

Review and Feedback on the HCBS Final Rule Transition Plan and Process

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Background

As required by the Centers for Medicare and Medicaid Services (CMS), the South Carolina Department of Health and Human Services (DHHS) submitted a plan for how the state will assess, and come into, compliance with the Home and Community Based Services (HCBS) settings final rule. Recognizing that the state is in need of additional affordable housing options for individuals with disabilities and life challenges, DHHS contracted with the Technical Assistance Collaborative, Inc. (TAC) to assist the Department with developing a strategic statewide housing plan. As part of that contract, DHHS also requested that TAC review and provide feedback on the Department’s process for coming into compliance with the HCBS final rule for residential settings.

Process

TAC staff reviewed DHHS’ dedicated HCBS website, including the State’s Transition Plan and “HCBS Rule Residential Setting Assessment.” TAC staff also participated in onsite assessments of Community Residential Care Facilities (CRCFs), Community Training Homes (CTHs) and Supported Living Programs (SLPs) in which individuals receiving HCBS services reside in all five regions of the state.

	CRCF Sites Visited	CTH Sites Visited	SLP Sites Visited
Upstate	0	4	1
Rock Hill	1	4	2
Charleston	1	CTH II – 3 CTH I - 1	1
Pee Dee	2	2	1
Midlands	2	6	2
Total	6	20	7

Observations

HCBS Final Rule Residential Setting Assessment

DHHS developed a self-assessment tool for providers to evaluate compliance with the final rule for all residential settings in which HCBS recipients reside. The assessment tool includes not only the criteria as stated in the final rule, but also the Exploratory Questions provided by CMS to assist states in ascertaining the qualities and characteristics of each residential setting.

DHHS has indicated that self-assessments have been returned from all but one provider. DHHS or its vendor will visit a sample of sites after reviewing the self-assessments. It's unclear how the Department will determine how many or which sites to visit. DHHS has indicated that providers will receive written feedback from the onsite assessment. It is also unclear if DHHS will take further action based on the overall findings from the onsite visits. For example, if a high per cent of sites are determined to need more remedial action than the self-assessment indicated will DHHS conduct onsite visits at additional/all settings?

DHHS has also indicated that Waiver participants will receive satisfaction surveys to complete about their residences. Self-reporting is a viable source of information if done appropriately. We recommend that DHHS require/insure that residents receive individualized education about the surveys and their intended use. In addition, DHHS should require/insure that residents will be able to complete the surveys in a location where they are comfortable providing honest answers to the questions. We recommend that DHHS require/insure that residents receive assistance from an un-biased party who will not try to "steer" the questions or responses.

TAC On-site Visits

While TAC staff did not conduct the residential visits as a formal assessment, there are a number of observations from the visits that are identified to help inform DHHS' ongoing process. Observations in bold-print are assessed as concerns that will need to be addressed either through heightened scrutiny or remedial action in order to comply with the Final Rule.

Community Residential Care Facilities and Community Training Homes

Physical Characteristics

- Well-maintained residences with home-like furnishings. **However, in many of the homes, individuals do not have residential agreements.**
- Occupancy ranged from 3 to 8 with most homes having 4 residents. While CMS has stated repeatedly that its focus is on the qualities of a setting and not the number of residents, recent guidance focuses on how the community perceives the setting...is it identified as a setting specifically for individuals with disabilities? DHHS can take the position that the homes do not stand out as "programs" and look no different than other homes in the community. Outreach efforts to engage neighbors could be helpful in this regard.
- In most of the homes observed, residents have individual bedrooms. In settings where bedrooms are shared, new individuals are typically limited to choice of roommates since they must move into the bedroom with the vacancy. Facilities indicated that roommates can be matched with someone else if needed as vacancies occur in the future.
- Most bedrooms could be locked from within, however there were a few sites with **bedrooms which could not be locked from the inside.** The Directors at these sites indicated that the absence of locks was due to "safety issues." If that is accurate it should be confirmed in the individuals' service plans.
- Office area in some homes were completely separate from residents' living areas, while **in other homes there were desks and office equipment in the living rooms and**

resident charts/information in the open for anyone to see. Memos correcting staff behaviors were posted in living areas in a few facilities.

- Bedrooms are furnished/decorated by residents and contained personal belongings indicative of their interests. One facility noted that families had interior decorators design the residents' bedrooms.

Accessibility

- Most homes are single-story. A few have ramps to facilitate mobility. Some of the residents have physical limitations. Doorways and hallways are able to accommodate wheelchairs. One home had a second-floor bedroom which offered a private bedroom/bath for the resident, however he is in his mid to late 50s and will need to either move downstairs or to another facility if navigating stairs becomes an issue. A second home had three steps the occupant had to navigate to access his bedroom.
- No home visited had adaptations to support individuals who are hearing or visually impaired.
- Homes are located in quiet residential areas. Depending in the area of the state, some homes are located "in town," while in more rural parts of the state, the homes would be considered to be part of the community. **Some homes reported little to no interaction with neighbors** while others reported frequent interaction.
- **The residences in the now defunct naval yard in Charleston were especially isolating.** The two adjacent homes are located in the center of the base, apart from the community. The area was spacious and offered residents open area for exercise; however, **the setting does not promote community inclusion.**
- It is evident that residents do participate in a variety of community activities of their choosing. Most settings have a van which staff uses to transport residents to daily programming, jobs, shopping, community activities, etc. While we would agree with the Director who commented that using the vans is not very "normalizing," the primary concern related to HCBS compliance is if the vans draw attention to the settings as specifically serving people with disabilities. The vans may also reinforce the practice of residents all going to the same day program.

Operational Characteristics

- Homes are staffed "24/7," however most residents participate in the residential providers' day programs. When residents were onsite during the visits and could be interviewed, some reported they were fine with attending the day program or sheltered workshop, while others said they would prefer to do something else. One facility director commented that some residents don't want to attend their sheltered workshop but said it "gets them out of the house." **It's questionable that all residents within a home would choose to attend the provider-run day program if they had an alternative.** The final rule stresses informed choice of daily activities.
- **At least 2 CTHs reported needing to "lay eyes" on residents every 15 minutes,** to assure safety. It was unclear if this policy was unique to the populations served by the

two programs, but it was not a policy observed in every CTH. If there is a need to assure safety in these homes the need for checks should be verified in the residents' service plans.

- There are menus posted in each home which are reportedly developed by a dietician and unique to the residents in each house. Staff reported that if the residents don't want to eat a menu item that it can be changed. The food is prepared by staff, who also do the grocery shopping. **Staff appear to do most of the "chores"** though residents can, and some reportedly do, help with laundry, carrying their plates from table to kitchen, etc.
- Snacks are reported to be available if diet allows. However, **it was not clear that residents have free access to food and drinks in all the homes. Restricted access should be validated in service plans if an issue.**
- **Residents' funds are managed and dispersed by staff.** Some program staff did comment that residents are working on money management skills. Policies on money management and each resident's plan of care should be reviewed to assure facility control is necessary.
- When asked about overnight visitors it was clear that it doesn't happen at this level of care. **One director indicated that she believed overnight guests would be viewed by state licensing staff as exceeding their census; during a recent emergency, the director was told by the state agency that she could not temporarily allow a resident from another home to spend the night in her fully occupied home.** DHHS should determine if having an overnight guest would be a regulatory violation and if so, addressing the regulation would need to be added to the Transition Plan.

Supported Living Programs

Physical Characteristics

- Residents have individual leases.
- **One group of apartments in the Upstate region is in an area that the Director and, reportedly, Case Managers do not feel is safe.**
- At an SLP II in Charleston, **three individuals have rooms in an apartment which also serves as the house manager's office.** These residents share the living area with each other and the house manager, **offering little independence or privacy.**
- Most SLPs visited are located within larger apartment complexes, with most of the apartments clustered rather than dispersed. An SLP III pilot in Columbia was a model program exception: the apartments were dispersed among different apartment complexes. In another location, **one set of apartments is located adjacent to a Community Training Home. Another provider indicated the agency was intentionally leasing apartments within the same area of a complex as opposed to dispersing them throughout the complex.**

Accessibility

- Absent public transportation in most SC communities, residents are transported to work/activities or may have their own transportation.

- All apartments were single story, though units at some complexes were located on a second story of a building. Units appeared to be ADA compliant.

Operational Characteristics

- SLP residents have more choice about their daily activities. Some were working, some were attending day programming and some were at their residences or visiting with neighbors.
- Residents have keys to their apartments and are allowed visitors at any time. One exception was an SLP II in Charleston. **The House Manager controls who the residents can have onsite in their apartment, requiring that she meets them first and approves of them. No one can stay overnight in these apartments.**
- **One resident was observed asking a Program Director for spending money and she replied that she would make sure it happened. The resident's service plan should verify why he doesn't have access to his funds and there should be a habilitation goal to build this skill.**

Overall Findings/Recommendations

Based on the sites TAC visited, there do not appear to be egregious violations of the HCBS Final Rule on residential settings. However, most if not all of the settings require at least minor remedies in order to be in full compliance. Some settings were assessed to have institutional-like characteristics – facilities that were converted from Interim Care Facilities appear to be challenged with transforming their service delivery to a more person-centered approach. Conversely, settings operated by private providers appeared to have a clear focus on providing rehabilitation and supporting independence. One private provider did raise a concern, however, when she reported that the facility's residents performed off-site volunteer work as opposed to earning wages, so as not to reduce their benefits.

We recommend the following actions in order to better align services with the Final Rule:

1. Require provider staff, from the direct service personnel to the Directors, to be trained in how to insure that residents exercise informed choice.
 - a. Verify that each individual living in a CRCF or CTH was offered a choice to live in a non-disability residential setting capable of meeting the individual's needs.
 - b. Address the lack of *choice* in daily activities/programs. Activities which are available to individuals without disabilities may be preferred by some residents.
2. Require residential agreements or leases for all settings.
3. As leases expire, disperse Supported Living apartments throughout complexes.
4. Insure office areas and equipment are separate from resident living areas. Resident information must be kept confidential and staff communications should not be displayed for residents and visitors to view.
5. Enhance skill-building in the residences...staff shouldn't do the daily activities, such as cooking meals or shopping for groceries, because it's quicker or easier than assisting

the residents to work on skill development. It was difficult to tell in some settings how much, if any, skill building was occurring.

6. Conduct a random site cost-benefit analysis to assess the implications of converting use of large vans to smaller vehicles. Transporting residents using smaller vehicles is less stigmatizing, incents individualized trips and destinations and is likely to have cost efficiencies; these reduced costs may be off-set however, if more staff are needed for transporting.

In Summary

DHHS is responding to its obligation to come into compliance with the HCBS final rule. The Department is wise to have taken the Final Rule seriously...given that there are 9 waivers supporting thousands of individuals with HCBS services in South Carolina, working towards compliance is critical. CMS is giving states time to comply with the regulation, but the agency is clear that it intends to enforce the Final Rule.

DHHS is in the process of identifying areas of vulnerability...several are identified in this summary. TAC recommends using a phased approach to the state's response.

1. Identify the most egregious facilities and/or areas of vulnerability most common among facilities.
2. Determine if the facilities can and are willing to come into compliance.
3. Determine strategies necessary for addressing the common violations.
4. Determine if there are state resources that can be used to offset the cost of efforts required for compliance.
5. Develop work plans with specific actions necessary and timelines to modify regulations, policies and procedures that allow or require providers to come into compliance with the Final Rule.
6. Identify options for re-locating residents if needed as a last resort. There may be some settings that will not want or be able to comply with the Final Rule and if so, finding and/or developing alternatives for those residents should begin sooner rather than later. Detailed plans with action steps and timelines will be required for your Transition plan update.
7. The Department *must* address options for daily activities in order for residents to have meaningful choice. Options include expanding Supported Employment services, training providers and residents on the ability to earn wages and not lose entitlements and increasing the use of natural supports and community programs.
8. Once provider assessment results are analyzed, begin development of detailed action plans and timelines for those remedial actions which will require substantive time and effort.
9. The Department may also want to create opportunities for success and examples of change by taking on some of the quicker and easier-to-achieve changes. This will show CMS, provider agencies and stakeholders that you are taking action to achieve compliance.

TAC staff would be glad to discuss these recommendations and respond to questions or concerns that you may have.

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