ICF/MR BRANCH NEWSLETTER

NC Department of Health and Human Services
Division of Facility Services
Mental Health and Licensure Certification Section

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IN THIS ISSUE

The purpose of this Newsletter is to provide information and updates on ICF/MR issues in North Carolina. We ask that you pass it on to the homes, facilities and organizations that serve your clients. Additionally, if you have any questions, comments or suggestions, do not hesitate to contact us at Jay.Silva@ncmail.net or Denise.Erwin@ncmail.net. You may also contact us by calling (919) 855-3795 and asking for an ICF/MR facility consultant or writing to:

ICF/MR Survey Team
2718 Mail Service Center
Raleigh, North Carolina 27699-2718

Comments from the Chief

Welcome back! We are excited to resume the ICF/MR newsletter with Joyce Cooper and Michele Brandow taking the lead as co-editors and authors. This past April, Jay Silva and I attended the ICF-MR Annual Conference in Greensboro. Jay fielded questions about interpretation of federal regulations, and I fielded questions about state licensure rules. This seemed to be helpful to participants, but it only happens once a year. Therefore, I would like to open this column as an avenue to answer questions that you think might be relevant to other providers. I invite you to send questions to Joyce or Michele, and we can put our heads together and respond in the next issue.

Stephanie Alexander, Chief
MH Licensure & Certification Section

ICF/MR Surveys for North Carolina - Numbers for the year 2006

Statistics for 2006:

The most frequently cited deficiencies for the calendar year 2006 are:

TAGS	Total Times Cited
W-154 Staff treatment, investigations	47
W-227 Specific Objective for Client Needs	60
W-240 IPP contains relevant support	33
W-242 IPP addresses all needs	38
W-249 IPP provided as written	222
W-252 Data taken as specified	35
W-257 Review and Revision	50
W-288 Management of Inappropriate Beh	48
W-369 Drug Administration	36
W-436 Space and Equipment	52

The information listed above does not include citations from life safety code surveys. *(*Note: All Wtags may be evaluated and cited by the General Health Survey)*

The following 33 facilities had deficiency-free annual recertification surveys during 2006:

Skills Creations of Wilson
Belmont ICF/MR Group Home
Ravendale Drive Group Home
New River Cottage
Robinhood Road Group Home
VOCA – College Street Group Home
Iotla Street Group Home
West Main Street Facility,
Scotland Forest Group Home
Watson's Group Home
VOCA-Otis Group Home
RSI – Silo Drive Group Home,
Jade Tree Group Home
Rolling Meadows Group Home
VOCA – Country Lane
RHA Stoneridge
La Grange Group Home
NOVA Airport Road
NOVA Highway 17 Group Home
Holly Street Home
Rones Chapel Road Group Home
Christy Woods Group Home
College Park Group Home
Twinbrooks
Smoky Mountain ICF/MR
Webster Group Home
Franklin Boulevard Group Home
VOCA- Oakhaven Group Home
Ellendale
VOCA - Oak Drive Group Home
VOCA - Blairfield
VOCA – Apple Valley
Bonnie Lane

If you did receive a deficiency-free annual survey (General and Life Safety) and we failed to identify your facility, please notify us at joyce.cooper@ncmail.net for inclusion in the next edition of the newsletter.

CREATIVE CORNER KUDOS

This part of the newsletter is being developed to highlight a facility's creativity in providing services for individuals. The intent is not to outline "best practices," but to acknowledge unique services/approaches provided to consumers in ICF/MR facilities.

1. This first KUDO highlights RHA's Southern Avenue home in Fayetteville. The home manager is scrapbooking outings for each individual in the home. The scrapbooks include all the things that make outings unique for the person, including snapshots, ticket stubs and programs. Related tags: W247, 136 and 148.

2. The second Kudo goes to group homes at Gaston Residential Services (Meeks, Springdale Lane, Franklin Street, Belmont and Cherryville ICF/MRs). All clients now have a computer available to them. The facility has developed an email address for each client within their company email system to enhance family contact and correspondence. In talking with one family member, they are now sending videos via internet to their person in the group home. Related tag: W148.

3. The third Kudo goes to the Macon Country group, having 2 ICF/MRs; Macon County ICF/MR and Iotla Street. In addition to having their own workshop, the facility also has its own fitness center for use by all clients and staff. Each client participates in a wellness and fitness program in the fitness center. Related tags: W196, 322, 435.

Center for Medicaid & Medicare Services (CMS) Notes

A "new" approach of collaboration between the Federal and State for ICF/MR surveys was implemented in 2006. This new approach was developed in response to feedback gathered by CMS from approximately 800 "look-behind" surveys conducted between 2001 -2005. The partnership surveys have been conducted with both federal and state surveyors on-site during recertification visits at sites identified by CMS.

E**vacuation and fire drill tags – W448-449**

Are your policies and procedures for evacuating the facilities during disasters up to date?
Following the aftermath of Katrina, we all are aware of how important it is to have a disaster plan in place that addresses the needs of some of our most vulnerable people.

At the recent training provided by CMS, providers from the Southern states devastated by Hurricane Katrina were recognized as having only minor problems for any of their ICF/MR consumers during that critical time.

Shift in focus as the ICF/MR client's grow older:

CMS is aware that the ICF/MR population is aging and as they age the needs will shift. The challenge for providers is to address each client's changing health needs while moderating their active treatment programs to accommodate to the changes in their healthcare status.

ICF/MR Retirement Status:

Retirement status is a component of the ICF/MR aging scenario. Retirement status is a choice made by each client in coordination with their interdisciplinary teams and guardians. Active treatment can be modified to accommodate and support this change.

ACTIVE TREATMENT AND RETIREMENT

We live in an aging society. Likewise, the number of people over 60 residing in ICF/MR facilities is also on the rise. We make transitions throughout our life and so should people living in ICF/MR facilities. The process of planning for retirement and actual retirement is a common practice of most people in our society who have spent the majority of their life working.

Many ask what is active treatment and how do you look at it in relation to retirement? Active treatment starts with assessments and as noted in W211, one should "take into consideration the client's age." The team needs to consider the implication for active treatment at each stage in the person's life. The assessments should address active treatment relevant to a person's chronological age. W211 further notes that the active treatment assessment process should be sensitive to where the individual is at in his or her life span. W211 also provides the example: "Infants and toddlers are expected to engage in more play-related, exploratory activities, adolescents are expected to engage in activities of increasingly greater responsibility in preparation for adulthood, adults are expected to support themselves or at least be engaged in training or education activities toward that end and elderly citizens, are expected to choose whichever form of productive activity meets their needs and interests for as long as they are able."

This does not mean all individuals reach a certain age and retire. Retirement as with all components of active treatment should be individualized. People living in ICF/MR facilities should be respected. They should be treated with the same rights and dignity as other older persons. Additionally, their choices should be honored and one must keep in mind, as W196 points out the team should focus on assisting individuals to function with as much self determination and independence as possible.

W196 further notes that the active treatment plan must include "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services." It may also be a program that is directed toward "the prevention or deceleration of regression or loss of current optimal functional status."

Once an individual is assessed to determine if he or she wants to and should go into a retirement phase in life, then the key word one might want to consider in the active treatment retirement plan for people in ICF/MR facilities is "active." However, it is often misinterpreted to mean "busy" or "moving." Active does not refer to this busy work. It does mean a part of active treatment is that the *team* is "active." Active is constantly assessing or re-assessing a person's individual needs based on various life transitions, medical or behavioral conditions or simply changes in what the individual likes. W249 even points out that the activities should relate to the persons strengths, needs or objectives and not be "make work" or what some call "busy work" or "non-developmental time fillers."

As mentioned previously, W196 also adds to the clarification of the word "active" by pointing out that each client must receive a continuous active treatment program which includes "aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services…." It is the team's aggressive and consistent process which makes it "active" treatment. Additionally, the word "continuous" here means the "competent interaction of staff with individuals served at all times…" not that the individual has to be *continuously* doing something.

W196 also points out major elements which should "be present and functioning in a consistent, cohesive manner." These elements include the assessment mentioned earlier; the identification of priority needs and establishment of a plan of action to meet the needs (formally and through activities which are relevant and responsive to individual need, interest and choice); consistent implementation in all relevant settings both formally and informally as the opportunity or need presents itself; aggressive and consistent training, treatment and services by trained staff in accordance with the individual plan; new skills and appropriate behaviors are encouraged and reinforced; provision of adaptive equipment and assistive technology necessary for him/her to function with

increased independence and choice; accurate measurement of performance and modifications of programs based on data and major life changes and individuals with degenerative conditions receive training, treatment and services designed to maintain skills and functioning and to prevent further regression to the extent possible.

It is also important to point out that W196 speaks to the fact that sometimes the effort to prevent or decelerate regression is a part of the overall active treatment program. W196 addresses active treatment for elderly individuals may increasingly need to focus on "interventions and activities that promote physical wellness and fitness, socialization and tasks that stress maintaining coordination skills and reducing the rate of loss of skills…attending a senior center may be a justifiable part of active treatment program for an elderly person."

The place a team may wish to start in considering retirement might be to ask what the person needs. Some other questions to ask would include: Do the person's needs now focus on medical issues? Does the person's social circle need to expand? Do the person's coping skills need to improve? Has the team discussed meaningful activities and has the definition of meaningful activities changed with the individual as he or she aged? Has the person demonstrated choices? Does the person still require training or supports to make those choices?

The plan should include the same things we would think of when we consider our own retirement. Such a plan might include some or all of the following: access to health care (hospice will come into ICF/MR facilities); advance directives relating to health care; leisure time activities; counseling services; long term care plan; finances; other retirement and employment options; guardianship; and self-advocacy training.

The team should look for ways which they can assist individuals in planning retirement. The plan may include ways to assist the individual

- to participate in activities, events and organizations in which other retirees in society participate;
- to build and strengthen relationships between the individuals and the community, the church, their families;
- to find places where their individual culture, gifts and talents can be shared with other community members;
- to find opportunities to do things they enjoy or learn new things (i.e. paint class, pottery, gardening club, dinner clubs, volunteer work, SPCA, hospital)
- to support participation in clubs and organization (i.e., Red Hat Club)

Assistance in participating in these things may require more staff. Of course a team discussion regarding a more medically involved individual would include other key factors.

Looking at ICF/MR regulatory components of active treatment (W249), you will find an emphasis not just on training but also on services to support the person in their needs and in the accomplishment of their individual goals. It must be clear that the program is, as defined in W249, "internally consistent and not simply a series of disconnected formal intervention applications." If the team carefully considers the things relevant to the unique individual, they can formulate an active retirement plan which works toward W249's call for "further development and refinement of 'appropriate' skills, including but not limited to leisure and recreation." Additionally, we should be able to track the specific needs or strengths justifying the activity, training or interactions and relate them directly to the strengths, needs and objectives in the individual program plan (active treatment retirement plan). Remember, Assess, plan, Re-assess, plan, re-assess, plan….. The cycle of life is full of transitions.

This may be only a glimpse and the big picture of retirement in ICF/MR facilities still has not come into focus for you yet. Hopefully, with the rising age of individuals we serve and a growing number of gerontologists more light will be shed on and eventually develop this picture for you and we will see successful active treatment/active retirement plans for those individuals who are of age and do express a desire to retire. Joy Alford

Specific additional information about ICF/MR programs can be found at the CMS ICF/MR Home Page: http://cms.hhs.gov/medicaid/icfmr/default.asp. All regulations and manuals are on-line and available on CD's.

Providers: Remember you may contact the Complaint section at ***(800) 624-3004*** *or* ***(919) 855-4500 (* this number replaces 919-733-8499)****. You may also Fax the section at* ***(919) 715-7724.***

We hope that you have found all the information we have provided helpful and educational. The ICF/MR Branch has a common goal with the various ICF/MR facilities in North Carolina to ensure the clients have the best life experience available to them. Questions/comments to michele.brandow@ncmail.net or joyce.cooper@ncmail.net.