Information Memorandum Transmittal
Aging and People with Disabilities

DHS | Oregon Department of Human Services

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Authorized signature

Number: APD-IM-19-039
Issue date: 6/25/2019

Topic: Long Term Care

Due date:

Subject: Communication to Community Based Care Providers Regarding Individually Based Limitations

Applies to (*check all that apply*):

- ☐ All DHS employees
- ☒ Area Agencies on Aging: Types A and B
- ☒ Aging and People with Disabilities
- ☐ Self Sufficiency Programs
- ☐ County DD program managers
- ☐ Support Service Brokerage Directors
- ☐ ODDS Children's Residential Services
- ☐ Child Welfare Programs
- ☐ County Mental Health Directors
- ☐ Health Services
- ☐ Office of Developmental Disabilities Services (ODDS)
- ☐ ODDS Children's Intensive In Home Services
- ☐ Stabilization and Crisis Unit (SACU)
- ☐ Other (*please specify*):

Message: APD providers must begin reviewing and documenting Individually-Based Limitations proposed and agreed to by Community-Based Care consumers or their representatives throughout a 12-month period from July 1, 2019-June 30, 2020.

The attached communication is being provided to all Assistive Living Facilities, Residential Care Facilities, including Memory Care Facilities, and Adult Foster Home providers during the week of June 24th.

If you have any questions about this information, contact:

Contact(s): Bob Weir	
Phone: 971-600-7876	Fax: 503-947-4245
Email: bob.weir@state.or.us	

Date: June 24, 2019

Subject: Home and Community-Based Services (HCBS) Individually-Based Limitations to the Rules (IBL's or Limitations) OAR 411-004-0040 http://www.dhs.state.or.us/policy/spd/rules/411_004.pdf

Dear HCBS Provider,

Starting July 1, 2019, providers will officially begin the process of formally documenting any Limitations needed for health and safety related to the following rights and freedoms**. This is a rolling implementation but must be completed by June 30, 2020. There are different processes for Medicaid and private-pay consumers. Please see more details below.**

As a reminder, the following rights may have an individually based limitation if needed by the consumer to ensure their health and safety:

- Access to food at any time
- Choice of roommate in shared units
- Control own schedule and activities
- Freedom from restraint
- Furnish and decorate bedroom or living unit
- Privacy - Lockable doors
- Visitors at any time

Private Pay Process

At each resident review conducted by the provider, the provider will now formally document any Limitations proposed for the health and safety of residents.

Please complete the attached document when Limitations are proposed and obtain the consent of the individual or their representative along with a witness signature. The witness may not be a staff person of the provider.

Should an individual not have capacity to consent, based on a Physician's written statement, efforts should be made to find a representative. If no representative can be found the provider may continue limits to protect the health and safety of the individual. The inability to consent, the attempt to find a representative, and the necessary documentation supporting the limitation should be noted in the consumer record.

Medicaid

For existing Medicaid Consumers, Case Managers will discuss the need for any Limitations at the annual reassessment. Providers do not need to contact the Case Manager prior to that reassessment for a limitation. If appropriate, any Limitations consented to will be documented on the Medicaid Service Plan by the case manager and documented in the provider's service plan. Following the first review, when a new need for a Limitation is identified, contact the Medicaid Case Manager. When a Medicaid individual cannot consent and there is no representative, one may be appointed.

For new Medicaid consumers, a provider may implement a limitation as described for private pay individuals. The Case Manager will review any limitations that the provider has implemented at the reassessment.

Reminder

All limitations should be formally documented by June 30, 2020. By following a schedule of documenting private-pay individuals at facility care plan review or during the annual reassessment for Medicaid, all Limitations should be documented during this period.

For Adult Foster Home questions, please contact: APD.AFHteam@state.or.us.

For Community-Based Care questions, please contact: CBC.team@state.or.us.

Individual Consent to HCBS Limitation(s)

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Date printed: _____ Individual's birthdate: _____

Individual's name: _____

Provider's name: _____ Private pay? Yes

Provider address: _____

Individually-Based Limitations to the Rules for individuals receiving Home and Community-Based Services (HCBS) in a provider-owned, controlled or operated residential setting:

This form is to be completed when there is an Individually-Based Limitation(s) to the HCBS rule requirements proposed in a provider-owned, controlled or operated residential setting.

Select the appropriate limitation(s) from the list below by providing the requested start and end dates for the limitation(s). These dates cannot exceed one (1) year.

Rights that may be limited	Requested start date	Requested end date
Access to food at any time		
Choice of roommate in shared units		
Control own schedule and activities		
Freedom from restraint		
Furnish and decorate bedroom or living unit		
Privacy — Lockable doors		
Visitors at any time		

1. Describe the Individually-Based Limitation to the Rule. (*Who proposed this limitation? What is it? When is it implemented? How often? By whom? How is the limitation proportional to the risk?, etc.*)

2. Describe the reason/need for the Individually-Based Limitation, including assessment activities conducted to determine the need. (*What health or safety risk is being addressed? Assessment tool, outreach, consultation, etc.*)

3. Describe what positive supports and strategies were tried prior to the decision to implement the Individually-Based Limitation. (*Include documentation of positive interventions used prior to the limitation; documentation of less intrusive methods tried, but which did not work, etc.*)

4. Describe how this Individually-Based Limitation is the most appropriate option and benefits the individual. (*Why/how does implementing the limitation make sense for the individual's personal situation?*)

5. Describe how the effectiveness of the Individually-Based Limitation will be measured. (*Including ongoing assessment and/or data collection and frequency of measurement.*)

6. Describe the plan for monitoring the safety, effectiveness, and continued need for the limitation. (*Who is responsible to monitor? How frequently? How is the ongoing need for continued use of the limitation to be determined? Etc.*)

Decision summary and signature section

Select appropriate limitation(s) below by including start and end dates, as applicable. Indicate whether the individual consents, or does not consent, to the limitation(s). Please request the individual, or legal representative/guardian (*if applicable*), initial each limitation to ensure the individual's wishes are accurately reflected.

I understand I am not required to consent to any proposed limitation(s).

Rights that may be limited	Start date	End date	Consent?	Individual's initials
Access to food at any time			○ Yes ○ No	
Choice of roommate in shared units			○ Yes ○ No	
Control own schedule and activities			○ Yes ○ No	
Freedom from restraint			○ Yes ○ No	
Furnish and decorate bedroom or living unit			○ Yes ○ No	
Privacy — Lockable doors			○ Yes ○ No	
Visitors at any time			○ Yes ○ No	

If the individual does not agree or consent to a limitation, it will not be put in place.

A copy of this document will be provided to the individual.

Individual statement

I have read the above information, or it has been provided to me in a format I can understand. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. Where Individually-Based Limitations were discussed, I was given additional options. It was made clear to me that I do not have to agree or consent to any limitations. I agree to the sharing of this information with my care team, when applicable.

Individual, or legal representative/guardian (*if applicable*), please review that your wishes to consent or **not to** consent are accurately captured in the box you have initialed, above. Then print your name, sign and date below.

_____
Print name

_____ _____
Signature Date signed

Feedback from the individual:

Statement by the person centered service plan coordinator or witness

I have accurately read the information to the above named individual, and to the best of my ability made sure that the individual understands the documented Individually-Based Limitation(s).

I confirm that the individual was given an opportunity to ask questions about the Individually-Based Limitation(s), and all the questions have been answered accurately and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and when consent has been given, it is done freely and voluntarily.

APD/AAA case manager or private-pay witness, please sign and date below:

Print name _____ Phone number _____

Signature _____ Date signed _____

Check the appropriate box for your role:

☐ APD/AAA case manager ☐ Private-pay witness

You can get this document in other languages, large print, braille or a format you prefer. Contact APD Medicaid Services and Supports Team at 503-945-6412 or email hcbs.oregon@dhsoha.state.or.us. We accept all relay calls or you can dial 711.