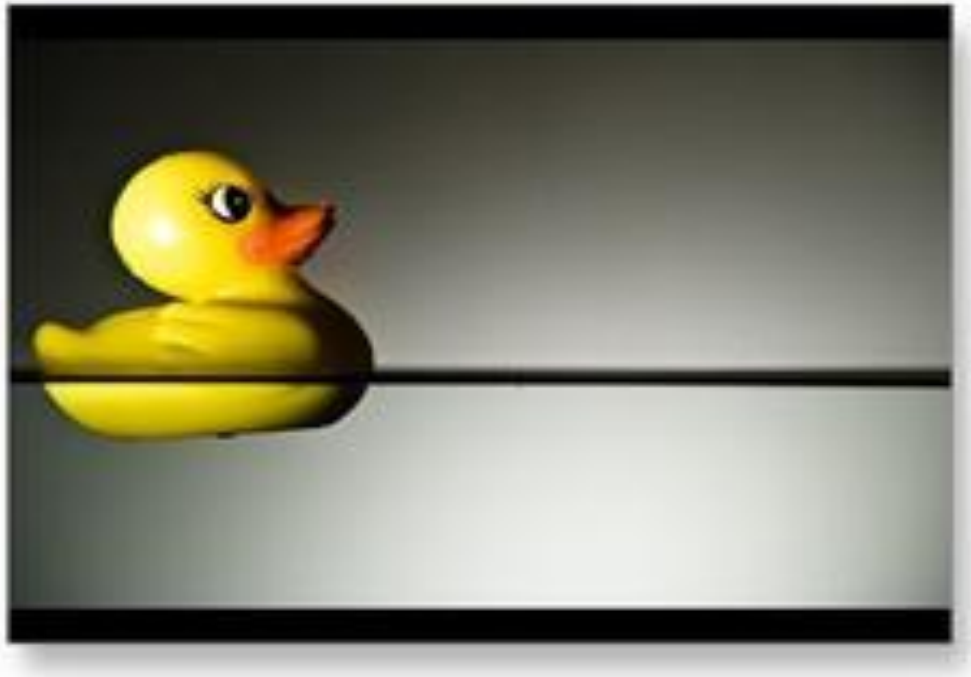
Notes on Goals

- Not all goals, including our own, are achievable, but we can often find substitutions that help satisfy.
- What is the “float under the boat”?
  - For example, a person wants to go to Japan because they want to see the gardens and architecture.
  - Como Conservatory has a Japanese garden, and the Mpls Institute of Art (and others) have marvelous art collections.
- Not all goals can be fully supported via HCBS services.
- Providers may be providing that support, or helping access other supports.

Helping People Fulfill Dreams

- A person wants to visit her sister in Chicago. She talks to her but she wants to see her. Can Skype be arranged?
- A person who used to farm wants to be around farming again. Are there 4H clubs, or animal shelters, or other ways to satisfy, to some extent, this desire? Finding the float....

- Finding the float



My Future Plans

- Person-centered plans should incorporate goals established by the person related to their “future plans”.
- CC/CM include these goals in the care plan, include action steps the person might take to accomplish the goal.
- Include supports the person can access to carry out action steps.

Modification of Rights

- Some people may require some modification to their rights because of health and safety concerns.
- Must be based on specific and individualized assessed needs.
- DHS has developed a form – DHS Form 7176H – for case managers/care coordinators to use when such modification is necessary. The form has a link to additional information.
- A YouTube video is also available describing policy, limitations, and how to use the form at:

https://www.youtube.com/watch?v=905SUoA2QYU&t=260s

Only a Case Manager Can Modify a Right within a Plan

- Only a CM/CC can include a modification of rights in a coordinated services and support plan (CSSP) or collaborative care plan (CCP).
- Providers may provide information but any modification must be approved by the CM/CC, developed and communicated to the provider, who must complete a portion of the form. There is an option for some providers to attach their own form but it must contain all of the elements.
- Provider section includes plan to implement, provide support to reduce or eliminate the need for the modification, attention to least restrictive, most integrated approach.
- Signatures are required from all parties, including the person.

Modifications

- Only in residential settings
- Only rights related to:
  - Privacy (e.g. lock on their door)
  - Take part in activities and have an individual schedule that includes the person's preferences (this right cannot be modified in CL settings)
  - Have access to food at any time
  - Choose his/her own visitors and time of visits.
- Access the available information, web pages, YouTube tutorial

Housing with Services

- For customized living, the enrolled home care provider is responsible to ensure they are delivering services in allowable settings.
- The home care provider has contractual or other arrangements with the housing provider.
- The enrolled home care provider completed an attestation for each setting in which services were (or will be) delivered.
    - This attestation included requirements typically governed by and documented in leases, such as policies related to visitors, locks, decorating, and so on.
- If a participant evaluation of any aspect of service delivery or setting indicates a need for follow-up as agreed to by the person, the CC/CM can bring all matters to the attention of the home care provider.
- The enrolled provider remains responsible for the delivery of services in settings that meet HCBS requirements.

Steps for Service Delivery

- Make sure staff that will be working with folks have skills to continue the conversation. “Getting to know” someone is not a one-time thing.
- Customized Living - make sure you are providing input as described in statute when lead agency assessments are scheduled.
- Make sure you forward a copy of the CL service delivery plan, with provider return with signatures.

Web Resources

- DHS Bulletins are found at

http://mn.gov/dhs/general-public/publications-forms-resources/bulletins/

- Information about Minnesota's HCBS Transition Plan is found at

http://www.mn.gov/dhs/partners-and-providers/continuing-care/reform-initiatives/hcbs-transition/ There is a great video here as well for an overview of the HCBS Rule.

- A good overview document containing all related initiatives, involved organizations is found at

http://www.dhs.state.mn.us/main/DHS-288325

Other Resources

- Support Planning Professionals Learning Community - The audio version of the SPPLC webinars

http://www.dhs.state.mn.us/main/id_007128

- How to sign up to receive monthly announcements

https://public.govdelivery.com/accounts/MNDHS/subscriber/new?preferences=true#tab1

Information

- See the CMS website for the language, fact sheets and additional resources

  https://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

  Excellent information about technical assistance calls completed related to the HCBS Rule.

- See DHS Bulletins 16-56-01, 16-56-02, and 16-56-03 for person-centered planning information.
  - 16-56-01, Attachment B has more complete information on planning requirements.

Questions?

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Thanks for joining us!

Minnesota's Olmstead Plan

- Minnesota's Olmstead Plan, which was approved by the U.S. District Court on September 29, 2015, describes a set of key activities the state must do to ensure all Minnesotans with disabilities live, learn, work and enjoy life in the most integrated setting of their choosing.
- Person-centered practices are the foundation of the topic areas and goals identified in the Olmstead Plan.
- More information can be found at

http://www.dhs.state.mn.us/main/opc_home

Jensen Settlement

- The Jensen Settlement Agreement is the result of a lawsuit of people who received services in the Minnesota Extended Treatment Options (METO) program.
- As part of the Jensen Settlement, DHS agreed to a number of activities, including to ensure that class members would have:
  - A current, up-to-date person-centered plan
  - Informed choice about where they live and services they receive
- For more information on the agreement, see the Jensen Settlement at

http://mn.gov/dhs/general-public/featured-programs-initiatives/jensen-settlement/