PERSON-CENTERED CONSUMER HCBS EDUCATION
Q & A SESSIONS

Table of Contents

Question Number	Consumer Related Questions	Consumer Related Answers
C1	How will it be determined that a client is no longer able to make choices?	Our starting position should always be that consumer has the ability to make choices. However, if there are concerns, A doctor or other qualified health care professional (Physician, Physician's Assistant, Nurse Practitioner, Qualified Mental Health Professional, and Psychiatrist) that knows the individual will be required to make this determination after 07/01/18. For now, we need to use our best professional judgement or seek guardianship. Regardless of a determination, we should support consumers' control over their lives to the utmost of their ability.
C2	Who makes the determination that a client representative should start making the decisions, versus the client? Is it the case manager or a medical professional that determines capacity?	We will need a determination from a physician or other qualified medical professional (Physician, Physician's Assistant, Nurse Practitioner, Qualified Mental Health Professional, and Psychiatrist) to make a determination on whether the person can make long-term care decisions. We are not

		asking for a determination on capacity. See above.
C3	If someone is in an AFH that has 3 rooms and a capacity of 5 (so 2 shared rooms), if a person moves out of a shared room, does the consumer still in the room have the right to reject a roommate?	Yes, but only for a valid reason other than they just like having a private room. We should encourage providers to work with the consumer in the shared room to find a process that supports the consumer's right to be involved in the process. See also Prov13
C4	In regards to right to have visitors at any time. What if it is a shared space and one resident wants visitors late and the other resident doesn't like the late night interruptions?	All individuals must exercise their rights responsibly. The exercising of any right cannot harm others. So if it affects another person's ability to sleep, for example, it is not ok. Some things to think about: • Could the visit occur in some other part of the house or setting? • Could the person go to the visitor's home to visit? • Does the person really want a private room or to move to their own apartment and receive in-home services? The care team should work to meet the goals of individual to be able to have the visits in a way that does not impede on the roommate's rights. By agreeing to a shared room, both individuals are agreeing to some level of compromise. If neither are willing to compromise, it is likely that they really want a private room. The choice may be to move or compromise. CMs should facilitate the consumer's finding other service options if the current provider is unable to provide a separate room.
C5	If a consumer is private pay and has a private room, then transitions to Medicaid, do they	Yes, if it was disclosed to them in advance in the written residency agreement.

	have to move rooms even if they don't want to?	
C6	Would the provider purchase the client's personal food using the client's funds? If the client wants the food prepared in the middle of the night, who would prepare it?	The right is for the consumer to have access to his/her own food at any time, not to have the provider drop everything and cook whatever the consumer wants at any time. Providers must provide three meals and two snack periods each day. Consumers are responsible for purchasing their own food outside of these licensing requirements; whether they give money to the provider to get when he/she gets groceries, or whether they go shopping on their own will need to be worked out between the provider and consumer. As far as preparing food in the middle of the night, we should think about how it would be done at home. HCBS is about being as close as possible to "home-like" conditions. If a consumer lived with family and wanted food prepared in the middle of the night, he/she would likely not wake the family to make food. He/she may microwave food or eat something that didn't have to be prepared. While not required, some providers are putting small fridges and/or microwaves in rooms for those residents who want to eat cold/frozen food or food that needs to be microwaved (e.g., popcorn) during the night.
C7	What happens if the client wants a visitor that will affect their own health/safety?	Consumers have the right to have visitors of their own choosing at any time. That said, neither they nor their visitors can break the law. For example, if a person had been a victim of domestic violence in the past, and now wants to visit with their former abuser, they may choose to do that. If, however, there is an

		Order of Protection or Restraining Order, the provider may call the police. The same is true if the visitors are doing/selling drugs, or prostituting – these are illegal and the provider may call the police.
C8	Is it ok for a visitor to climb in a window when visiting the client?	If the visitor enters the ALF/RCF/AFH through a means other than what is normal (e.g., front door), that is not ok. The provider has a right to know who is in their building. Additionally, the provider is responsible for the health/safety of others – so he/she needs to know who is visiting. While having visitors sign-in is considered too institutional, providers can ask that all visitors check-in with the front desk/provider upon entering the building/home.
C9	Most clients will have a choice in who their roommate will be. But if the client lives in a Memory Care Community, how would they indicate they don't want a roommate?	Consumers do not have to sign-off/approve prospective roommates; but they should be included in the process of selecting a roommate. Maybe they meet, or talk, with the prospective roommate before the selection is made. Maybe the provider shares information with each person about the other's interests. For consumers who are in a Memory Care Community, choice of a roommate may be determined through person-centered planning between the Case Manager, the provider, the consumer's family/friends and the consumer, if possible. Even if a consumer has a cognitive impairment , he/she may have ways to communicate through body language, eye movements, and other physical actions (e.g., shoving someone).
C10	If the client has no one on the list of possible representatives, who would qualify as someone they	No, because there is a conflict of interest for any paid provider to be the representative. The consumer can appoint a friend, either

	appoint? Could they use someone who works at the AFL/RCF/AFH?	from their current setting or from the broader community. End-of-life statutes allow for the use of any adult who knows the person and we are mirroring that process as closely as possible for consistency unless there is a conflict of interest. We can encourage consumers to build new relationships and appoint their friend(s).
C11	What if a client wants to have their visitors at any time, but the provider isn't ready to allow it yet?	We need to manage our consumer's expectations. Providers are not required to grant these rights/freedoms in full until 7/1/19, so we need to make sure our consumers understand that. On the other hand, we can talk with providers about trying to allow a right/freedom for the one consumer who requests it.
C12	We have a consumer in an AFH and they do not want a lock on their door because they are fearful, do they have to have a lock even if they don't want one?	Yes; the default is that every bedroom/unit door has a lock. The consumer does not have to use the lock, but they cannot opt to have no lock.
C13	What if the client gets a visitor in the middle of the night? Does the provider have to let them in?	The right to 'visitors at any time' is for the consumer, not the visitor. If the consumer doesn't want visitors after they go to bed, or doesn't want certain visitors (regardless of time), the provider should honor that wish. Providers and consumers should work together for how to handle visitors "at any time." If the consumer knows when the visitor is coming, the consumer could wait at the door and let them in, to ensure no one else is disturbed.
	Provider Related Questions	**Provider Related Answers**
Prov1	Are the facilities going to be trained on the priority list of representatives?	Yes, we want them working to capture the same information for the same reasons.

Prov2	Will the AFH's residency agreement override the consumer's rights? What if the AFH residency agreement says their resident can't paint their room, but the resident decides they would like to?	The agreement can't be tougher than the community standard for renting an apartment. If most apartment rentals in an area wouldn't let you paint, then the provider is within their rights to not allow it. The residency agreement is a contract that the resident signed and agreed to when moving in. The residency agreement cannot limit the rights allowed under CFR. The agreement can be used to define how the rights are exercised.
Prov3	I can hear AFH providers say that they will have to pay someone to be up all night because residents want food heated up, want their laundry done at night, or have friends over, what do we tell the providers?	The care team should work together to help the person achieve the goal of having access to desired foods or visitors as the individual wishes. The team should work creatively to problem solve in a way that meets the individual's goals and does not use additional staffing. For example, the provider may put a dorm fridge and microwave in a resident's room, so the resident can heat up their own food at night without disturbing others. Another example is if a resident wants friends over late at night, they may choose to visit in the resident's room, or in a common room, where the noise will not bother others; the resident can unlock the door when the guests arrive and then lock up when the friends leave, so the provider does not have to wait up. For some circumstances, however, it may be necessary to consider an exception. Additionally, the new rights are not intended to allow consumers to have unreasonable expectations such as full meals at any time or laundry done at night. For consumers who want that flexibility, they may want to choose a different service plan/setting.

Prov4	Do providers get keys? What happens for those with cognition/behaviors of self-harm…. Lock the provider out of their rooms?	Yes, but only appropriate staff may have keys. Locking one's self out of room or forgetting the key in their room and locking him/herself out is not sufficient reason to remove locks. Limiting rights cannot be for the convenience of the provider, there must be a health or safety issue to the consumer or others in the facility.
Prov5	How can the provider charge more if the resident is Medicaid for a shared room if they refuse roommates? Per Medicaid contract it states provider agrees to accept the rate authorized by DHS as payment in full. Provider is not to charge the client additional amounts beyond what DHS determines. If they do can they only charge the PIF or what they would get from another resident and would DHS pay for that?	To avoid some of the issues raised in the question, we are working with the AFH and CBC rules to make it clear that a legitimate reason for move out is violation of the shared room clause of the residency agreement.
Prov6	Will the provider rates change to accommodate the shared versus private room client options?	No; providers can have shared rooms. The shared room model is not prohibited by HCBS rules. The Medicaid system, i.e., the case manager, must offer the option of a private room; which can be an in-home plan or a residential setting that offers private rooms. If individuals know their rights and no one accepts shared rooms the provider world may see that they are no longer marketable and shared rooms will go away over time. However, there is no expectation that providers change their service model.
Prov7	Do these new rules apply to specialized living situations like, Quad, Inc.?	Yes, the HCBS rules apply to Specialized Living.

Prov8	Do we anticipate that we will have more exceptions due to monitoring freedoms? (e.g., have to get up in the middle of the night to: (a) feed someone; or (b) help client get out/back in bed to visit)	While it is possible that we may see an increase in the number of exception requests, it is not an absolute that they will be needed. Providers may naturally overreact as they start to implement the new HCBS rights for their residents. Usually a discussion and creative problem-solving will resolve any issues raised. Again, it is important to remember that the provider does not always have to accommodate requests. The provider cannot put in place any barriers but they do not need to go beyond their service agreement with the consumer to meet requests.
Prov9	Are there rules about how long a visitor can stay? Do providers have to feed visitors who stay for 24-hours or more?	Generally speaking, a visit is less than 24 hours. But we usually know it when we see it. We don't have specific rules about visiting. Sometimes family comes and stays for days or weeks during the consumer's dying process or other special circumstances. Other times family may visit from out-of-town. We usually "know it when we see it." Providers are not required to feed visitors.
Prov10	How do these rights work for out most complex consumer placements? Are there exceptions? For example, a consumer with a TBI with dangerous behaviors. A locked room may place that consumer at greater risk due to caregivers not being able to quickly reach the consumer if self-harming.	Prior to HCBS, Health Systems Division (formerly Addictions and Mental Health) had already had this rule in place; i.e., locks on all bedroom/unit doors. They found that providers get used to unlocking and opening doors. They timed the process and found that providers 'gained muscle memory' for this task that took approximately three seconds to do. If the consumer is self-harming, we will look at them on a case-by-case basis; but we will need to try lesser remedies before we could do an Individually-Based Limitation (starting 7/2018).
Prov11	Isn't that inconsiderate for the other residents if a visitor comes	The provider and consumers should work out a process for how to handle "after-hours"

	and rings the doorbell at 2 am, waking up the other residents? What about the other resident's rights?	visitors. The resident may meet the visitor at the door at an agreed on time to let them in, so no one is woken up. Or the consumer may not even want visitors at that hour, regardless of who it is. Additionally, CMS envisions robust conversations between all residents and the provider in addressing the conflicts between the rights and the realities of living in shared spaces.
Prov12	If a consumer is able to invite anyone they want at any time of the day, how do ALFs, RCFs and especially AFHs keep their other clients safe? Some of these people we place are homeless. Their friends are not always of the best character. How do you prevent an AFH provider from having issues with becoming a flop house?	When we surveyed our consumers at the end of 2014 (approx. 10,000 individuals), about 30% responded. Of those, 96% believed they already had the right to visitors at any time; so we do not anticipate a huge change. Providers do have the responsibility to keep residents safe. They may continue to have guests check in when they arrive, so the provider will know who is in the building/home. While some visitors may be "scary looking," providers cannot limit visitors based on appearance. If the provider believes something illegal is going on in the resident's room, or if the visitor has put the health or safety of residents at risk, they have the right to have the visitor leave and ask that visitor to not come back. Also, residents are responsible for control their guests; if the resident lives on the first floor, the guest would have no reason to be walking through the 3rd floor. In this case, the provider may ask the guest to leave. Finally, we need to manage our consumer's expectations. While they have the right to visitors of their choosing at any time, providers are not required to come into full compliance with this provision until July 1, 2019. We can encourage providers to work with those consumers who really want

		to exercise this right; we can promote compromise and creative strategies during this period of transition.
Prov13	We have providers who are fearful that they will be held accountable for individuals' bad choices. For example: An individual's doctor puts her on a diabetic diet. The provider has been diligent in making sure the meals served meet the prescribed diet. But the individual chooses to eat a pint of ice cream every day, not following the diet. Would this provider get in trouble?	No, a provider will not be held accountable for decisions made by individuals they provide care for, as long as the individual is able to make long-term care decisions and understands the risks involved with making those decisions. For example, residents have always been able to refuse medications; and providers respect that right. Residents have the same right to refuse a doctor's orders about special diets (or whatever the case may be). Today, we will talk to the individual to see if he/she understands the risk involved with their choice (e.g., eating a pint of ice cream every day will make blood sugars increase and could lead to hospitalization, diabetic coma, and other issues). We may talk about alternate options (sugar free ice cream) and discuss adverse outcomes from past choices. If the individual understands the risks, but has made an informed choice to act in a way that could negatively impact their health or safety, we should document that they want to make that choice. In the short term, the education CMs are providing about HCBS rights/freedoms may stimulate a conversation that would not have happened prior to July 1, 2017.
Prov14	What if providers are unwilling to work with individuals' requests to exercise their HCBS rights?	Right now, providers are in a transition period. While they do not have to be in full compliance with all HCBS requirements today, they must be making measurable progress toward it. There are a few providers who say

		they won't come into compliance until the 'drop dead date', because they either do not like the changes, are fearful about the changes, or they may not understand them. Since 2016, we have been educating providers about these rules, and we will continue to do so moving forward. At the same time, we ask CMs to begin educating individuals about their HCBS rights. As the second half of 2017 unfolds, we anticipate that providers and consumers will be discussing HCBS and coming to terms with how consumers can exercise their rights and how providers must adapt. We are also working with Licensors, Surveyors and OAAPI/APS, so we all shift our understanding of access to rights, elements of risk, and accountability together as one organization. If you feel a provider is expressing an absolute unwillingness to make measurable progress please report that to the appropriate SOQ contact or email HCBS.Oregon@state.or.us.
Prov15	How will Licensors and Surveyors track a provider's HCBS compliance?	Licensors and Surveyors are using ASPEN to note compliance, or non-compliance, with HCBS rules, with the exception of Multnomah County AFH Licensors. The Multnomah AFH Licensors are still using the 517E, 517F and 517G forms to track providers' progress on HCBS compliance through Survey Monkey.
Prov16	An issue being raised by providers is the idea of visitors of their own choosing at any time. I have had clients in the past who have called prostitutes to come over. And so providers are wary of this	We meet with a variety of provider groups often, and this question always comes up. In late 2015, we surveyed the people who live in these settings and about a third responded. Of those, 96% believe they can already have visitors whenever they want (even though

	particular freedom and how it will impact the rest of the residents and how it will impact their own families who live in the same home. What is this going to mean in terms of some of our clients have a long history of alcohol and substance abuse, and if we have had to say, "You can't have those visits past 10 PM because of the nature of those visits," because they have been a drunken free-for-all? What if the resident has prostitutes over? What if the visits turn into substance abuse or alcohol-related parties? How do providers keep other residents safe?	visiting hours were still in effect at that time). For the remaining 4%, the provider can have definite protocols around safety and security, like checking-in with the provider if people are going to visit because they need to know who is in their setting at any given time. Prostitution, drugs or anything that is illegal is not ok under HCBS. The provider can call the police for any illegal activity; and the person will suffer the consequences of that criminal behavior, which may include being arrested and ultimately, evicted. The person and their visitors cannot put others at risk; their right to have visitors does not trump the rights of others. It is important to remember that the rights are the consumers, not the visitors. The consumer must also be able to safely manage their rights. From provider questions we have received, we know many feel a loss-of-control around visitors. We try to reassure them that the right to visitors does not mean their lives will be turned over or that their home becomes a flop house. They can use this time to talk with prospective residents during the screening process, like, "We have open visiting hours, but we also have expectations that we have a calm home and a safe environment. You would want to be safe. We want others to be safe." It's not that they can't have visitors; it is more like, "if you are going to have visitors, we expect you not to break the law, to keep your visitors under control while visiting with you." Providers should talk with current residents,

		too. It is the resident who needs to manage their own visitors to ensure everyone is safe. Since we don't have the formal Individually-Based Limitation process in place, the provider still has the authority and ability to limit visitors at this time. Providers may continue to do what they have done in the past. But we want to help them to start allowing/agreeing to reasonable requests from residents. [E.g., Someone has a visitor. If the provider would normally have visitors leave at 7PM, regardless of whether they were in the middle of watching a movie quietly in the resident's room, and it will go to 8PM to finish, could the provider let the movie go until it is over before having the visitor leave?] A resident cannot have a visitor climb in through a window to visit with them and say, "I have a right to visitors"; that's not ok. Visitors need to come through the front door. Also, doors can be locked at night and a process can be developed to for how "after hours" visits can happen. Options might include having the resident wait by the door to let the person in, then locking it behind them; or having the visitor call ahead to let the resident know what time they will arrive; or the visitor could knock on the door or ring the doorbell when they arrive. We want to be reasonable about this. Providers can come up with solutions for how they want to handle these situations.
Prov17	How are we supposed to be reassuring our providers that they	Nobody has the right to harm others. If an individual crosses this line there can be

	are going to be able to feel safe? We are seeing more and more cases that are complex with TBI and those where mental illness is combined with their disability. It is people who cannot live on their own, they have gone through multiple placements. I found a provider who is willing to accept them with an exception due to the behaviors, and now we are essentially giving these clients a green light to continue with some of their behaviors that have gotten them there in the first place.	consequences up to and including move out. With rights also come responsibilities and we are expecting individuals to use these rights responsibly. If the individual is able to make long-term care decisions and understands the risks, they may make choices that put themselves at risk. Past move outs may have been related to a provider's fear of being punished or blamed if any individual under their care experienced harm. This is a big cultural shift for providers and all of us that work in long-term care. These questions and this discussion are so important in adjusting to a new way of thinking. We may not have all the answers, so we will work with providers and case managers. We know there will be some tough cases. Sometimes, it may be that the foster home won't be the proper place for somebody that is going to continually be disruptive or going to have visitors they can't manage or control, unless they are willing to voluntarily abide by some restrictions. The federal regulations dictate that if a person is competent, he/she has to agree/consent to restrictions that are proposed. However, that process of obtaining consent for Limitations doesn't begin until July 1, 2018. More details and trainings will occur before then.
Prov18	We have had similar cases of providers admitting clients from other jurisdictions (DD client, or Mental Health client; in one scenario it was a homeless person), and often times they are	It is totally appropriate for a provider to talk about the characteristics of that home/facility as part of the screening and admission process and discuss the resident agreement. They can also determine that they cannot meet the individual's need. We can encourage

	from out-of-county. There was a very poor pre-admission screening. So, a lot of red flags and now we are getting calls that residents are drinking a lot, loud, having visitors; all that could have been avoided if they did a thorough pre-admission screening and took in residents that were more compatible to their training and their license.	providers to do better screenings but cannot force them to do so.
Prov19	Providers have expressed concerns about the visitor's length of stay.	Visiting does not equal moving into the facility. Providers have asked what a reasonable length of stay is. We don't have any rules about it, but generally we have said that visiting isn't more than 24 hours in a row. It is hard to make rules about it, since we know that they may not always be addressed in the same way; e.g., when someone is in the dying process, families are around them night and day until the person actually passes. But everyone knows that it is truly visiting around an end-of-life – not moving in.
Prov20	What if an individual continually rejects the roommates offered to reside in a shared bedroom/living unit?	The individual may be suggesting, through their behavior, that they may prefer a private room and that option should be discussed during the person-centered planning process, even if that means moving to another care setting. Consumers have the right to be offered a private room but the provider does not need to change their business model to accommodate single rooms. The provider does need to make sure that consumers feel included in the process of deciding who their roommate will be.

		All individuals must meet the terms of their landlord/tenant (residency) agreement. If the individual continually rejects roommates without good cause, this would be a violation of the shared room clause of the landlord/tenant agreement, which would be a reason for involuntary move out. See also C3.
	Staff Related Questions	**Staff Related Answers**
S1	When the local office is unable to resolve the inevitable conflicts that will arise between providers and residents, what steps will the local office take to reach a solution. Will there be a hierarchy of steps to take? Will local licensors take the lead?	The HCBS Policy team meets with the SOQ Policy team, which includes both AFH and CBC Policy folks, weekly. Please raise the conflicts or issues in the weekly field follow-up calls or email Bob Weir, Chris Angel, or the appropriate SOQ mailbox: CBC.Team@state.or.us APD.AFHTeam@state.or.us Providers can also use those email boxes, or they may email: HCBS.Oregon@state.or.us Additionally, the Long Term Care Ombudsman may be an option to resolve some of these concerns.
S2	Will Case Managers be involved in the Limitation process when it is implemented next year?	Yes, Case Managers will be integral in putting Limitations in place, whether it is in a Foster Home or in an RCF/ALF.
S3	We have time before we have to implement this; i.e., we don't have to implement it for everyone starting tomorrow, right?	Yes, first we are doing an educational process this year. Next year we will start the Limitations on a rolling implementation at assessment and reassessment. Over the next year, as Case Managers meet with individuals at intake or their annual review, the Case Manager will go over the two areas discussed at the webinar: (1) Request representative name who the individual would like us to use in the future, if the individual can

		no longer make LTC decisions [SDS 737, revised 7/2017]; and (2) Go over the individual's HCBS rights, freedoms and protections [APD 0556V]. Advocate for the individual with the provider, as appropriate.
	OA System Related Questions	**OA System Related Answers**
OA1	Will OACCESS allow the individual to list their priority for the various reps?	No, but the revised 737 form will allow the individual to list their 1st, 2nd, and 3rd choice.
OA2	Is there a plan to update a drop down list on OACCESS to include definitions of relationships to the consumer?	OACCESS already has a drop down within Contacts called "Relation to Primary App". Each of the relationships around our appointing a representative are listed there with the exception of Guardian/Legal Rep – which is found under the "Contact's Rolls" drop down.
OA3	'Natural Supports' are used as part of the care plan. Could be confusing to use the same designation as client representative. Would it make sense to use a different role such as 'alternative contact'?	We are open to feedback in this area. If we can reach consensus on an already available role that can be agreed upon for the list of potential representatives we are open to changing direction. However, we need to be aware APD's access to programing changes will be extremely limited for the foreseeable future.
OA4	If OACCESS will not allow multiple reps., how to have the 231 info and the decision maker information on the record?	OACCESS allows for multiple contacts. When assigning the following roles in OACCESS, it is critical that we have just one person assigned to each role at this time, so there is no confusion about who is responsible for that role: **Client Representative**: There should be only one listed. To be added to the revised version of the 737; **Authorized Representative**: This role is taken from the 231, and is specific to applying for benefits and renewal;

		Consumer Employer Representative: This role is assigned via the revised version of the 737, as well. It is specific to choosing someone (either the individual or someone else) to perform Employer Responsibilities
OA5	Will OACCESS have a drop down for the Employer Rep.?	Yes, it will be called "**Consumer Employer Representative**."
OA6	There are likely to be client reps already listed in OA for some consumers. Will there be some sort of mass change to deal with that?	As we talk to consumers over the next year at their annual reassessments, we can confirm who they want as their Client Representative. We can update OACCESS at that time. There is no need to search them out and change them at one time.
OA7	Why does the 737 list three choices for Client Rep when we are only supposed to add one to the Contacts Tab in OACCESS?	See answer for F13.
	Policy Related Questions	**Policy Related Answers**
Pol1	Will this affect how abuse is tracked?	No, the way we track abuse should not change.
Pol2	This information is gathered on all individuals applying for service benefits, not just the ones with cognition issues, correct?	That is correct. It is important that we gather the "Client Representative" information while individuals are competent, for use at a future time when they may not be able to make long-term care decisions without support.
Pol3	So is a process being developed for making decisions for or placing restrictions on a consumer who is not able to consent and is a safety risk to themselves or others? I read the process draft and it mentions that a provider could restrict a person's rights for up to 30 days pending a medical professional's opinion/ determination. How are	It is important to note that the process is draft at this point. However, in discussions with stakeholders (including consumer-advocate attorneys from Disability Rights Oregon, Legal Aid Services of Oregon, the Oregon Law Center and the Long-Term Care Ombudsman) it is generally agreed that there needs to be some emergency process to protect individuals. We don't want a provider to let someone just wander out the door and get lost, or walk into traffic and say, "But we do not have the ability

	sidestepping the 14th amendment due process to deny other constitutionally protects rights/civil rights without due process being afforded to the person?	to stop the person." Providers have been making these very decisions for a long time, so limiting their time frame to a 30 day emergency period would be moving in the right direction.
Pol4	Can we give this information to hospitals and other social workers who help place consumers? So everyone is on the same page when it comes to finding placement?	You may let them know about the contacts we want to identify and hopefully they can be a help.
Pol5	Do consumers pay half the room and board if they share a room?	No, there are no changes in this area; consumers sign an agreement to pay full room and board for their room (shared or private)
Pol6	What happens if one person wants a lock on the door but their roommate doesn't?	Having the lock is the default; the lock must be in place. Neither person needs to lock the door. Or, either person may lock it. This is something that has to be worked out between the roommates.
Pol7	How would CMs pay for locks for clients who would like one but do not want to use their own money to purchase it?	The lock is the provider's responsibility to have in place. No resident should be charged for the lock. No Case Manager should purchase the lock. Please notify CO if you are asked to do so.
Pol8	Compliance on person-centered plans, hearable for APD or issues will be sent to licensing? Can the consumer file for a hearing? When is this effective? Plans developed after July 2018?	All of the HCBS expectations will be part of a provider's responsibility and regulated like any other licensing violation. The consumer will not be able to file for a hearing but they may complain that the rules are not being followed. Anyone can complain at any time and the complaint will be investigated. Current rules say that the individual preferences of the consumer are taken into account when developing the service plan so some of this is current expectation. We are working on an

		appeal process when appointed decision makers are used. Talk to aps supervisors. Do not flash a solution they were not part of (we are working on solution)
Pol9	How is the CBC related email different than the office of licensing for complaints related to care?	The CBC email is for general HCBS questions, not complaints. It was developed by the SOQ CBC Policy Team specifically for answering questions about the HCBS transition. It is monitored by Policy staff not complaint investigators. During the transition period, we are generally working with providers and giving technical assistance rather than investigating wrongdoing. We recognize that non–compliance with HCBS rules can also rise to the level of abuse. For example, not feeding someone violates the right to access to food at any time - but it is also abuse. Abuse needs to be reported through normal processes whether or not it is HCBS-related.
Pol10	What does "New Policy – Get as many people as possible" mean (on PowerPoint, slide 7)?	We used to get one or two contacts for the consumer. Now we should get contact information for as many people as possible (from the list of prospective Client Representatives (see slide 7), to ensure we have people to contact if the consumer becomes unable to make LTC decisions in the future. Since people move, die, etc., we should attempt to get as many contacts as possible while the consumer can help us with that process.
Pol11	Do these rules apply the same to PACE-funded settings?	Yes. The application of these rules to private-pay is an Oregon decision, not mandated by CMS. These rules apply to all provider-owned, controlled or operated, licensed settings, regardless of who is funding the service. The rules apply to Medicaid and private-pay.

Pol12	Will minutes or notes be captured on all Q&A calls, then distributed?	We will record the Q&A Call-ins, and add any new questions to this Q&A document, that will be posted in CM Tools section, online.
Pol13	Can an ALF resident have lunch with a Memory Care resident in the Memory Care facility?	If the ALF and Memory Care facility are in close proximity, the ALF resident may visit the Memory Care resident as long as there is supervision for the ALF resident. Both have the right to visitors of their own choosing; but the ALF visitor must stay impair the facilities ability to meet the MCC resident's needs and service plan. The facility has a responsibility to ensure the interaction is within the parameters needed for people with dementia. E.g., The facility should work with the ALF resident who is the husband of the MCC resident and so he does not try to help transfer her.
Pol14	Re: private room – client resides in a memory care and it is the client's family that is insisting on having a private room but the client is currently doing well with a shared room. Would they still be supported even though the client is not aware and it does not affect the care that is being provided?	We could look at moving the consumer, but some questions should be considered, such as: • Would the consumer stay in the same facility, or is the private room only available at a different location? • Why are they wanting their family member in a private room? • Have we discussed 'transfer trauma' with the family? • What does the Client Representative want to do?
Pol15	A consumer with quadriplegia has an accordion door and cannot physically unlock the door. Does he have to have a lock on the door?	The default is that the lock must be in place; it can be an automated lock. The consumer does not have to use the lock, if they don't want to. But we need to ensure providers do not (un)intentionally coerce consumers; e.g., "Nobody else has locks on their doors; you don't want a lock, do you?" Additionally, in the example provided, the doorway needs to

		be reviewed to ensure that it meets licensing requirements.
Pol16	The rule states that 'each individual has the freedom and support to have access to food at any time' not access to their own food. We were told during that community meeting that providers do have to make some kind of snack available to residents at all times.	The federal regulations and our Oregon Administrative Rules are specific to a consumer's ability to access their own food at any time, not a provider's food. Regarding food, providers are responsible for three meals and two snack periods; while consumers may access their own food at any time.
Pol17	Are there going to be concessions for folks with dementia who may lock themselves in their rooms? This seems like a safety concern.	Having a lock on the door is a default. The functionality of these locks are such that a person cannot enter the room (if the door is locked) without a key; the resident and qualified staff will have keys. The door automatically unlocks when you turn the handle from the inside of the room, so there is no safety concern – the individual cannot get locked in his/her room. Again, qualified staff will have keys and can enter. Qualified staff means those staff who have a business reason to enter the room (e.g., RN, CNA would be appropriate; the dishwasher from the facility's kitchen would not be appropriate).
	Guardian/Rep. Related Questions	**Guardian/Rep. Related Answers**
GR1	What about APS cases that we cannot find anyone? We seem to get about 5-10 a year that I know about. I can't imagine that APD can fund several guardians.	APS being involved puts it under the DHS umbrella. We are not implementing a process to appoint guardians for these individuals. When the individual has never appointed a representative and can no longer do so and does not have a guardian, we will be using the authority we already have in Oregon Administrative Rule to appoint a representative for the individual.

GR2	What if the person cannot assign a guardian? For example: Consumer is in memory care. Has never had a rep. Now that the consumer is not able to make that decision; to assign someone to represent them. What do we do?	When the individual has never appointed a representative and can no longer do so and does not have a guardian, we will be using the authority APD already has in Oregon Administrative Rule to appoint a representative for the individual. If this example/question means there is nobody on the list of people we would normally contact, then APD will contract with an entity that we will appoint to provide decision making support for the individual. This would be less restrictive than guardianship and presumably less costly. Or, we may need to pursue guardianship.
GR3	Where do we find these appointed reps?	We start with the priority list and use the ones that exist, if any. If there are none, we will use a contracted entity. If we cannot use that, we may pursue guardianship.
GR4	What if the person they want to appoint as their rep. is their HCW or an employee of a facility where the consumer lives?	This is not allowed, as there is a conflict of interest. Paid providers cannot be used as the Client Representative.
GR5	Is there only one rep. allowed at a time?	A person can have different representatives for different roles, but for the following roles we need one person so there is no confusion: **Authorized Representative, Client Representative, and Consumer Employer Representative.**
GR6	Will the appointed rep. be able to manage funds? Payments to facility? Bank account issues?	We are unsure of the answers to these questions at this time. We will provide additional training on these issues as final decisions are made.
GR7	What type of screening, if any will the Department be responsible to conduct when appointing someone to be a rep? Background	Q1. Screening needs to be determined; these decisions have not been finalized. Q2.There should not be multiple representatives designated by the individual,

	checks, etc. What happens when multiple reps do not agree on how to proceed?	to avoid this very issue. If we are using the priority list when children or siblings are involved the majority opinion is followed. If there is no majority (e.g., there are 2 children, or 4 siblings and the opinion is evenly split, then they will need to come to consensus. Remember, not making a decision is a decision.
GR8	Will we be asking the rep. if they are willing to participate? They may not want to be appointed as a rep.	Yes, they must be willing to act as the representative.
GR9	What is the difference between a client rep. and an authorized rep?	**Client Representative** is for making long-term care decisions if the individual cannot. They also may be the person that is involved day to day to make decisions. The **Authorized Representative** is for the roles on 231 form (application, renewal, etc.). They can be the same person or different people.
GR10	How do we explain to potential reps. what kind of responsibility they will have and the liability involved? They may choose not to be a rep. according to what 'making decisions' really means.	We explain that their relative or friend needs help with decision making and ask if they would be willing to help. We can provide examples of the types of decisions we would be asking them to make. If they are not willing we will move to the next person on the priority list. The representative has similar liability to family members making decisions or guardians. As long as they act in the best interest of the individual their liability should be limited.
GR11	If a person has a substantiated APS, can they still be a rep. for a consumer?	We do not know at this time what screening will occur.
GR12	If we can't find a rep., someone in Salem will, correct? How do we	If there is no representative, there will be Central Office assistance around "next steps." We may use a contracted entity to act as the

	notify that person that a rep. is needed?	person's representative. A transmittal will soon be published that explains these steps and who to contact. However, it is our hope that the appointment will be done at the Case Manager level. We will likely have another webinar when the process is ready to use, with the details for each of the following steps: (a) Talk to a licensed medical professional about whether the consumer is able to make LTC decisions for him/herself; (b) Contact the Client Rep, if one is designated; (c) Go down the list of people who we would contact; (d) If no one is found, appoint representative (detail to be provided later).
GR13	Can a rep. be appointed without going through the court system?	Yes; see OAR 461-115-0090(3).
GR14	Are we still going to be using 'Emergency Contact' and if so, how are we using it?	Emergency Contact may still be used. We will try to define the roles better for future trainings and consistency. For example, the Emergency Representative may live locally and be better able to respond to day-to-day issues, while the Client Representative may live out of state but can still be contacted for critical long-term care decisions.
GR15	What happens if the person selected as the rep. declines?	We won't use them. The Client Representative must be willing to act in this capacity.
GR16	What if the HCW is the only person that speaks their language, can they be a rep. then?	No, the **Client Representative <u>CANNOT</u> be a paid provider for the individual. The Consumer Employer Representative** cannot be the Homecare Worker and provide paid Medicaid services to the individual.
GR17	Will the state appoint a rep. for someone applying for services, but doesn't have capacity to apply	Yes.

	or designate someone to speak on their behalf?	
GR18	I have heard that AFH owners can be designated on the 231 as an Authorized Rep. is this true?	No, for the APD program, AFH owners should not be designated on the 231 as an Authorized Representative as it is a conflict of interest.
GR19	What happens if we work down the list of reps and multiple family members argue over what is best for the consumer and the consumer did not appoint a priority of reps?	Then we will use the priority order outlined in the presentation. This is why it is so important to get the persons wishes while we have that opportunity.
GR20	Does the consumer get the change who their rep. is or the order or reps; like person in slot one overrules person in slot two?	Yes, the consumer can change who their Representative(s) is, and the order of who is their first, second and third choice representatives are at any time, until it is determined by a physician or qualified medical professional (Physician, Physician's Assistant, Nurse Practitioner, Qualified Mental Health Professional, and Psychiatrist) that they are no longer able to make long-term care decisions.
GR21	Does the designated reps. ability to make choices for another person need to be proven?	Consult with your local manager and Central Office if you believe a representative may not be capable.
GR22	Can the Client Representative and the Consumer Employer Representative be the same person?	Yes; but the consumer cannot appoint a paid provider as the Client Representative or Consumer Employer Representative, as that would be a conflict of interest.
GR23	What Rules prohibit a paid provider to act as a client's representative(s)?	OAR 411-030-0040(8), 411-030-0100(6) and 461-115-0090(2) There are also CFRs that prohibit paid providers from being a representative.
GR24	How will Client Representative information be gathered for private-pay consumers?	We are asking providers to ask for and track this information. We are working on the solution for private pay and do not have the specific answers at this time.

GR25	Does the resident have to authorize their designated representative in writing?	Yes, we need to get the consumer's choice of Client Representative in writing. If we don't capture it in writing, we'll need to narrate it. If it is in writing, we can store the request electronically (or however each office stores these types of documents). The Client Representative and the Consumer Employer Representative will be captured on the revised 737. The Authorized Representative and the Alternate Payee will still be captured on the 231.
GR26	If the individual does not have cognition, they couldn't sign the 737, right?	Correct, if there is no Client Representative already designated, we would have to move to appoint a representative for them using the list of people.
GR27	When I worked in a NF, it was a conflict of interest for the person to use another resident, or that other resident's family, as a representative. Is that true here? Do you mean NF or CBRF?	In Community-Based Care settings, consumers may select whomever they want to represent them, with the exceptions of paid providers (for whom there is a conflict of interest) and persons who have no longer have cognitive ability.
GR28	What if the consumer wants a client rep? Is a doctor/medical professional still required to authorize it?	No. If a consumer wants to have someone (e.g., adult daughter) represent them and make LTC decisions for them now, while the consumer does not have any cognitive issues, they can do that. We just want to be sure to also include the consumer in decisions.
GR29	What is stopping a consumer from picking another consumer to be the appointed rep? Example two memory care consumers choose each other to be the others rep. No other family or friends available.	The consumer should pick a Client Representative who does not have cognitive issues that would prevent the chosen individual from acting as the representative. We are trying to obtain names of family and friends from consumers prior to their developing cognitive issues. Nothing prevents consumers (e.g., friends who live at the same ALF) from choosing each other as Client

		Representatives, so long as both have the cognitive ability to carry out those responsibilities.
GR30	If you have a client rep, can you also be a client rep? For example, roommates in a facility.	Yes, as long as both individuals have the cognitive ability to act as such, they may choose each other to be their Client Representative. However, the Client Representative role is to make decisions about whether or not a consumer's HCBS rights should be limited. Unless the consumer desires it to be different, the Client Representative will only be involved if/when the consumer no longer has the ability to make LTC decisions for him/herself. Once that happens, the one who lost his/her cognitive ability cannot act as the Client Representative for his/her roommate.
GR31	How does HIPPA affect this assignation of client rep.?	The role of the Client Representatives will be to decide whether or not an Individually-Based Limitation to the consumer's HCBS rights should be allowed. There are seven areas where a Limitation may be considered (*refer to* Person-Centered Consumer HCBS Education & Gathering Representative Names June 2017 presentation, slide 14). HIPAA does not apply to a Client Representative's role. (See OAR 411-005-0010 – 411-005-0045)
	Form Related Questions	**Form Related Answers**
F1	Is the language on the 231 changing?	No.
F2	Do you have to get a new 737 if a rep's address changes?	The form should be updated annually, so it would capture changes, including who the Client Representative is, representative address changes, etc. An updated form would only be needed if changes are being made.
F3	Why not use the 231 instead of the 737 since the 231 is already	The 231 has a broader use for the purpose of application and renewal, and other program

	formatted to address representation?	areas besides APD (e.g., SNAP). It is 'owned' by both OHA and DHS. Since the 737 is an APD form and was already being amended to allow for designation of a Consumer Employer Representative, and because DM/PMs requested we limit the number of forms, it seemed the best decision to include the designation of Client Representative on the 737.
F4	Will the 737 be modified?	Yes, the intent is to have the form work for identifying the Client Representative (the one that would make decisions if person is not able) and the Consumer Employer Representative (the one that takes on employer responsibilities).
F5	Will a brochure or publication be developed to help Case Managers explain the HCBS rights, and help consumers to understand them?	Yes, we have created a visual fact sheet (APD 0556V) that was included with the training materials. It is currently posted on the CM Tools website and APD's HCBS website. We have printed flyers that will be sent to each APD/AAA office, to be given to consumers at their annual redetermination meetings.
F6	Will the 737 apply to in-home and community-based settings? Will it be confusing, since it is currently used for CEP?	The revised 737 will apply to in-home and community-based settings. We will gather Client Representative information even if the consumer is currently receiving in-home services because he/she may lose ability(ies) in the future and may move to a community-based setting. The Consumer Employer Representative section will only be used for consumers receiving in-home services. We believe the revised 737 will be easy to understand.
F7	Will there be a form for the client or client rep to sign when they	The revised 737 will be used by the consumer to designate their choice of Client Representative. There is no form, however, for

	take on that title? How does this differ from an Authorized Rep?	the Client Representative to sign "agreeing to" take on this role. The Consumer Employer Representative will need to sign the revised 737 in order to consent to taking on the responsibilities of that role. The Authorized Representative and the Alternate Payee must sign the 231, consenting to taking on the responsibilities of those roles.
F8	If the person doesn't have cognitive ability to make this decision then we wouldn't have them sign a form, correct?	Correct; the consumer would not be able to designate a Client Representative and sign the revised 737 if he/she does not have the cognitive ability to make this decision.
F9	If an individual needs to have an Individually-Based Limitation, how should the provider document it and how do we document it on the 517? [*AFH Licensing form*]	The timeline for implementing Individually-Based Limitations has been delayed until July 1, 2018. During this time, providers will continue taking the same steps they now take to keep residents safe. In the spring of 2018, we will begin training APD/AAA Case Managers, Licensors, Surveyors and HCBS Providers about the Individually-Based Limitations process and how to complete the form(s).
F10	Will an HCBS Freedoms variance form be published this month?	There is no HCBS variance form. The HCBS Individually-Based Limitations form (APD 0556) will be used beginning July 1, 2018. A provider cannot limit all individuals in their facility, which is why there will not be a variance. Each consumer must be assessed and have a person centered service plan. Other options must be explored and tried before a limitation can be imposed. Only after other interventions have failed may that specific individual have a limitation applied.
F11	Can a client's HCW be their Client Representative or their Consumer	No, a Homecare Worker (HCW) can NEVER be the consumer's Client Representative or

	Employer Representative (on new SDS 737)? ***NEW DIRECTION AS OF 10/2017:*** *We previously said the individual could choose whomever they wanted, and we'd double check to ensure that person wasn't a paid caregiver at the time we needed help with making LTC decisions. This has changed; the individual cannot designate a person who is currently their paid provider to be their Client Rep or Consumer Employer Rep.*	Consumer Employer Representative due to conflict of interest. Both are designated using the SDS 737 form (revised 7/2017). If their current Client Representative becomes a paid caregiver (e.g., daughter was the Client Rep but is now going to be the HCW), the individual will need to complete a new SDS 737, designating someone else (who is not a paid provider) to be their new Client Representative (i.e., the daughter cannot be the Client Rep anymore).
F12	Does designating a Client Representative work differently when the client lives at home?	No, we still need to request the client designate Client Representatives via the SDS 737 (revised 7/2017), even if he/she is receiving in-home services, since the consumer's service needs and/or cognition may change at any time.
F13	Why does the 737 list three choices for Client Rep when we are only supposed to add one to the Contacts Tab in OACCESS?	Because people move, die, fall in/out of favor, we want the consumer to provide us with as many possible names Client Representatives as they can. Without a designated Client Representative, the State, the courts or a contracted agency, will appoint a representative on their behalf if one is needed (beginning July 1, 2018). OACCESS currently has the capability to list one Client Representative; that will be the consumer's "First Choice". The second and third choices will be noted in the case record (either by EDMS or in narrative), following your office's policy.

F14	How often do we go over the Client Rep designation form with clients?	We will review the SDS 737 (revised 7/2017) with the consumer at each redetermination. The consumer is not required to designate anyone. However, we will still need to explain that if they fail to designate someone, we will appoint one (if needed), starting July 1, 2018. At each review, we will also share the order we will use when appointing a representative, as listed on the SDS 737 (revised 7/2017).
F15	Why does the 737 list three choices for Client Rep when we are only supposed to add one to the Contacts Tab in OACCESS?	Because people move, die, fall in/out of favor, we want the consumer to provide us with as many possible names Client Representatives as they can. Without a designated Client Representative, the State, or a contracted agency, will appoint a representative on their behalf if one is needed (beginning July 1, 2018). OACCESS currently has the capability to list one Client Representative; that will be the consumer's "First Choice". The second and third choices will be noted in the case record (either by EDMS or in narrative), following your office's policy.