COLORADO
Department of Health Care Policy & Financing

Transcript of January 17, 2019 Rights Modifications Training Webinar

Background

On January 15, 17, and 22, 2019, the Department provided trainings to clarify the process for implementing rights modifications under the HCBS Settings Final Rule. The trainings were similar to each other and covered:

- Individual rights under the HCBS Settings Final Rule;
- The rights modification process, including the federal criteria that must be documented, obtaining the individual's informed consent, and who does what;
- Common "what if" scenarios; and
- Updated deadlines for providers and case management agencies.

During each training, the Department and staff with the Colorado Department of Public Health & Environment (CDPHE) also responded to questions from participants.

The following transcript was prepared by Caption Colorado staff during the January 17, 2019 webinar. Department staff have corrected some typos and made some edits for clarity but cannot guarantee that the transcript is fully complete or accurate. The transcript may not accurately represent what was said but rather what the Caption Colorado staff member heard through audio portion of the webinar.

Transcript

Good afternoon everybody this is Michele Craig thank you for joining us today for the rights modification training.

And before we launch I want to go over a few housekeeping items. Due to the large number of participants all participants will be on mute and without the ability to unmute yourself. We invite you to share your comments and questions in the chat box. Slides and associated materials and referenced like rules and frequently asked questions documents are available for you to download on the webinar screen in the file panel which should show at the bottom of your screen. I'm joined in this presentation today by a few of my colleagues here at HCPF and the Colorado Department of Public Health and Environment, and we will be presenting the information. As we switch to new presenters, we will introduce ourselves and our roles. We are also going to try to be really good about our use of acronyms because the training today is available to service

providers and case managers with a single-entry point and with the community centered boards and we all have our different acronyms so we will try to be really careful about that. If you catch an acronym that you don't know feel free to put that in the chat box. So are there questions or comments in general before moving on?

As I mentioned earlier I'm Michele Craig with the Department of Health Care Policy and Financing, and I will be doing the introductory part of the presentation and just so you know I am the unit supervisor here for the complex needs program development and evaluation unit. The mission for the Department of Health Care Policy and Financing is improving healthcare access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. The training on rights modifications today fits in this mission to include outcomes so people can lead the lives they want to in dignity, respect, and choice. In our statute we have this statement and its essentially the right to humane treatment. Every person has the right to humane treatment. It is the responsibility of all service agencies and community centered boards to prohibit mistreatment, exploitation, neglect or abuse in any form. Sometimes we focus heavily on the regulatory requirements when it comes to rights modifications and we kind of miss a crucial piece that every person has the right to humane treatment. This means that our first consideration when it comes to modifications should not be compliance but the person. This is a quote by Nelson Mandela that I think is very applicable. To deny people their human rights is to challenge the very humanity. I find this quote particularly impactful in our discussion of rights modifications. Dignity and respect should not be denied to a person just because they have a disability and there is a reason for rights modification. Modifying the rights of another human being is a matter to be taken very seriously and to be well thought through with all alternatives being explored before arriving at the decision to modify a person's rights.

The purpose of our training today is to provide information for case management agencies (CMAs), that includes, as I mentioned earlier, community centered boards (CCBs) and single entry points (SEPs), as well as all of our provider agencies, so home- and community-based services (HCBS) provider agencies, on the use of rights modifications when all options for less restrictive interventions have been tried without success to support an individual's health and safety needs and/or the health and safety needs of the community. I want to emphasize that this training applies to all of our home and community-based services waivers.

Topics for today. We set this presentation out in four sections and as we go through each section the presenter is going to present the information and then we will pause for questions before moving onto the next section. So the first section is going to be individual rights under the home and community-based services settings final rule. The second section is going to be about rights modifications, particularly what those requirements are and collecting the informed consent, as well as the roles of the service agency and the case manager in collecting the informed consent. Then we will have a section for what if. We did a rights modification training back in June of 2018 and then through various work on the settings rule, we always got a lot of questions as we present this information, people have questions about their own work, they say what

about this, what about this person, and while those are great questions we want to answer and work through together we are going to address those in the what if section. So if those are coming up feel free to put them in the chat box or jot them down and we will address them when we get to the what if section. The final section is about deadlines. With the deadlines the other question that comes up in these trainings is when does all of this go into effect and when do we have to start getting informed consent. We are going to address that in this section. If you'll bear with us as we get through the requirements and everything else, we will talk to you about that at the very end and when everything needs to be in place. So I don't see other questions or comments on the introductory section so I will turn it up to my colleague, Leah Pogoriler, to discuss individual rights under the home and community-based settings final rule.

Good afternoon everybody, this is Leah, what I'm going to do for this first section of the presentation is just describe the rights of the federal rule protects for everyone who is receiving home and community-based services. And this is probably a little bit of a 101 session and you may be familiar with this already as you've read guidance and prior issuances and attended prior trainings. But we're just going to set them up and lay them out here so that when we do get to modifications, we understand what rights are being modified, or what rights are protected and when you do modify them, there's a special procedure for doing that.

The rule that we are talking about was issued by the federal Centers for Medicare and Medicaid services which is called CMS. That rule came out in 2014 and when it originally came out states were given a five-year period to transition into full statewide compliance. When the new administration was elected, they realized that the states needed more time so they extended that by a few years and right now we have taken as a state, two extra years. We're in the process right now of getting all the providers and all the case management agencies into compliance and helping on a very one-on-one basis working with the Colorado Department of Public Health and Environment (CDPHE) to help everybody understand what changes need to be made. So the theme of the rule or the piece that we are talking about today, it's a pretty big rule, the piece we're talking about is setting out criteria for all the settings, in other words all the physical locations where people live or receive home and community-based services which is all the services provided under our waivers. And the theme of the rule is really making sure that if a service is home and community-based, that the setting is in fact homelike if it is a home, and whether it's a day setting or residential setting, that it's really integrated into the community and not institutional. There are separate services that are institutional but we are not talking about those today. So the rights are listed on the following slides, and this is just a paraphrase of the rule, the rule provides more detail, and if you take a look at the FAQs we get into the detail of what this really means and how you implement it.

Just to summarize the first right is that the setting or the location is integrated and supports people in having full access to the greater community. The second is that the setting is selected by that individual from among the various options that are presented

to them, so they have an informed choice, and the options include non-disability specific settings and the options include if you're talking about a residential setting, they have a choice for private unit. So what that means for you as a provider is set out in those FAQs. Some of this work is for the state to do making sure those options are available statewide. So another right that everybody has wherever they're living or receiving HCBS is that they have the right to privacy, dignity, respect, and freedom from coercion and restraint. That's a basic element that we would all want for ourselves, of course. Then people have the right for their settings to help them optimize their own initiative, autonomy, and independence. The setting needs to facilitate their individual choice regarding services and supports and who provides them.

The rule also has some sections that specifically provide what are called the additional conditions and we will go through those in a moment. The first one is that if it's a residential setting the person has the right to have a lease that gives them the same responsibilities and protections from eviction the same as other tenants in that area would have, in that city, county, state. Or they have some kind of written residential agreement that gives them comparable protection. The theme is making sure there's stability in where they live just like anybody who rents an apartment they don't get moved around willy-nilly. Some other additional conditions are that people have privacy in their units, that's their bedrooms or apartments or whatever it may be, and that includes that they can lock their doors and have some privacy that way. Only certain designated staff that have been agreed to have a way to open their doors. If they have a roommate they get to choose who the roommate is. And they can furnish and decorate that unit just like anybody else could with their apartment. And another additional right is that people have the right to have freedom and support to control their own schedules and activities. And they can access food at any time. We know there are a lot of questions about access to food and we will get into that quite a bit in the FAQs about how that should work.

Another right is that people can have visitors of their choosing at any time and we understand that to mean that people can talk to their friends or family, it's in person or by phone or whatever their chosen mode might be. And lastly the setting has to be physically accessible. For these additional rights that we have just looked at on the last few slides, when the rule was originally published it seemed that those rights were provider owned or residential setting. An example would be an ACF or group home. What happened is that it later became clear that in CMS's view some of these additional rights are a part of the basic rights on the earlier slides that apply to all settings. So just an example of having access to food or talking to your friends and having visitors that's really relevant to whether people can engage in community life to the same degree as individuals not receiving HCBS. It's relevant to whether people can exercise individual initiative and autonomy and independence which are the basic rights apply everywhere. So these additional requirements in practice apply even to day settings and other settings that are not residential, except for that requirement of the lease or other residential agreement and privacy in the person's unit that only makes sense in the content of a residential setting.

So on this slide we provided some more information about all the information we covered here. You can download these slides and get the links. The first is we wanted to draw your attention to the website we have about all our work to implement this rule. The Statewide Transition Plan, it's a little out of date now, but it gives you a sense of where we are headed and what needs to be done. The Systemic Assessment Crosswalk, that's a document that lays out any area where our state statutes, regs, rules, waivers, need any changes to those authorities to bring the state into compliance. That's a roadmap of changes to come, we haven't made those changes yet but when we do that process will go through stakeholder engagement and public comment. We wanted to preview the areas where we think there will be some changes. And this last bullet point we sent them around before this presentation but in case you missed these links. We got a lot of questions from providers. The FAQs are our attempt to answer the real-life questions we got from providers and case managers and other stakeholders, advocates, so please be sure to take a look at these to understand how the rule needs to work in real life.

We have one question so far in the chat panel. Does this apply to sex offender settings? If the person is receiving, if it's a setting where anybody receives home- and community-based services, then yes. The rule does apply. I think we have some slides later where we will talk about the situation. Some common what-ifs that come up, in the case of a person with a history of sexual behaviors.

Moving on to the next section. We set the table to discuss the rights that people have under this rule. Now we will talk about how the rights can be modified if needed. To be sure we're all talking about the same thing in terms of what a rights modification is. It's any limitation or restriction to the rights that people have under the rule, that we just went over. We tried to provide a picture to show what that means compared to older concepts that we have been using and it's a pretty big circle. Anything for folks in the waivers serving people with intellectual and developmental disabilities, you may be familiar with rights suspensions and restrictive procedures which are in the little blue circles there. Those are all encompassed in the bigger circle. We also wanted to make sure, just clarifying what that means. The distinction between those two used to be the motivation for the mod--.

This is Michele. The rights suspensions and restrictive procedures are language specific to three of our waivers, developmental disabilities (DD), supported living services (SLS), and children's extensive supports (CES). The reason you would use that. Rights suspensions were for health and safety needs only and required notice. Restrictive procedures were used for a method to modify a person's behavior did require informed consent. So what we are saying now is regardless of whether it's a rights suspension or restrictive procedure, it requires informed consent so agencies have to ensure that informed consent is obtained. And I'd also like to point out, make sure that the rules for restrictive procedures and modifications have additional requirements about documentation and some things that are slightly different. So make sure you follow the rules for both of those and then over the next two years we will be working to align the rules as well.

[Leah] So right now we are in a state where the old rules fully apply, and the federal rules also apply, so it's a bit of extra rigmarole, and we do appreciate that and we are thinking about ways to streamline all this so it's easier to implement. So before we move on from those, under the waivers that Michele was talking about, in some cases there was an approach where depending on the reason or the circumstances that restrictions weren't treated as either of these concepts and it was just handled informally. But now whether it was handled informally in the past or not, if it's a restriction of the individual rights that we went over we do need to go through the process that will discuss later today. So even if there is a good reason for it that needs to be documented and we will get to some of those examples coming up. If there isn't a good reason then it of course may not be implemented. Even if the person consents. The consent needs to be documented and if they don't then it cannot be implemented. So just as a common question that comes up. We aren't saying that just providing services and supports in itself is a rights modification. Even if a person's support includes one-on-one support. That is not necessarily modification. It would become a rights modification when that person expresses disagreement, they say leave me alone, I want to be alone in the bathroom, whatever it may be, if it's imposed on them that is a modification. So Michele pointed out that under the current rule the right suspensions just required notice and now they require informed consent as well.

Another example of things that used to be handled informally in that bottom blue circle. A lot of house rules. And that is for any provider type, ACF, group home, host home, a lot of house rules in practice do restrict everybody's rights. That will no longer be acceptable under the federal rule and we will explain what common changes need to be made and Barb will provide some examples on that. And one last question we want to hit before moving on from this slide. The federal rule that we are talking about doesn't change the scope of what has to be reviewed by human rights committees. Those are sometimes called HRCs and they are used under the waivers for people who have intellectual and developmental disabilities. If it needed to go before the board, it still does, if it didn't need to go before that board, it still doesn't, but there's no change to that piece of the process.

[Barb Rydell at CDPHE] As was just relayed, the rights modification are for health and safety. So cameras on a whole are not allowed in residential settings, whether it be a host home, group home, or an ACF, unless there is an individual situation that for health and safety you need to have it, then you would run it through this whole process. On top of that, you would also make sure that there is some mitigation so that other individuals in the home don't have a camera on them potentially when the other person is out of the place. Or maybe you only have it at night for seizures because the individual, you want to hear are they thrashing or are they having a seizure. This requires the full rights modification process, hopefully nobody else is in that bedroom, or you might try to consider something else to mitigate. That's the first example and another one is people being able to come and go outside. If somebody wants to come outside, whether they express it verbally or behaviorally, and you're not going to let them go outside, in essence then you've got a rights modification going on. And another example that was touched upon was the house rules. ACFs have in their rules

that they are required to have such rules, historically that has open things up to include some broad restrictions based on typical practices, saying we've got these visiting hours and these times that you can use the phone. So we are making sure now and you're making sure that those things are no longer broadly taken away. People have the right to have visitors and the right to have access to food. They have the right to have alcohol. You can't require that they can only have alcohol if a doctor allows it. It would be more of that individual situation if you've got somebody who really has a health and safety issue. Then you would work with them individually and maybe they would be agreeable. You may have to help with the rights modification. These are the things that we are working with providers on making some changes. The final example on this slide is the day program requirement that all participants turn in their cell phones for the day. Individuals have the rights to keep their phones on them, like you or I do, so that would not be the ability to do a broad basis rule, but if you had an individual with a specific issue, you would work with them individually.

For children, we will at some time have PTPs coming out for CHRP, and we've done some CHRP home visits. How do we deal with rights modification for kids. It's really looking at a typical child and comparing it to this child who's getting Medicaid waiver services. A five-year-old would have a time that they go to bed, they would not have their own key to their home. But a 16-year-old would have much looser kinds of approaches and certainly have their own key to the home, so we will be looking at those homes to make sure that the kid based on a typical childhood has the same rights in place, and any individual modifications will need to follow the process. So thank you.

This is Kyra Acuna with the Department of Health Care Policy and Financing. I'm going to go over rights modifications and criteria. Rights modifications are based on the specific assessed need of the individual, they are not opposed across the board and not based on the convenience for the provider. It goes back to the example that Leah and Barb mentioned, that were previously typical in group homes and alternative care facilities such as everyone waking up at the same time, everyone eating at the same time, or having a set bathing time. The process for modifications is person centered and ensures that the individual fully understands and agrees to the modifications.

Rights modification criteria. Any rights modification must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan and these following 8 items can serve as the template for providers in creating their form. So number one, identify a specific individual assessed need. Number two, document the positive interventions and supports used prior to any modifications to the person-centered service plan. It also needs to be documented the plan going forward for the provider to support the individual in learning skills so that the modification becomes unnecessary. You can see FAQ part one for more details on this. Number three, document the less intrusive methods that have been tried but did not work. Number four, include a clear description of the modification that is directly proportionate to the specific assessed need. This cannot be an all or nothing modification. Number five, include regular collection and review of data to measure the ongoing effectiveness of

the modification. Number six, include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. Person-centered service plans are typically revised at least every 12 months or when the individual circumstances or needs have changed significantly, or at the request of the individual. Number seven, include the informed consent of the individual. Informed consent must be in writing. Consent must be limited to a specific modification applicable to the particular circumstances and may not be a general consent to whatever modifications a provider sees fit to impose. Number eight, include an assurance that interventions and supports will cause no harm to the individual. So documenting any ways in which the modification is paired with additional supports to prevent harm. For example, if an individual is restricted from going out on their own because of past sexual misconduct, identify staffing and other measures taken to ensure they can still engage in the community. Another example is if an individual with compulsive eating behaviors is restricted from unlimited access to food at any time, identify the measures taken to ensure that they will still eat nourishing food and have choice of food.

This is Leah again. I will add on those prior slides, that whole list is from the federal rule, we just paraphrased it a little bit there. I will add a few more details about how this process works and when it is available. Under the rule when it was originally published, that list of criteria and 8 items that need to be looked into and documented, that process was really available only for what the feds called additional conditions, which included things like access to food at any time and access to visitors. The rule did not create a process to modify any other rights. But after the rule came out CMS indicated that some of those basic rights that apply at all settings can also be modified if a similar individualized process is followed. I will give a couple of examples. One of the basic rights is that people have a right to have access to the community and be integrated in the community. The question was asked in Colorado and of the feds many times, which is what do we do with people where if it's not safe for them to wander in the community. Maybe they have Alzheimer's or dementia for example. So CMS issued guidance that basically lays out a process for those individual cases for using restrictive egress measures or controlled egress measures and it really is quite individualized. We didn't lay it out here in the slide because it's very much like what we looked at the prior slides for other kinds of modifications. If you need more detail on this one in particular, that’s in our FAQ part one.

Another example that CMS has given us, is that when they were looking at our systemic crosswalk listing changes we thought we needed to make to our state rules and regulations and waivers. They said if you're going to use restraints or restrictive interventions then that is okay provided that any use of those kinds of measures is really compliant with the existing waiver and rules and regulations. Even though of course one of the basic rights that we looked at earlier slides was that people have a right to freedom from coercion and restraint. So if you're a provider type or setting type where restraints or restrictive interventions of some kind may have been allowed in the past, those options will continue to be available under those same rules and regulations. If there's some kind of restraint or all kinds of restraints that were not available to you in the past, it continues to not be available. So the process that CMS

has given us for these basic rights is pretty similar to what we just put for those additional rights. There's one additional footnote which is the right to have a physically accessible setting is not subject to modification. Everybody has the right to access the setting where they live or receive services. For some questions about how that works in practice, take a look at that FAQ part one because we did provide details about that.

This is Kyra again. Who does what. The provider, if a provider believes that a modification is needed for current client it should initiate the process by collecting information on a form it develops and provides to the case manager. The form should include information addressing the 8 required items, leaving signature collection to the case manager, and this 8-item list was detailed in just a few slides prior and can serve as a template as a form provided by the provider. A template or form will not be provided by the state. Many providers already have forms along these lines for use with rights suspensions and restrictive procedures. This is not the end of the process as it then goes on to the case manager. So expand on this and why the provider is the one that initiates the process. It's because one, they are in the best position to identify potentially necessary rights modifications for individuals. Two, they are the ones implementing the rights modification and need to do so in compliance with the HCBS Settings Final Rule. At the end of the day if the appropriate documentation is not compiled the provider needs to stop using the modification.

This is Victor Robertson, the case management unit supervisor here at the department, and I'm going to talk to you about the case manager's role in this process. As Kyra said, the provider will compile this information and forward it to the case manager. Hopefully the case manager has been looped in and is aware of the issues going on, and this is the next step in the process. The case manager then has the responsibility to meet with the individual and have that conversation with the individual about their rights and talk with them about the modification that is being proposed. Ensuring that that individual understands all of that information. The case manager should also have a conversation with the individual about their options and alternatives to the modification. Understanding that this is a modification proposed by a provider, to this particular provider proposes to provide services. Once the case manager is assured that the individual understands all this information, they should acquire a signature reflecting their informed consent. The case manager then has a complete packet of information including all the documentation that was referenced earlier and the signature of the individual. The case manager then needs to provide a copy to any provider that has a role in implementing the modification.

Additionally, the case manager may also initiate this process, it doesn't necessarily have to begin with the provider agency. So if it's a new enrollment or somebody who is in transition, a case manager can complete these eight steps and initiate that process if that is appropriate. If case management agencies already have forms that they're using, you continue using that as long as you're ensuring compliance with all the federal requirements, there's no need to duplicate work that's already been done.

After the process has been completed and the signature has been obtained on the consent then the case manager needs to document that. Currently we don't have

standard way for documentation. In the interim, we are going to have to use what is available. If you're a case manager and you currently use the DD service plan on the BUS, you know there's an HRC section there where you can document the modifications in that area. If you don't use that section you're going to have to use a different method for documenting that, that would go for all other waivers that don't use that. The recommendation is to use detailed log notes outlining all the requirements. We are currently having work done to modify the Benefits Utilization System, the BUS, to add a rights modification tab that will have fields where it can be entered and stored in a uniform place. That's in the works and will be communicated once it's included and ready for use. Additionally, we are developing a new case management system called Aerial, and we are addressing that need for a rights modification documentation currently. So when that system is rolled out it will also have a dedicated area for rights modification information.

So the case manager maintains a copy of the finalized rights modification with all the required documentation, so at the case management agency, you should have a physical copy or scanned copy of that in the client's record there. The case manager needs to distribute that information to service providers who should also have a physical or digital copy in the record. We expect that agencies have that information on hand and can make it available upon request by the department or the department of public health and environment. We do not expect those to be sent to every instance but we will need to have that made available upon request.

[Leah] I'll just add, while we're on that last part about giving the materials. The provider transition plan platform which is a web based system where providers are taking account of what kinds of compliance issues they might have and what kind of changes they need to make. That platform has a way to attach documents. So if you provide adult residential services, which again we used the example of alternative care facilities, group homes, or host homes, any kind of adult residential setting, you should already be in that platform and working on your provider transition plans. The kinds of documents you will upload on this front, we will generally just ask for your policies, procedures, your general documents that you use across all your settings. But in an individual case, CDPHE, when they are reviewing those documents and working with an individual provider, they may ask for examples and show us how you implemented this with so-and-so, and you can provide it through that very same system.

[Jen Larsen] We have quite a few questions and we can try to go through them. The first we have is a follow-up to our original question about sex offender settings. So even if the program has limitations, part of it would then require a rights modification.

[Leah] That's right. We even are going to hit that on our what if slides coming up.

[Jen] For adult day, if clients are taken via non-medical transportation to a park or the movies and the entire group doesn't want to have one of us with them, do we first obtain documented consent?

[Leah] I think we're having trouble understanding this one. It seems like the question is, you have a group of adult day clients, and the whole group of participants does not want a staff member with them. If that is the question then please come back to the chat box if that's not. This is the kind of thing where people want to go out alone and they are indicating verbally or non-verbally that they want to be independent in accessing the community, then that is a right modification.

[Jen] In other words, refusal, do we document it?

[Leah] I think I don't have more to add to that, but if we misunderstood the question, let us know.

[Jen] What should PASAs do when a client wants to purchase, or use, and store marijuana in the home?

[Leah] We'll have to get back to you on that one, thanks.

[Jen] What if the host home provider has security cameras before the client moved in?

[Leah] If we are talking about external security cameras, like a little light or something goes on on the driveway or checks when packages are delivered, we aren't really concerned with that. We are really concerned with cameras inside the living area where people live. In an ordinary home they are not on camera. So whether those were there before or after, if they're going to be in use, that's a right modification.

[Jen] Alcohol at adult day: this is an unofficial house rule we implement - no alcohol on the premises, for safety. Do we need to modify this now?

[Leah] Yes. Barb, did you want to elaborate on that, because I'm sure you've seen it.

[Barb] This is a little confusing because it's saying alcohol at adult day. Typically with adult day we would not be saying you've got to allow alcohol with them, that wouldn't be an issue, but then the question says house rules. So if it's a house rule that people cannot have alcohols, then we would say no, you can no longer not allow people to have alcohol. I hope that answers one or the other way.

[Jen] Would it be appropriate for a home care agency to request a client not drink alcohol while the caregiver is on shift?

[Leah] If you're talking about an agency that's coming into the person's own private home. The private home is certainly subject to the rules that we have been talking about. By and large we are presuming that private homes are compliant with the rule and we are not doing the whole provider transition plan process for them. If you have a problem with an individual person who is not safe for the caregiver to come in then that's the kind of thing you want to go through this process for.

[Jen] What if an ACF or alternative care facility has security cameras in the common areas?

[Leah] That would be subject to what we just described, if it's in a living area where people normally are not on camera. If there's a need for it because some individual benefits from that and they'll be more independent with the cameras than without, then you would do the modification process with them where they consent to it and you have to let other people know who are living there that you've got a camera in here, and here are the measures we're taking to protect your privacy when the other person isn't around.

[Jen] Along the lines of the security cameras, some have chimes when doors open and close. We have been told because this 'announces' the movement of individuals, the chimes are not allowed.

[Leah] It would be along the same lines as the camera, that's a pretty good analogy. So it may or may not be allowed if it's helping that person to move around or not move around safely. It may be something that they want and that they consent to, and then it's documented in their plan, and again you would use measures so that it's not interfering with everybody else to the extent that you can, and that they know that it's there.

[Jen] If the individual in services is refusing to have a door to their unit (he has a sheet for privacy but refuses a door), are they allowed to make that decision? What steps do we have to take as an agency to support the individual in this decision?

[Leah] These are rights for the individual and they can choose to exercise them or not. If for some reason I did not want door I could take it off presumably. [As explained to this provider after the webinar, the default is that the provider should install doors with locks and let the individual choose whether or not to use them. Installing a sheet or curtain in lieu of a door would be a rights modification that would require addressing the 8 criteria discussed above.]

[Jen] To clarify, the 8 criteria items should be documented in the person's service plan, preferably under the human rights committee section?

[Victor] Not everyone has access to that section because it's exclusive to the DD service plan on the BUS. So the only individuals that would have that on their BUS record are those involved in the DD, SLS, CES waivers. It is one option for you at this time if you do have an individual in those waivers, you can certainly use that if your agency is currently using the DD service plan. For now, a detailed log note will suffice until we have that change to the BUS where fields specifically tailored for this information will be made available to you.

[Jen] Are the service providers the ones who initiate the modification/suspension or is it the case manager after the IDT has met to discuss the issue?

[Leah] So what we said on those prior slides is it can really be either, it may be one or the other depending on the circumstances. So the provider may be working with people right now today that it knows they've already had some kind of rights modification in

place or need something along these lines and it needs to be documented. If you're in that position as a provider you want to be the one go ahead and start this process so that when we come up with the deadline that we're going to get to later in this presentation, you don't run out of runway to keep implementing a modification that you think is necessary. On the other hand, it's not exclusively the provider, and even if the provider starts it, at some point they hand it off to the case manager to be finished, discussed with the individual, and documented in their person-centered plan. It may be that the case manager is the more appropriate person to start the process altogether if you have someone who's new to a waiver or they raise a new need or issue in their conversation with their case manager. Maybe they've got the information to start the ball rolling. And in any event the case manager is the one who finishes it by putting it in what's now the BUS, which again stands for Benefits Utilization System. As part of that process for the case manager, if any of that information that was originally compiled the provider is changed or supplemented or modified as you go through those conversations that you're having, you would mark up that sheet and put the final information into the BUS, don't put outdated information in, put the final version in.

[Jen] In the past we outlined supervision guidelines in the developmental disabilities section, does this override the need for a suspension if they have limited time in the community, or do we not specify time any longer?

[Michele] For the service plan documentation in the BUS, in the DD section, historically I think there was documented people's supervision levels and even in there there's a description of what different supervision levels mean. Whether or not that continues to be documented, like Victor said, not everybody uses the DD section for the DD, Supported Living Services, or CES waivers want it specified that specific. So that's up to the case management agency. I would think that people's supervision needs should be documented somewhere so everyone is in agreement. But getting back to what Leah said earlier, in looking at people's supervision requirements it really comes down to the person's choice. If they are wanting to really be independent and they can voice that to you either through spoken language or behavior, using communication through behaviors, then it would be a rights modification if you're going to limit their right to not be supervised and they don't want to be supervised.

[Jen] What is the course of action if an individual chooses not to sign the consent?

[Leah] We are going to get into that in a moment. That is one of our big what ifs.

[Jen] If the person served has a guardian, do we obtain consent from the person or their guardian?

[Leah] We are also going to get into that. You guys are asking great questions.

[Jen] What if a person does not agree to the rights modification and refuses to sign informed consent. For example, a person who self-injures with sharps wanting to access sharps? How do we protect them from themselves?

[Leah] On the radar, we will hit it coming up. Looking at these questions, maybe we should just move to the what if's and then we'll pick up here. So we're going to take a break from the questions and just move on to the what-ifs which is what's on everybody's mind right now it seems. These what if's, this is not going to be comprehensive to every kind of question that may come up. These are the biggies that we hear about most often and we wanted to provide some commentary.

The first one is what if an individual doesn't give their consent, they choose not to, or maybe they gave their consent and then they revoke it?

[Michele] We have a question come up frequently about court-imposed restrictions or modifications. Obviously if a court has imposed that, that's a legal issue, the person needs to comply with the court orders or they are likely going to go to jail. Where we think that becomes a rights modification for HCBS providers is when the HCBS provider is taking action to implement that court order. They are still modifying a right even though it's a court order. The reason for that is the person has a right to provide informed consent to say, hey agency, I know you're going to implement xyz action for the court order to help keep me out of jail. An example of that is somebody who has some adjudicated sex offenses, what we see particularly with people with intellectual and developmental disabilities, that means they can't live within so many feet of school or be near a school, sometimes internet access can be limited. And you can't impose those but you would need to get informed consent and follow the same process.

[Leah] I will be clear because I think I stated it unclearly the last time we did this presentation. So if you're talking to your colleagues who were on the first one, this is a little more clarified and different sounding from what was said last time. So what we said before is if it's a court order, then you don't need consent. But what we should have been clear about is the court imposes what it imposes without consent on an individual, but if the provider gets involved, if the provider is going to do an action or prevent an action, then that is a provider involvement that does go through the process we were talking about before.

So what do you do when there's not a court order. That would be maybe you have someone with a sex offense but they weren't adjudicated, or maybe there is an order and it's really vague and doesn't necessarily detail what you think needs to be implemented to keep people safe. Or of course the whole wide world of any other kind of modification that does not ever involve a court, you could have someone with compulsive eating or anything under the sun that wouldn't come up before a court. The question to ask is, is this modification really needed, and in the world we're living in, under the federal rule, is that we need to be person centered. That rule really honors the dignity of risk. The thinking is any one of us has the right to make choices that are sometimes bad choices and those add up to a good life. We like to splurge on things that are unhealthy and not exercise, whatever it is. We all do things that aren't perfectly healthy but are fulfilling for us as people. The people receiving services have that same interest and that same right.

So with that said, suppose you're in a situation, and an example was given earlier in the chat box where you have somebody who self harms, where if they have sharps, it's not going to be safe for them or it's not going to be safe for people around them. In that kind of situation when there's a risk to someone's health or safety, the first thing you would do of course in advance, if you know the person has that situation, is you would plan for it in advance and build that kind of rights modification into their service plan from the beginning. If you have something coming up where they develop a new behavior that was not an issue before, or maybe they previously consented that you're going to screen my bag and take out my sharps if I come home with any when I come home, but now today when I come home, I say you can't have my bag, leave me alone. In my case because I do have that behavior there is a risk to my health and safety or someone else's. And in those kind of situations the guidance that we got from the feds is for the short term, in the immediate situation that you're trying to resolve, you can continue to use that modification that was in place or that you think needs to be suddenly implemented to protect health and safety. That's subject to two things. One, you need to do what you can to de-escalate the situation. That may be temporarily increasing staffing or it may be other measures as needed to try to cool things down. The second thing is as the provider if you're doing something like that where in the short term you're effectively imposing a modification that the person never agreed to or has announced that they don't agree to, you need to reach out to the case manager right away to set up a meeting. If it's Saturday afternoon, leave a voicemail and get that meeting set up as soon as you can for Monday morning. Because in the interim you're working without that person's consent and you need to have that meeting right away and the case manager needs to make themselves available as soon as they can. So that you can then have this conversation about going forward, what do you want. Are you agreeing to this modification or are you not, and you aren't, then we'll get another slide.

This is Michele. For those agencies that are already implementing rights suspensions without informed consent, people can choose not to follow that now. It's a piece of paper, you can tear up the piece of paper, you can go to different service agencies. So if you have people with sex offense issues who are not supposed to leave the house to go near a school, people can still leave the house and go near a school, we don't necessarily physically restrain people. People do leave. So agencies are already working with this now and finding ways to really talk with people and understand what their feelings are about a rights modification, maybe working with them, negotiating about what parts of it you can implement to help keep them safe.

[Leah] So that does lead right in to the next slide. In the end people can decide that they don't consent to the modification. That's part of the choice under the rule that they can choose to agree, they can choose to disagree. And in that case the issue rests with the case manager to help them understand their options and that may include consequences of not agreeing to the modification. Maybe this provider won't serve you, maybe no waiver provider will serve you in your area and then you'll have to look in other parts of the state or look to other kinds of providers. And as Michele said, that possibility has always been out there for years, it is not really unique to this rule. You

had a rights suspension where originally you only had to give the person notice and didn't get their consent, in practice that person could decide they didn't consent and walk away. So you had this concern out there all along you probably all have very good techniques for addressing it and handling it and you would want to draw on those.

The other big what if category that we get is there's a guardian what's their role, or there isn't a guardian, who does what. Regardless of whether there is a guardian or anybody with any kind of legal role, no matter what, the individual should be leading the person-centered planning process where possible. They should be front and center and leading that process and expressing their preferences, and that is listened to and taken into account even if there's a guardian out there. Guardianship is the most common relationship that we see but there may be other kinds of court orders out there, and we aren't trying to rule them in or out, if you have some other kind of court order that gives you legal authority to make decisions for someone, we're just going to call it guardianship here. So if there isn't a guardian for that individual then only that individual can be the one who decides whether they grant or deny or withdraw consent to any kind of modification. There's nobody else who has a legal right to make their decision for them.

We have a footnote here that authorized representative status, which is something that is under some of our waivers and certain service types and provides a support role, if you're an authorized representative, that kind of status is not decision-making authority and is not authority to make the decisions we are talking about here today. So if there isn't a guardian and somebody involved, case manager, provider, says this person's going to make a bad decision, you want to draw on tools like supported decision-making and other kind of supports to help offer advice to that person, pointers and examples and anything else that can influence their decision in a positive way without forcing them to choose one way or the other. And lastly if there is a guardian that's really not the end of the story. That's because in Colorado we don't have all-purpose guardians, we have limited guardianship, so that means that the court order will say that this guardian has the ability to make xyz kinds of decisions but not other decisions. So a common one may be that the guardian can make financial decisions but not necessarily any other kinds. So you have to look at that paper from the court and see if it gives them the authority that they might want to make that decision. If it doesn't give them that authority, then again, they don't have it, and it's the individual is the one who has that right. So there is a lot more that can be said about guardianship. We had training a while ago on our website. The link is still there so if you want to go look at the slides, go look at the settings rule website under trainings.

We're going to talk about some deadlines for what we have been discussing and then we'll go back to the question box. Over the next six months now that we have clarified the lay of the land here. Providers, if you work with individuals where you think effectively a rights modification is in place for this person already, or needs to be better documented, or should be in place for this person, go ahead and start the process. That means starting the paperwork and then handing it to the case manager. The case manager should meet with individuals, and for 99% of these cases, that's just meeting

on the normal schedule that you already have with that individual, you probably already have a meeting set up with everybody on a regular schedule. The case manager picks up that paperwork and discusses it with the individual to make sure they understand it, if there are any edits that the person wants to make or that come up, just go ahead and edit it, and then put it in the BUS. Get the person's signature. If anything has changed on that form they should sign the updated revised form, it can be informal just scribble out whatever isn't right and make it right, so that they are signing whatever they actually have agreed to. And once you typed it all up into the BUS you'll provide a signed copy back to the individual with their whole service plan, and of course any provider that's involved with it. So on previous calls the case management world was given the word pause or told that there's a pause on this process. The pause was for this training, and that pause is over now.

So by the end of July, this summer, what happens. Each provider by that point should have a copy back from the case manager of the rights modification that's been signed and consented to. Or they stop implementing the rights modification. So if a person didn't consent or not everybody did what needed to happen then that rights modification cannot continue after that date. And again. Once the provider has that information back they need to keep that in their file and may need to show it to us or CDPHE or in some cases the feds. Example being if your setting is subject to heightened scrutiny under this rule, that basically means CMS scrutiny, they will take a closer look at your information so they may need to see that down the road.

We provided some references here. These are all links if you have the slide deck from the corner of the download screen. The text of the rule itself. That's helpful to look at because a lot of what we did today was just paraphrasing the rule. The next is the link to our final rule website with all the materials on it, FAQs, guidance. Then there's a link to our department regs. All the principles that we discussed today aren't codified yet, as we discussed at the beginning. So right now we are going through that provider transition plan process and understanding the nitty gritty of what all the providers need. Then we'll be moving on towards rules and codifying everything. There's a link to all the waiver applications, so if you're a provider type, you may work under one or more waivers, so they're all available for you. Then the statutes and regs. That's especially helpful to understand current policy and concepts and acronyms and so on. Then the long-term services and support page has one-stop shopping for a bunch of other resources for you. Back to questions.

[Jen] Jeff has a couple of them here and I'm going to jump down to his third one which is kind of a summary. A clarifying question. A rights suspension used to be defined by the lack of consent involved. So what is a rights suspension now?

[Michele] It is still a right suspension. But it falls under a rights modification. What is happening now is the rights suspension still needs to follow all the requirements of the 8.6 rules. But instead of just handing the person notice, essentially that person needs to sign consent and that consent is obtained by the case manager. Hope that clarifies.

[Leah] We do appreciate that there's a lot of rules now and we are aiming to streamline down the road.

[Jen] Along those same lines, if an individual agrees to their supervision level, do they need to have an informed consent for rights modification? If not, should the agency get their signature stating that they agree to their supervision level and that they understand it is not a rights modification?

[Michele] Just make sure it's documented in the service plan. It's not necessarily a rights modification if you just provide services and supports.

[Leah] If you're just providing services and supports that the person wants and agrees to, you do not have a rights modification. But in any event, totally outside of this rule, the person always agrees to their service plan and consents to that.

[Jen] We have cameras in our resident kitchen for safety. Are you saying everyone who uses the kitchen must sign a rights modification?

[Leah] The residents, if people live there. I'm not really concerned with your staff, although that may be an OSHA violation or other bodies of law may come into play. If we're talking about someone's home, and the kitchen is part of their home, then yeah, that's a rights modification.

This is Barb, we have seen some house rules for ACFs in particular where people are not allowed in the kitchen or maybe they have a camera for the kitchen. You'll see in the provider transition plan, people need to have access to the common areas and no there should not be cameras in there. If you have someone really does hurt themselves with the kind of foods they are eating, they have Prader Willi syndrome or something going on, you will work with that person individually and give them support and potentially a rights modification if needed. But generally you would not have a camera in the kitchen anymore.

[Jen] What if the resident signs that they are aware that the cameras are for their safety and they are okay with them?

[Leah] If that's really the case with that individual, then that's potentially fine, you could have someone who understands that they have particular health concerns where a camera is actually helping them be safer in the community and in their home. But you wouldn't do that across the board, as a boilerplate part of your contract when you come to live in this facility everybody agrees quote-unquote for our safety, because in that case it's really not for everybody's safety. It's not individualized. And if you do have a resident where it really is warranted for them, you still need to make sure that everybody else knows it's there. You're not totally in private when you're watching TV in the living room because there's a camera here for someone's safety. We do turn it off when they're not here. But just so you know it's here and if we don't turn off, sometimes you may be on camera.

[Jen] Can a caregiver give a ride to the client to the doctor or shopping?

This is Michele. Yes. Especially if that part of the service you're providing. Residential services typically will involve the care provider driving the person to an appointment.

[Jen] For the detailed log note, do we need to include information for all of the 8 points or can we state to reference the informed consent in their client file for more information? I am guessing we would also summarize we received the rights modification . . . the rest of the question is not clear.

[Victor] At this point in time we would ask that the case manager summarize those 8 points. If there's anything of particular importance it should be highlighted in that log note. You can reference that the full information is available in the client's file, but anything that's particularly pertinent should be documented in that log note. From what I have seen of upcoming changes in the BUS there will be fields for each piece of information and the case manager will be entering that into the BUS at some point, so it may not be a bad habit to start now.

[Jen] Was it stated that if a right is restricted due to a court order it is not considered a rights modification. That was what we talked about on Tuesday.

[Leah] The clarification to what we talked about, I think I glossed over it in an oversimplified way before, I basically said if it's a court order, it's not a rights modification and you don't get consent. I oversimplified it. The more correct answer that we're giving today and of course we will follow-up with this in writing so that everyone has it is that the court imposes whatever it imposes on the individual and that piece of it happens without anybody's consent in some cases. But when the provider is involved in taking an action and getting involved in implementing anything like that, then that is a rights modification and the provider's role does go through this rights modification process that we discussed. If your staff are going to not allow the individual to go out in the community on their own and they always have to have someone come with them, somebody is going to look over their shoulder when they go online. If the person is going to comply on their own and they're capable of that and reliable on that, then you might not get involved. But if you do get involved then that's a rights modification that goes through this process.

[Michele] Another way to think about it is people have a choice to follow their court orders. The court can tell you to do something. You can certainly choose not to follow that. And if you choose not to follow it, that might mean going back to jail, or going to jail if you hadn't been. So just looking at it from that perspective. By a provider limiting someone's right and making that choice [inaudible].

[Jen] Going back to the sex offender program are you saying that everything that is limited in a sex offender program that would require a separate rights modification for all of those limitations?

[Leah] Yes. So when we get those new fields up and running in the BUS you'll see that, if you're a case manager. The checkbox for Internet access being restricted, checkbox for community access being restricted. Whatever it is, you would add them up and it

would each be a separate modification that needs to be acknowledged and agreed to. If they do agree that you're going to work with them to implement those restrictions.

This is Barb and I have one other quick comment about this question. Just want to caution folks that sex offender programming makes it sound like everybody has the exact same everything because they have the specific kind of diagnosis or issue. Make sure that things are individualized. Not an overall program where everybody has the exact same rules. That would kind of fall into the house rule issue. Instead do exactly what they are talking about and look each individual separately and do those rights modifications based on that person. Because one may have something that another one should be able to do freely and not have that right taken away. So be careful about having a quote-unquote program and instead make it more individualized.

[Jen] Are cameras in a day hab setting a modification?

[Leah] I believe we said that if the camera is in a normally private area like a changing room or bathroom, if it's in an area where people normally have an expectation of privacy, then that situation is a rights modification as if it were in someone's home. On the other hand if you have a shop floor or commercial setting, people are generally prepared to encounter some cameras in those kinds of areas. All you would need to do is make sure that people know you might be on camera here. Did I accurately describe where we landed in the FAQ?

[Barb] Yes, that was perfect, thanks.

[Jen] We did make a slight change to the slides on number 30 to address the court-ordered modifications just so you know about that. When someone binge eats on a frequent basis, and eats the vast majority of the food that is allotted for the entire house's meals, causing a significant increase in the budget allotted for groceries, does that not infringe on others' rights in the home or are we as providers expected to provide whatever amount of food is necessary so that individuals can eat as much as they want?

[Leah] There’s a third way there, which is you would discuss a rights modification with that individual who has the problem. Maybe there's a lock on the pantry or the fridge and everybody else can have access to it because they can eat safely and it’s not a harm to them or others. And that individual can’t do that safely, you would just work with the one person and do your best to minimize that impact on everyone else.

[Jen] Are care managers going to be required to complete the meetings with the members in a face to face meeting for all the modifications or can these be over the phone?

[Victor] I think within the course of your interactions with that individual, whatever's appropriate.

[Leah] Pursue whatever kind of meetings you were already pursuing, or calls.

[Victor] Whatever is appropriate for that individual. If it requires an in-person meeting to be sure they fully understand the rights that are being modified, if it's a quick phone call, that's appropriate as well.

[Jen] If an emergency move is made and an individual switches to a new residential agency, how does the agency go about implementing an immediate suspension that night to protect their health and safety? Can they give verbal consent that night and have it included in the actual written informed consent? How long after obtaining verbal consent should the formal written informed consent be presented and implemented?

[Michele] We did address this because a lot of the questions came in. Leah did speak to what to do in an emergency. If you need to keep someone safe you can take that action. If it's an emergency you go ahead and implement it and then in a reasonable amount of time you need to meet to determine if it's still needed or to do something else and if you want to keep that suspension you need to get informed consent.

[Jen] Are these what-if scenarios part of one of the FAQ documents?

[Leah] Yes. All these what-ifs draw on information that has already been published, with that slight tweak regarding the court order situation.

[Jen] Again those documents are on our website and are available for you to download in the files panel if you want to click on those, you can get them right now. Where do consent and liability or caregiver neglect cross paths?

[Leah] I'm guessing this question is getting at the dignity of risk. The fact that people have rights and take sometimes take risks including risks that turn out poorly for them. Maybe they wished they had done it differently. That's the freedom that we all our lives. I'll back up. There are some health and safety rules that have always existed, including HCPF rules, CDPHE rules if you're any kind of licensed facility. All the health and safety standards that have been on the books in the past and that may be adapted in the future those all still apply, and so you're all still complying with those, but where there is a gap and that isn't a rule that specifies down to the detail what to do what this person can do in this situation, what the federal rule says is that the person makes the choice, and they choose how much risk they want to take.

[Jen] What about situations where the provider doesn't feel they can safely serve the person without a modification, but you are unable to find an alternative provider? At what point is the current agency no longer responsible for that person? Referring to situations where the provider agency gives notice, the case manager can't find an alternative provider, and the person has nowhere to go.

[Michele] There are a couple pieces to that. One would be that a provider can choose not to serve a person. For the DD, SLS, CES waivers, there are rules around providing 15-day notice of termination of services. That's all in place whether there's a rights modification or not. The other piece to this is that receiving services in the waivers is a person's choice and they are voluntary programs. If a person is really saying no to a

rights modification that really is needed to prevent them from returning to jail or no provider wants to serve them, then it's a voluntary program and maybe that person is choosing not to receive services in the waiver. I know that sounds very harsh but I think there are situations that people come across anyway, rights modification or no, where it's difficult to find a provider, so it's a matter of those individual cases continuing to look at maybe the rights modification being implemented and changing it up. Maybe just being creative and not an all or nothing thing. Finding out what might be acceptable to the person. If the agency is saying we're going to lock all your cabinets and the person says absolutely not, coming to a middle ground about some other options that would still keep the person safe and allow them to have the degree of respect that they want and some freedom in making choices.

[Leah] The federal rule doesn't change the existing rules around termination of services or a person who changes providers or moves to a different setting. All those rules regarding notice and dispute resolution and grievance and appeals. That's all summarized in pretty elaborate detail in FAQ III and those processes still remain available.

[Jen] A clarification about the website where you can find the training on guardianship. I added a link to that in the chat. It was also a couple of slides back. It's the HCBS Settings Final Rule website. You should be able to find it. Are rules and regulations being changed to include new language for rights modification, and is there an effective date?

[Leah] Yes, down the road all the federal criteria that we were discussing are going to be added to the HCPF rules, for all waiver provider types. If you want to take a look at what kinds of changes, in a lot more detail, at the level of if you're an assisted living here's the row in the chart to look at, if you're a group home here's the row to look at, that's all set forth in the crosswalk and that link is somewhere up here in the slide deck. The timing of it, we did have an original date we were aiming to do it by. But we are looking at taking a little longer now, in part because of the need for you all to get your hands around it and for us to understand whether any additional questions come up. Is it going to work to put it on the books the way it is. We are trying to understand from you all how it's working. So you should start now and then as we get further down the road we will build this into the rule.

[Jen] Regarding rights, can a home health provider not allow a person to smoke pot or smoke cigarettes in their home? If yes, why is this different than not wanting a person to drink alcohol in their home?

[Leah] I think it's a host home provider, probably. It's your home and you could say there's no smoking in the home, but you would need to provide an area outside because some people do smoke cigarettes and have a right to do that. So there would need to be an area somewhere for them to be able to do that near their home, outside.

[Michele] So it would be rights modification? Just like alcohol, if I want to drink alcohol in my home, I can do that, if I want to smoke in my home, I can do that. If my host

home provider is saying I can't smoke in the home because it's a hazard to everyone else in the house, you have to smoke outside, it's a rights modification, right?

[Leah] I think we said we treated smoking as [not] a rights modification as long as there's somewhere they can do it.

[Barb] Right. We have been okay with following some other rules where by all means everybody needs to have a place to smoke, it does not need to be inside, they can have a safe place designated outside for people to smoke. But we've seen some rules where you can't ever smoke, it can't be on the property at all, you have to go across the street, and that we are not okay with. They have to be able to have a designated area, and outside is fine, because of the health effects of secondhand smoke. That's not a rights modification.

[Jen] If the person does not want a lock on their door or a house key to carry on themselves does this need to be documented and how?

[Leah] Barb has run across this sometimes.

[Barb] What we've been saying is go ahead and put a lock on their door so that they have that option and they can choose not to use it. The example I gave last Tuesday, we came across a host home provider who was very worried about having a lock on someone's door until she realized that the person already had it and they just were never using it. So if you have somebody for health and safety reasons maybe they have seizures and you need to get in quickly then you can potentially have a rights modification where they really cannot have that. The other thing is that you can have your staff have an emergency key available. So if for any reason somebody needs to get into the bedroom for emergency reasons, that's fine. People need to have the ability to know their privacy is respected and that people won't be able to walk in and to know that their belongings are safe if they leave the home. We have had complaints in group homes and other settings where individuals have said their things have been stolen before. We've said pretty soon you'll be able to lock your door and hopefully that will help. It's a rights modification if you don't allow them to have that option.

[Jen] How does this apply to access to personal funds, many individuals would easily over spend if given unlimited access to their checkbook, and many individuals require a second signature on checks, or would like a larger budget than they can afford?

[Leah] What the rule says is that people have a right to control their money the same way that anyone else can. If you have a person who that's not a great idea for, and they are going to make ruinous decisions if they have free spending, then that's exactly the kind of conversation that you would have following these points that we discussed today in this presentation. It ends up being a rights modification that you would put in their person-centered plan, if the provider is going to be involved with managing money. If they have somebody else who manages their money, then someone else manages their money, and you may not be involved with it.

[Jen] Can an informed consent can be lifted by the person or guardian at any time?

[Leah] Yes. The right to grant, the other side of the coin is the right to take it back. The footnote on that is what we looked at on a prior slide where the person, in the heat of the moment, and there's a health or safety risk, they're saying don't do this and you need to do it because of the health or safety risk. The guidance we were given and that we are sharing with you all, is if there is a health and safety risk after they've revoked their consent and they're saying don't search my bag but I have sharps in here, then you would continue to do the modification in the short term to preserve health and safety, but you would also take immediate measures to get the case manager involved to see in the long term what their position is.

[Jen] If an individual agrees to a decision because they feel it's best for them as well, then they don't need an informed consent, but then they have to agree to certain decisions through an informed consent?

[Michele] If they agree to it, that means they are giving their informed consent. The idea is that if you're going to modify a right, you include those 8 items that Kyra went over, you present it to the person, and if the person is saying they agree to it, they are giving their informed consent.

[Jen] If a court has to order a suspension for a PRS, is that considered an ILD? Who initiates the ILD court process?

[Michele] The acronym is imposition of legal disability. A court can impose an ILD. If you want to read more about that, that's toward the end of our statute in 25.5-10, it talks about all the things that an ILD can do. So depending on what it is. Not quoting the statute, it says something like anyone can petition the court for an imposition of disability. Hope that answers your question. I would refer you to that section for more information on an imposition of legal disability. But if the court did issue a rights suspension through an imposition of legal disability, the provider implementing it would just need to get the informed consent.

[Jen] You've addressed cigarettes - which makes sense - but can you please address marijuana?

[Leah] We'll have to get back to you on that because it's a separate question and we are taking notes.

[Jen] There's a question of whether a home health aide coming into an individual's home can limit that individual's smoking.

[Leah] If a home health aide wants to go into someone's home and they don't want to be exposed to secondhand smoke. That's the person's home and they can do what they want in their home so you need to find someone who's comfortable with that.

[Jen] Has there been clear direction given to all of us regarding marijuana because it is federally illegal? Providers would not need to provide a place for them to smoke marijuana, correct?

[Leah] Same answer.

[Jen] Would it be a rights modification if an HHP, guessing host home provider, puts up a chime to alert her when the individual was going outside to smoke and when he would get up during the night to go smoke then she wouldn't allow him. Isn't the chime a rights modification and her not allowing him to go outside when he wants to smoke another one?

[Leah] Yes, those are both, that's right.

[Jen] Concerning risk, residents should be allowed to take the risk of consistently drinking alcohol or doing drugs (smoking marijuana or meth) even if it results in conflicts with medication or causes them to fall or other health conditions?

[Leah] That's the first time we've been asked about meth, I think. The reason we were wanting to do a little more thinking about marijuana is because it's illegal under federal law but Colorado has special provisions that make it legal in some circumstances in some settings. So we are trying to work through that. Meth is pretty well illegal everywhere and I don't think any provider needs to allow that or support use. I think I lost the thread of the question though. The default under this rule is that the person chooses how much risk they want. And people can have a drink in the evening. Everybody likes to do that even though it is not the greatest healthiest thing to do. If you have an individual who when they do that, it is actually unsafe for them because of a medication interaction or some other thing, or they can't do it in moderation and it's always to excess and it's disruptive to other people, that's the kind of situation where you would want to look at a rights modification. To frame it differently, a lot of what we talked about today is what counts as a rights modification and how do you do it. We aren't saying that any kind of restriction can't happen period, or can't happen ever. It's here's how it happens and here's how the individual gets involved and agrees to it.

[Jen] In the adult day setting, where they aren't all day: how do we avoid an alcohol fueled party, or drug consumption, with the risks that come with it? We are still liable for our clients.

[Leah] I think I misspoke on that earlier because I missed that this person was asking about adult day. I was assuming we were talking about someone's home. I think a day setting like any other commercial premises probably does not allow alcohol. That's a typical – ask whether a typical program, does the YMCA allow alcohol, probably not. I misspoke earlier, I'm sorry.

[Jen] The risk with substances is to others also, not just the person taking the risk.

[Leah] Yeah, and so if you're around someone who's using a substance and it's bothering you, you may want to look into a rights modification with them and explain to

them why it's bothering you, and would they agree to do something else or do it elsewhere.

[Jen] We have reached the end of the chat questions. Give it another minute maybe.

[silence]

[Leah] Seeing no further questions in the chat box, we want to thank everybody for their time in joining us. We hope this was helpful. I think that will do it, you can all hang up.

[Various] Thank you, bye.

[Event concluded]