State of Vermont

Comprehensive Quality Strategy Systemic Assessment

Section III State Standards:

Home and Community Based Services

Specialized Health Population:

Developmental Disabilities Services

Global Commitment to Health Managed Care

February 2016

Table of Contents

BACKGROUND

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home- and community-based settings (HCBS). The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS's intent to ensure that individuals receiving services and supports under 1915(c) HCBS waivers, 1915(k) (Community First Choice), and 1915(i) State Plan HCBS Medicaid authorities have full access to the benefits of community living and are able to receive services in the most integrated setting.

The State of Vermont has been particularly progressive in pursuing a home- and community-based continuum of care that offers meaningful community integration, choice, and self-direction, and strives to promote health, wellness, and improved quality of life. In doing so over the years, the State has used many authorities available under the Medicaid State Plan's rehabilitation option, as well as former 1915(c) waivers and Medicaid Section 1115 Demonstration projects. Additionally, guidance and assurances for home- and community-based care in Vermont are codified in statute or placed in rule. As a result, the term "home and community based" is used in Vermont to represent a broad array of services and supports that may not be typical of 1915(c) populations and CMS rules in other states, but that have been authorized under its Section 1115 Demonstration.

Because of Vermont's public managed care delivery system, the State is integrating person-centered planning and integrated community setting assurances into its Comprehensive Quality Strategy for all Specialized Programs. Regardless of the services that beneficiaries choose, Vermont's values are in alignment with the Federal HCBS values. As such, at its discretion and over time, the State's Comprehensive Quality strategy will review the rules and guidance supporting all Special Health Need Populations served under the Demonstration. The ultimate goal of these efforts is to promote enhanced quality in all services provided in community settings authorized under the State Plan and the Global Commitment Demonstration. This report focuses on the Developmental Disabilities Service (DDS) Program.

ELIGIBILITY AND ENROLLMENT

Persons may become eligible for participation in the DDS by meeting Medicaid Long-Term Care eligibility rules; 1915(c) institutional eligibility rules; Medicaid Aged, Blind, Disabled (ABD) rules; and by also meeting statutorily defined criteria for developmental disabilities. Final program participation is determined through criteria established in the State System of Care Plan related to funding priorities. Less than one quarter of the calendar year 2014 DDS program expenditures were for persons eligible under HCBS institutional eligibility rules.

DEVELOPMENTAL DISABILITIES SERVICES

DDS supports are meant to maximize independence while protecting the health, wellness, and safety of consumers who are considered part of a vulnerable/special health needs population under the Global Commitment to Health Medicaid Managed Care model. Services to children under 21 are expected to focus on developmental growth and assistance with skill building whenever possible. DDS programs for persons over the age of 21 are meant to provide long-term services and supports, and enrollment is frequently expected to be life-long in nature.

The DDS program includes services and supports provided by private non-profit developmental disabilities services providers throughout the state to assist individuals who have a developmental disability to live and work in their communities. Services include service coordination, community supports, employment supports, respite, clinical services, crisis services, home supports, and transportation. The State's only public institution providing developmental disability services, Brandon Training School, was closed in 1993. The last sheltered workshop was closed in 2002. All program services are provided in the community. Individual support plans and associated services are highly individualized and based on person-centered planning, consumer choice and allowable services as defined in the DDS State System of Care Plan.

Home Supports include services, supports, and supervision provided to individuals in and around their residences up to twenty-four hours a day, seven days a week (24/7). An array of services are provided to individuals, as appropriate, in accordance with an individual planning process that results in an Individual Support Agreement (ISA). The services include the provision of assistance and resources to improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include support for individuals to acquire and retain life skills and for maintaining health and safety. Support for home modifications required for accessibility for an individual with a physical disability may be included in Home Supports. Home Supports does not include costs for room and board. Below are the types of residential arrangement available in the DDS program.

Supervised Living - These arrangements include regularly scheduled or intermittent hourly supports provided to an individual who lives in his or her home or that of a family member. Supports are provided on a less-than-full-time (not 24/7) schedule.

Shared Living – These arrangements provide individualized support for one or two adults and/or children in the home of a contracted home provider. Home providers typically have 24-hour, seven-day-a-week responsibility for the individuals who live with them. No more than two individuals may live in or receive respite in the same home. All shared living arrangements must meet DDS safety and accessibility standards prior to participant placement. Home providers are considered independent contractors with a Host Agency responsible for quality oversight and case management services on behalf of the participant. Home providers do not serve as case managers or guardians for persons in their care.

Staffed Living These arrangements provide individualized support for one or two adults and/or children in a home setting. Home settings are staffed on a full-time basis by paid providers. No more than two individuals may live in or receive respite in the same setting. All staffed living arrangements must meet DDS safety and accessibility standards prior to participant placement.

Group Living - These arrangements require the setting to be licensed by the Division of Licensing and Protection. For recipients who are under the age of eighteen, the setting must be licensed by DCF as a Residential Child Care Facility or Foster Home. Group Living arrangements include supports provided in a home setting for three to six people that are staffed full time by paid providers. The Vermont State System of Care Plan does not allow

funds to be used to increase the availability of settings that provide residential supports to more than four persons over the age of 18 without approval of the Commissioner; no setting may serve more than six adults. Currently, there are no group settings for children that exceed two participants.

ICF/DD - An Intermediate Care Facility for people with Developmental Disabilities is a highly structured residential setting for up to six people. ICF/DD settings provide needed intensive medical and therapeutic services.

Table 1: Overview of DDS residential arrangements

Residential Type	Persons Served June 30, 2014	Who controls/owns setting	Regulatory Framework
Supervised Living	317	Participant or family	• DD Act and Regulations
Shared Living (1-2 persons)	1,319	Contracted Home Provider	• DD Act and Regulations
Staffed Living (1-2 persons)	44 (35 homes)	Participant or family or DA/SSA Provider	• DD Act and Regulations • DCF Residential Treatment Regulations (for recipients under 18)
Group Living (3-6 persons)	91 (20 homes)	DA/SSA Provider	• Residential Care Home Licensing Standards • Therapeutic Community Residence Licensing Standards • DD Act and Regulations
ICF/DD	6 (1 home)	DA/SSA Provider	• DD Act and Regulations • Medicaid State Plan & Federal Rules

Employment and community supports are offered to participants in everyday community settings where the participant lives and recreates. DDS does not support sheltered workshops or free standing disability-specific day treatment centers. In some cases Group Community Supports are offered as learning opportunities for two or more persons who have similar interests. DDS program benefits are outlined on Table 2 on the following page.

Table 2: Overview DDS Program Benefits

42 CFR 440.180 HCBS Service	Vermont DS Benefit Name	Coverage Authorization (Medicaid State Plan or HCBS)
Case Management	Service Planning and Coordination	HCBS and State Plan, Targeted Case Management
Habilitation	Home Supports (supervised, shared, staffed, group and ICF/DD)	HCBS
	Community Supports	HCBS
Respite	Respite (in home or shared living setting)	HCBS
Other Cost-Effective Alternatives	Crisis Services	HCBS and State Plan
Day Treatment, Psychosocial Rehab, Clinic Services	Clinical Interventions	HCBS and State Plan
Expanded Habilitation	Employment Services	HCBS

VERMONT POLICY OVERVIEW

The DS program has a variety of written materials associated with its operations. These materials range from APA-promulgated rule and licensing standards to operations manuals, provider certification standards, audit tools, and training guides. The following documents were reviewed as part of this project:

- 18 V.S.A. Chapter 204A Developmental Disabilities Act (i.e., DD Act)
- Regulations Implementing the Developmental Disabilities Act of 1996 (March 2011)
- 18 V.S.A. Chapter 206 (i.e., Act 248)
- Vermont State System of Care Plan for Developmental Disabilities Services (2015-2017)
- Protocols for Evaluating Less Restrictive Placements and Supports for People with Intellectual/Developmental Disabilities Who Pose a Risk to Public Safety (April 30, 2015)
- Behavior Support Guidelines for Workers Paid with Developmental Services Funds (October 2004)
- Vermont Council of Developmental and Mental Health Services: Needs Assessment
- Guidelines for the Quality Review Process of Developmental Disability Services (June 17, 2009)
- Individual Support Agreement Guidelines and Basic Form (March 2003)
- Housing Safety and Accessibility Review Process (March 2006)
- Shared Living in Vermont: Individualized Home Supports for People with Developmental Disabilities (2010)
- Health and Wellness Guidelines (March 2004)
- Policy on Education and Support of Sexuality (January 2004)
- Service Coordinator Home Visit Requirements (May 2010)
- DAIL Residential Care Home Licensing Regulations (October 3, 2000)

- DCF Residential Treatment Licensing Regulations (January 2011)
- Therapeutic Community Residences (TCR) Licensing and Operating Regulations (Jan. 6 2014)
- Human Rights Committee Guidelines((November 2006)
- Administrative Rules on Agency Designation (June 2003)
- Critical Incident Reporting Guidelines For DDS Programs (February 2016)

Appendix A and B provide a more detailed crosswalk of Vermont policy documents to the federal HCBS rules. Elements responsive to federal rules were scored using the following categories:

Alignment:	State policy documents show alignment with federal rules.
Partial:	State policy documents show general alignment with federal rules, but lack specificity.
Silent:	State policy documents do not mention specific terms contemplated in federal rule.
Non-Comply:	State policy documents are in conflict with the terms contemplated in federal rule.

A brief summary of findings is provided below.

The DDS statutory and regulatory framework appears to substantially align with the values in the federal framework and requires many of the same safeguards. Vermont rules and guidelines expand beyond the federal framework and support independence, personal autonomy, and choices in such areas as the expression of sexuality, ability of a person to administer his or her own medications, and the right of person to choose what he or she wants to do, within the framework of laws, rules, and societal expectations applicable to all Vermont citizens. In addition, the Guidelines for the Quality Review Process for Developmental Services (June 2009) includes outcomes and indicators that fully support the values of both the Vermont and federal frameworks.

Employment and community supports are offered to participants in everyday community settings where the participant lives and recreates. In some situations Group Community Supports are allowed and may include site-based activity schedules in some regions. In these regions provider agencies open up their facilities for enrollee use in promoting various social, recreational and leaning opportunities for persons who have similar interests. Examples include, cooking classes using the office kitchenette, computer skills using office equipment, hobby or special interest groups using conference room space. Group Community Supports are bound by all DD Act and DDS regulations and policies identified in the following sections, however there are no specific guidelines for situations where activities are planned using provider controlled locations and schedules.

All residential and service arrangements in the DDS Care program must be commensurate with assessment findings; the participant's individualized support agreement, abilities, and desires; and meaningful choice per DD Act regulations. In addition, the DD Act and its regulation define Restrictions of Rights as any actions that limit those civil rights adults ordinarily expect to exercise. Any use of a caregiver's authority over the individual that interferes with an individual's autonomy, rights, activities, or privacy in ways that cross over the line ordinarily found in consenting relationships between adults is prohibited unless identified through the assessment process and agreed to in the ISA. A participant's or guardian's disagreement with an intervention is considered a restriction of rights. Any restriction must include consumer and guardian consent and be accompanied by a clear Behavioral Support Plan or a Psychiatric and/or Medical Treatment Plan.

Both the Individual Support Agreement and the Behavioral Support Guidelines provide instructions for person-centered planning, integrated home settings, and protection of individual rights and autonomy. The ISA is considered a written legal agreement and includes information about the person's preferences and goals. The behavioral support guidelines specifically note that any restriction must be fully vetted, planned for, and agreed to by the individual and the individual's team (excerpt below). In addition, each local agency must have a Professional Review Committee for the review of certain more restrictive interventions. Lastly, the State's Human Rights Committee must review all requests for restraint as defined by Vermont guidelines, which may include perimeter locks and other interventions that restrict a person's movement, choice, and autonomy. Vermont guidance suggests that all aspects of a person's needs, preferences, and choices must be incorporated in planning (including those outlined in the Federal HCBS rules) and documented as part of the person-centered planning process. Excerpts regarding restriction of rights are provided below.

> ***Restrictions of Rights*** *are actions by Developmental Services- paid workers that use the caregiver's authority over the individual and that interfere with an individual's autonomy, rights, activities, or privacy in ways that cross over the line ordinarily found in consenting relationships between adults. Restrictions of rights limit those civil rights adults ordinarily expect to exercise.*
>
> *Restrictions of rights include any actions which restrict rights guaranteed by the Developmental Disabilities Act of 1996; specifically, restrictions that interfere with:*
>
> - *Privacy, dignity, and confidentiality,*
> - *Association with individuals of both genders,*
> - *Communication in private by mail and telephone, or*
> - *Contact with family.*
>
> ***If a person or guardian objects to any other restriction of rights, activity, or autonomy, it should also be treated as a restriction of rights.***
>
> *A restriction of rights may be needed to protect the emotional or physical health or safety of the individual or others. For instance, contact with family members may be restricted for the safety of the individual or the safety of a family member.*
>
> *Restrictions of rights shall not be used as rewards or punishments to change behavior. For instance, a program may not restrict a person from calling his family when he is "noncompliant" and allow him to call when he is "compliant."*
>
> *There is often a fine line between a reasonable safety precaution (e.g., locking up chemical cleaners or prescription drugs) and a limitation of autonomy (e.g., locking up kitchen cabinets or the refrigerator). Similarly, there may be a fine line between a house rule (e.g., don't tie up the phone for more than half an hour) and a punishment (e.g., you can't use the phone because you didn't clean up your room).*
>
> *Room monitors and door alarms are considered restrictions of rights. Locking the door of a family member's bedroom may be a reasonable protection of privacy, but locking a person out of the kitchen or other common areas of the house would be a restriction of rights. Locking a person into his or her own bedroom is never permitted. Restrictions of rights must be individually considered, with sensitivity to unnecessary overprotection and to the inequality of power that is inherent in paid caregiving services.*
>
> *It is the responsibility of the individual and his or her guardian and other ISA team members to identify measures that are restrictions of rights and continuously reassess the need for those restrictions.*
>
> ***Excerpt from DD Act Regulations Section 10.7 Quality standards for services***

To be certified, an agency shall provide or arrange for services that achieve the following values and goals:

(a) The civil and human rights of individuals are encouraged and respected.
(b) Individuals direct their own lives.
(1) Individuals make the decisions that affect their lives.
(2) Individuals have the opportunity to manage services and choose how resources are used.
(c) The needs of individuals are met and their strengths and preferences are honored.
(1) Services are developed with the person and family's/guardian's input and reflect the individual's strengths, needs, and goals.
(2) Services are individualized
(d) Individuals live and work as independently and interdependently as they choose.
(1) Services foster personal growth and encourage the development of practical life skills.
(2) Individuals are safe in their homes and communities.
(3) Individuals who choose to work have meaningful jobs that are suited to their interests and have the supports necessary to maintain those jobs.
(e) Individuals experience positive relationships, including connections with family and their natural supports. Individuals are encouraged and receive guidance to maintain relationships that are meaningful to them.
(f) Individuals participate in their local communities. Individuals have a sense of belonging, inclusion and membership in their community.
(g) Individuals experience optimal health and well-being.
(1) Individuals have their medical and health needs met.
(2) Individuals are encouraged and supported to maintain healthy lifestyles and habits.
(h) Individuals communicate effectively with others. Individuals are able to communicate effectively in their preferred mode. (Communication Bill of Rights)
(i) Individuals have timely assessments and service plans.
(j) Individual critical incidents and other reports are made in a timely manner and are in compliance with Department policy.
(k) Individuals have trained and responsive workers.

Summary and Options for Next Steps

The Vermont regulatory framework for Developmental Services is progressive and comprehensive; however, State budget limitations and the impact of the recent recession have resulted in a significant downsizing of functions in quality and policy oversight and data analytics. In an effort to limit impact on direct care appropriations in specialized programs, necessary reductions in State resources were made in infrastructure. Subsequently, monitoring adherence and improvement has been difficult. The State has been challenged with finding more efficient and automated ways to collect and monitor quality indicators, including consumer self-report data, grievance and appeals data, and provider performance measures. Efforts at modernizing the IT infrastructure across AHS should result in the development of new business processes to support necessary quality monitoring and provider performance management in these critical areas.

A preliminary list of options for enhancing quality oversight and providing more specific and direct guidance related to State and federal values and rules is provided in Table 3 on the following page. This list should not be considered exhaustive; more extensive stakeholder engagement may yield additional opportunities for ongoing quality assessment and improvement.