



# Transcript of April 5, 2018 Conference Call Regarding HCBS Settings Requirements

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## Background

On January 30, 2018, the Department issued [Part I](#) of its responses to frequently asked questions (FAQs) regarding the federal home- and community-based services (HCBS) Settings Final Rule.

On April 5, 2018, the Department held a public conference call to address follow-up questions relating to FAQ Part I. (See [Communication Brief](#) issued March 22, 2018.) The following state staff participated in the call:

### Colorado Department of Health Care Policy and Financing (HCPF)

- Leah Pogoriler, Strategic Policy Advisor
- Lori Thompson, HCBS Specialist
- Kyra Acuna, HCBS Adult Waiver Specialist
- Dennis Roy, HCPF Federal Policy Liaison

### Colorado Department of Public Health and Environment (CDPHE)

- Kara Johnson-Hufford, Branch Chief, Health Facility Quality Branch
- Barb Rydell, Community Settings Supervisor, Health Facility Quality Branch

### Colorado Department of Human Services (CDHS)

- Nancy Harris, HCBS-CHRP Waiver Administrator

The following transcript of the April 5, 2018 call was prepared during the call. Department staff have corrected obvious typos and made some edits for clarity but cannot guarantee that the transcript is otherwise complete or accurate.

## Transcript

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All guests have been muted. You can unmute by pressing \*6.

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Hello, everyone. This is [Leah Pogoriler] and let's go around and say hello.

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[laughter]

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Do we have our [CDPHE] folks on the line?

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Everyone should be able to hear. Could you email her the moderator code -- [Technical difficulties]

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Because of the volume of questions we received, we are going to dive right in with just a few introductory notes. One is thank you for so many questions. If you have a question very often somebody else has the same question so it is helpful for us to see what questions are out there and be able to fill in the gaps for all of you. I will add this call is being recorded and if everything is functioning the way we think it is, there is also a transcript being generated. We will put that online after the call for folks who could not join us or could not access -- access the call. We intend to put what we say here in writing. I [do not] have formal clearance. Please understand because questions were trickling in up until yesterday, all of what we are saying [in] our answers -- this is what we think makes sense but none of [this has] been formally cleared and would have to be before we could put it in writing and make it official. With that, we are going to start going through all of your questions. We are trying to make it easy for you all to take notes and find the material we are referring to. This will proceed in order of the written FAQ. If we got your question, it may not be in the order you are expecting it. Please bear with us.

The first question relates to requirements for all [CHRP] settings. Does the settings final rule apply to the [CHRP program]? A lot of the materials had -- have cited [CHRP]. In general participants in the program have the same rights as everyone else. If you think a person in the program should have a rights modification because of their individual circumstances, you should follow the process and FAQ item number 29. We think it is fair to acknowledge the younger the person is, the more rights modification may be warranted. As the person gets older, you would need more robust reasons for any modifications and a more robust process for revisiting them and helping the individual not need those modifications. There is one difference when you [Indiscernible] which is if the participant is under 18 they cannot legally sign a lease and we haven't issued guidance on leases as a whole so stay tuned. I want to pause and invite Nancy to unmute herself which is \*6.

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You worded that very appropriately. I just want to make sure anyone listening regarding this needs to remember it needs to be documented clearly in the service plan for that individual.

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Thank you very much. We will move on to community integration [and] individual autonomy. The first question was if the provider is an individual Representative payee and involved in many budgeting decisions they need -- may need to restrict spending behavior. What [due] process does the state see needing to be implemented on top of

the [rep] payee role --? Before you are becoming that role, you should take a look at FAQ 35 where we talk about money management policies and how you have to acknowledge that the individual may be able to do these activities independently. If you think they cannot, there is an assessment of their skills and the . . . person centered plan shows what they need and what you are providing to become more independent over time. That is whether or not you are a rep [] payee. If the provider is going to be a rep [] payee, additional guidance [is in] FAQ number seven -- there is additional guidance in FAQ 7. When you say you are going to follow the Social Security roles, you are stating you will be able to restrict spending or whatever the rules say you have to do or can do. I don't know the rules, but if you are acting as the rep [] payee those of the rules that you and your individual are agreeing to and you need to make sure the individual understands what the policy means and how it will affect them. Barb has a special comment to [add here].

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I just want to mention along with what Leah covered, [what] we also look for is to make sure as a rep [] payee you understand some individuals may need full assistance but others don't necessarily and we will also look to see that regardless of ability if there is a broad statement in a policy or procedure that in order for someone to access or make decisions about spending money, they have to go through a department available during work days. Those kinds of things broadly restrict individual rights even with a designated rep [] payee so you want to make sure you have a way to make decisions if they are able to at any time.

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Thanks. If you are moving through the written FAQ, the next [heading] is security and we did not receive questions on that so we will move to the heading called privacy, dignity, respect and freedom from coercion and restraint. We had a question whether internal monitoring devices such as audio monitors and chimes require informed consent? The answer is yes. If you take a look at FAQ 12 we look -- talk about if it indicates a person need[s] support in moving within the setting and an internal device would be helpful, the modification should be reflected in their person-centered plan. That is a rights modification and you can look at item 29 to see how the process goes for doing rights modifications and it includes informed consent. We also wanted to flag [] that exterior door chimes and other egress alert devices are handled very similarly and must be documented in the individual's person-centered plan as a rights modification, which [] also means getting informed consent. Barb also wanted to add a point here.

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Yes, just to make sure with any rights modifications there is mitigation done and what we do is we make sure the person will be on vacation so that should not be on. Sometimes they are used only to alert staff at night that someone needs help because they are getting out of their bedroom. Therefore the [chime] should not be on constantly. It should only be activated at night.

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Okay. We had a question about cameras in public areas of group homes. They would like to know the basis for the determination that there is a violation of privacy when using these given that CCTV has become quite common in public areas of society. The

response is we are not aware of any thing that qualifies as a public area of a group home. There are common areas like living rooms, kitchens, dining rooms and so on but those are not public areas. There are parts of the residence -- they are part of the residence private homes. We don't accept cameras on us at all time when we are in the living area with them or alone. Our basis for this determination is the settings [rule] which says everyone has rights to privacy, dignity and respect especially in the . . . place they live. There is guidance for concerns with cameras and we share those concerns. Any setting that has cameras in these areas without appropriate individualized rights modifications in place has a significant compliance issue and that needs to be remedied right away. This is a good example of a kind of fix that can and should happen now, not years from now. We have talked about the fact that we are still trying to collect cost information through the web-based provider transition plan which is having technical issues and we are still developing it. If you can do something that is not as expensive as hiring a new staff person or buying a vehicle, this is the kind of thing you should do as soon as you identify the issue.

Population served, we didn't have questions on.

We will move to additional requirements for residential settings. There was a question here about [leases] that require renters to meet current law and enforce quiet areas in multifamily complexes. Are these that apply to typical individuals with and without IDD in alignment with the rule? And our response to item 34 in the FAQ, we talked about house rules that prohibit bringing sex workers into the home to engage in sex for pay and we said we don't object to rules like that even though they limit the [residents' ability to have visitors]. Under similar reasoning we wanted to say a rule that prohibits other kinds of unlawful behavior in the same way as another typical lease is okay. Quiet hours are a little different because they can affect lawful conduct in a way that is overbroad. Here we wanted to draw your attention to item number 35 where we listed some problems that were seen during site visits and they cited house rules and leases and other documents that limit rights through really broad-based requirements that there is a curfew or mandatory hours where you are in your room and what they suggest is if you're having problems with people being loud at night you can try individualist -- individualized approaches such as a rights modification. I'm going to pause here.

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Just to reiterate for our part when we are out and are able to talk with places with multiple people in homes. What we look for really is exactly what was discussed. We will see places where people are told all of your TVs and radios must be off by 10 o'clock and everyone has to be in their room by 10 o'clock until 6 o'clock in the morning. We just make sure facilities understand that if they really do have someone causing destruction they can address that individually. Thank you.

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Okay. We're moving on to the header called additional requirements relevant to all settings. The first sub-header is additional requirements in general. We had a few questions here that we wanted to go into. The first here is in the FAQ we mention that CMS told us during a call that individuals receiving [HCBS] should experience day

settings with the same degree of access as individuals not receiving it. To exercise personal choice when to eat and visit with others and so on. The questioner wants to know since most workplaces have standards of conduct that do limit personal choice about when you eat and visit with others, how should providers comply with the rule and help people learn the rules they need? If the provider is supporting an individual in a workplace setting that is not provider owned or controlled, [then] the usual rules of the workplace apply. Here we are talking about individual [ ] supported employment at [Target] or group supported employment at an office. In these kinds of settings employees usually cannot eat when they want, take phone calls and the same goes for supported individuals. That said, supported employment groups can include people without disabilities and if you as a provider extend those people courtesies like being able to take an occasional personal phone call or having a soda while they work, you need to extend those to people with disabilities. The second part is if the provider is supporting an individual in a setting that is provider owned or controlled, here the default is individuals are not limited in their ability to eat, drink, text and so on and if the provider -- if it becomes a problem than the provider should work with the individual to help them learn the skills and techniques that they need to handle these freedoms in a socially acceptable way. If that doesn't work then you can follow the procedures on an individualized basis.

We had a follow-up question on this which is what if the setting is provider owned or controlled but it is supposed to be like a typical workplace, such as coffee bars, restaurants and patronized by members of the public. In that case the provider can institute general rules about eating, drinking, texting as long as the rules would be found in a typical workplace of that kind and apply equally to staff with and without disabilities.

We had another question, how does the department instruct providers to ensure they are meeting the requirement about the quote unquote same degree of access as individuals not receiving HCPF? While simultaneously working to meet the standards that supported community connection activity [should] use the community as a learning event because many have standards of conduct that they do expect everyone to follow. Many volunteer activities also have expectations. We wanted to point to our item 21 where we said nonresidential settings that are not provider owned or controlled should comply with additional criteria like access to food and visitors to the same extent as they do for other individuals. That means participants have the same rights and freedoms and same obligation and expectation as everyone out there in the community. If the museum doesn't let people eat in exhibits, then your participants cannot either. If a library doesn't allow people to have phone conversations in the reading room, then your participants can't either. The same expectation of consistent standards of [conduct] would apply in volunteer activities also.

We had a number of questions about access to food which is the next header here. The first question is what is the expectation of a provider to demonstrate that special diet is followed while [also ensuring] ready access to snacks and ready meals. The expectation for residential . . . providers is [in] FAQ 22 and for non-residential providers it is 23.

When considering special diets you should also take a look at item 24 where we say access to food can be restricted but only on an individualized basis set forth in item 29. We also say if a person has a rights modification that restricts their access to food at any time, other people that are not subject to that need to access food at any time. If the fridges locked for one person been other piece of -- people need a key to the lock or method that we can dive into in the second here. [Barb], I think you had a note here?

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We just want to make sure we don't always automatically restrict access for individuals who do have a recommended food or diet issue. If you think about ourselves, who don't have an IDD or disabilities but we may have diabetes or should lose weight, we all have access to food and we don't always make decisions that are perfect. As we work through that I think we need to not automatically restrict just because a doctor recommended a particular food or dietary restriction of sorts.

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We had a question here which relates to a woman who has [Prader-Willi] syndrome. I think most of the IDD folks know what this is. It is a genetic condition that makes it so people don't have a sensation of fullness and would compulsively eat and it's a risk to their health and safety. The question is a woman has [Prader-Willi] syndrome and she moved into a host home and they want to know -- the [gist] of the question is what you do with her and what do we do if a second person moves into the home who does not have Prader-Willi? This provider should work with [the] individual [] and her case manager to implement a rights modification as described in item 29. This process is in addition to the current process for implementing a restrictive procedure. If and when another person is getting ready to move into that host home, and we are talking about another person receiving services, the provider needs to work with the new person to avoid having to modify their rights at all even informally. For example, the second person could get a key or key code to access a locked refrigerator or pantry. We had a suggestion from Shiloh Carson, perhaps if the individual wants a mini fridge or cabinet in their own bedroom, that could be an option. Unless this new person has Prader-Willi Syndrome, you will work with them to avoid any kind of rights modification formal or informal. They should just get access to food and there are ways you can do that with technology or the right kind of refrigerator.

We had a related question, follow-up to the first question, which is could we walk through the different options available for that second individual? In the question they suggest a private refrigerator and cabinet for the second individual and that is a great idea. They could be in the second person's bedroom so that they have their own lock. It could be in the host home kitchen with a lock that some people can open and some cannot. There are other options in the written answer [to] item 22, footnote 6. You could go with a kitchenette but if you have a big enough host home you could have a separate kitchenette. If providers have other creative methods to address this we would love to hear from you and be able to share them with others. For the person . . . who has -- Prader-Willi [Syndrome], they should document and share the relevant portions with the provider. For the second individual there is no rights modification if you are providing the private refrigerator so there is no need for special documentation and that

person-centered plan that they create. The provider created individual plan should reflect that there is a special arrangement. That's all you would need to do.

We're going to move on to private communications and accessibility. There was a question that in a host home environment it can be challenging to make all of the appliances accessible and if the person wants to continue to live in that home that doesn't have some accessibility features like frontloading washers, is that allowable? The answer is assuming the home complies with all of the other existing legal requirements like ADA and safety codes, then yes. It is allowable. This is the kind of situation that we had in mind at the end of answer 26 where we say if immediate achievement of the standards, or prompt achievement, as needs arise would entail significant capital expense such as buying new laundry appliances, providers can wait to incur that expense until that part of the setting is rebuilt, remodeled replaced. Barb I have a note here.

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[The provider needs to] take a level of financing -- functioning into account. We really have people with accessibility issues who would appreciate the opportunity to start to learn to help in the kitchen or do laundry. Anything that we can do to help address these barriers to be respectful of them and work with them on their independence would be great but we do still on occasion find settings that simply are not physically accessible. Even ramp or [stairs]. When you are setting up homes and have people, they are able to maneuver around common areas and their own bathroom and bedroom areas. Make sure those are physically accessible.

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Okay. There was a question, how does the physical requirements of homes as required by the final settings rule apply to host homes and the requirement of new sites needing to meet the standard? There is a concern about limiting accessible housing. What we said in our answer to number 26 is that delayed compliance due to cost concerns isn't allowed for new settings and that position was driven by the CMS requirement to which we are all subject. New settings are supposed to comply with the settings rule from the outset. The transition period is really only intended for settings that were in operation when the rule came out. So how do we apply this to host homes? We wanted to refer you to a communication briefly issued on this in November. You can get that on the settings rule website. We have all of our guidance listed on our website. There is also an office of community living website where you will be able to see that communication brief. We talk about what to do with a new setting and how you should handle that. The gist of what we said is that our main concerns are really new providers, like a whole new entity coming on board here and the situation where an existing provider [adds] a whole new service type. If you are a provider and have been providing services for years and you want to work with some new host home providers, that is not something we are planning to track or assess in the provider transition plan system that we are developing. That is a transition plan system for entities covered by the transition period. We do want to keep in mind that none of us, especially us, we will not have flexibility after that transition period ends.

Let's move on to intersection of settings criteria with person centered planning. The first header was individual choice and I think we didn't get any questions on that. We will move to rights modification. Lori, can I put you on the spot so I [can] drink some water?

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Historically unsupervised time has been dealt with like an -- a restrictive procedure. What guidance does the department offer the individuals who are unsafe to self or others in the community? We fully understand the dignity of risk but currently support individuals that have recent history of violent our drug crimes. What is our responsibility as a provider to keep individuals out of jail or the community safe? Our response to this is if people pose a danger to themselves or others in the community, [then] a court may have already posed some restrictions on them and so the agency or service provider needs to follow those to make sure they are documented in the person-centered plan. Without a court order, if you think some kind of limitation is necessary, then the agency needs to follow the procedure and item 29 for implementing rights modification.

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The next one says the DD waiver places responsibility for health, safety and welfare of individuals with the provider. How does the withdrawal of notice for the continuation of protections -- I think this question is asking what happens if the individual withdraws their informed consent? What if the person engages in behaviors that could land them in jail or engage in self injurious behavior so that they would need hospitalization? We are concerned for the person, the community and the liability. In response to this we want to refer to item 32, which talks about what happens if the individual refuses consent or withdraws consent to some kind of modification that the provider believes is necessary. If the modification is really necessary and the individual or their guardian won't grant consent, then the provider can decide that it can no longer offer services and give notice to this individual with time allowed for the person to provide a new provider. That is all pretty much [in] existing rule. While you are waiting for your new provider to be arranged [for] this person, you may be able to take actions not because you have consent but justified even without consent because you are engaging in self-defense or defense of others. We will get into that in a little more detail in a bit.

There was a question about how difficult it is to amend a service plan via the [Bridge]. Does the department plan on looking at the system to make it more compatible with amendments? The answer is yes. It comes from [Brittani]. The continue -- department is continually looking at the [Bridge] for improvements as we come into compliance with CMS. Some of this will be addressed in the new support plan based off of the new assessment process.

There was a question about what to do with informed consent and court orders, or lack thereof when you have a person in [SOMB] therapy. What we're talking about here for people who don't know the acronym it is sex offender management board therapy. How do you protect people in the community when you also have to get the individual [in] services permission to limit their access to the community? We really wanted to make sure we are on the same page here and giving you consistent guidance. Lori and I -- all

of us had a call with a representative of the Colorado division of criminal Justice office of domestic violence and sex offender management. That's a mouthful but that is the board or office that would be involved in the subject of this question. We do have a representative of that office on the line right now and we will invite her to chime in. Here is what we discussed. As we just said, in answering a few prior questions, if people pose a danger to others, a court may have made restrictions and you need to follow them and make sure they are documented in the person-centered service plan. I want to pause and say throughout this call, just like in the FAQ, we are talking about the plan the person develops with their case manager.

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Historically for the IDD system that has been called long ago with the individualized plan and now it is technically in the [Bridge], it is called the service plan. For other services and populations, it is sometimes called a care plan.

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I think it sounds like the greater concern is what happens when a dozen -- person doesn't have a court order but you think some kind of limitation is necessary? This is really relevant. If you are working with someone who may have had their criminal case dismissed on competency grounds and was never convicted and is [not] under a court order to participate in therapy, to not look at pornography, to not spend unescorted time in the community and so on. What you should do is follow the procedure [in] item 29 for implementing rights modification. You don't sit on your hands and say there's nothing we can do. You identify the kinds of rights modifications that you think are necessary and you work with that individual and case manager to implement the restriction.

We have heard the concern [] that some individuals will [not] consent to rights modification and you may have to tell that person if you don't consent to these restrictions or modifications then we cannot serve you safely and you will have to find a different provider and that -- I think we all acknowledge that is not a great situation but it is also not very different from what has existed up until now. Individuals -- if you wanted to impose a suspension on them and they don't want it they could always just walk away from you as a provider maybe to another provider and maybe not. We have great respect for you all as providers and expect that you probably have some good techniques for handling that kind of situation and you probably want to draw on those kinds of techniques going forward.

The next question, when an individual is on probation or parole [and] the court doesn't provide specifics -- they may say no contact with a minor but they don't specify exactly how much supervision. This provider would typically implement line of [sight] supervision as a right [suspension]. How does the department be able to do this and ensure protection for the community? The answer is pretty much what we just said in the prior question. If there is not a court order, follow the procedure [in] item 29 which means you are getting informed consent and documenting a lot of other details.

This is a new question, will the department be creating a consent form that complies with the federal standards? The answer is we as a team on this call implementing the settings [rule] have not been planning to create such a form.

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As one would assume that the consent for the most part that you all have been using for other things, at least in the IDD community, you need to have an informed consent for that behavioral [ISSP] and you need to have informed consent any time you use medication. I would at least take that as a beginning point or starting point to develop your providers on informed consent.

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Thank you. We had a question, enforcement of providers complaining with the rules setting and providing documentation on following all the recommendations from a human rights committee can be a concern. We understand the oversight agency is [CDPHE] and will they be for noncompliance of consent forms? The question -- I have to tell you we didn't quite understand the first part about what the concern is with enforcement. Please let us know if this doesn't answer your question. The settings final rule prescribes the detailed process for modifying rights and informed consent is one part of this process. Case management agencies are involved in the entire rights modification process, specifically collecting all that information and making sure it's all there. [CDPHE] will continue to be HCPF's partner to make sure they comply with the full federal settings [rule]. That is what we think the question is getting at and if that is not what you are trying to understand, please submit a new form of that question. The provider who thinks the rights modification is necessary should be involved in the front lines of collecting the information and getting the informed consent but it is all centralized and stored with the case manager.

We had a question, what is the expectation on the provider to ensure health and safety when an individual revokes consent for support around management [of] critical health needs by -- like [brittle] diabetes. Can the . . . department provide clarification about when consent is revoked and the individual's immediate health and safety could be in danger? This question also wants to know about pica where people eat nonfood items. The answer here is to refer to item 32 where we say that if the requisite consent is not provided or withdrawn, you may decide you can no longer safely serve this individual and give them notice to find a new provider. After the consent is withdrawn, you can't take actions that were legal only because you have that consent. You can still take actions that are legally justified on some grounds other than consent such as self-defense or defense of others. If someone is about to eat something that will send them to the hospital, then intervention to prevent them from seriously harm -- harming themselves may be warranted as defense of others here. If you do that, then you need to refer to the rules for restraints and emergency control procedures because it may be something you have to report you do it. -- If you do it.

Related question is what risk affecting a person's health and safety is an allowable risk? How do providers [know] when we are appropriately following the recommendation to allow for some dignity of risk versus our obligation to provide for the individual's health and safety? The answer here is if there is an existing standard then you as a provider

have to follow it. Just as an example, [an ACF] has to [follow HCPF's regulations for ACFs, as well as CDPHE's regulations for ALRs] which include requirements related to health and safety. If there is not a statute or regulation on a subject, the settings [rule] helps you fill in the gap by having a process led by the individual in which the individual decides what kind of risk they want to take and what restrictions they will accept. As a provider your role is to help the individual understand the risk and make informed choices and to help them learn skills so that over time they can make better choices and need fewer restrictions. If you think a rights modification is necessary and the individual doesn't, go back and look at item 32 which helps you see what to do in that case.

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This is Nancy. I'm going to have to break off to go to another meeting but thank you for presenting all of this great information.

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Thank you for joining us, Nancy.

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Goodbye.

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We are about to transition to a subject we did get a number of questions about and this is about the timeline and FAQ to obtain an informed consent [or] eliminate rights modifications by May 31, 2018. We heard from several providers and case management agencies that this is not enough time to do all the work that needs to be done, find all the information and get all the documentation. People are worried that it is too much of a time crunch. The short answer here is the deadline made sense to us and was [vetted] at the time but we hear you. . . . We all want you to have time to do things the right way. Based on this input we got from all of you, and further consultation within HCPF, here is our plan. The plan is to revise the deadline to take advantage of an existing individualized service planning cycle. Everyone has to have at least one big annual cycle where they are updating their service plan and they are getting updated information. This is talking about the person-centered plan that they are creating with a case manager for their whole system of support and services. You should take advantage of that annual cycle to get all of the updated documentation and consent into place by next May. May 31, 2019. We acknowledge and understand that person centered plans can take effect up to 90 days after you get them documented so that means by August 31, 2019, the updated rights modification goes into effect or is eliminated depending on what you were able to agree to [and] document with each individual. I want to flag that because of this, the reality of the way the case planning works and because we are still doing ongoing development with OIT on the web-based platform for provider transition plans, we are looking at extending the statewide compliance deadline by one year to March 2021. That is something that we still have to talk with CMS about and get approval for so that is not final, but it is what we as a settings [rule] team think makes sense. That is what we will put forward. We will have to issue something in writing. This is the first time we have discussed it outside of the state agency and before it goes into writing I think we will have to [have a] more official conversation with CMS, hopefully soon. I think you cannot count on this [as] the

absolute final date but what we are advocating and think makes sense based on the situation.

There is one caveat which is this extension doesn't mean that providers can [defer] compliance until 2021. It means by March 2021 everything is supposed to be wrapped up including time for us to make final compliance determinations and help individuals in non-compliant settings transfer or transition. That will take time. As you as a provider fill out your transition plan and identify issues, which you may have already done, you need to be taking whatever remedial actions are identified now unless there is a real barrier to doing so like statutory barriers or major compliance costs. We had a few questions that are similar to that so let me make sure we answered all of those.

There was a question, is the May 31 deadline related only to the assessment of rights modifications or the entire provider transition plan? The answer is yes, the May 31 deadline only relates to rights modification. There are other steps that providers can take right now or as soon as they complete their PTP to ensure overall compliance with the rule.

There was a question will rules be altered prior to May 31? Is there a process to get an extension? When are we going to amend regulations to include this work? Because of the extension I just described, that is an extra year and the new deadline is pretty far off. We are not currently considering additional extensions on top of that. [As] for the rules and regulations, some of you have -- as for the rules and regulations, we don't want to rush that or impose a potentially unfunded mandate on providers or others. So if you can be taking reasonable steps to come into compliance now, you should. In your PTP, you will have a way to let us know if you are facing significant compliance costs. If you are going to have to hire people or anything based on the rule as you understand it under the last FAQ. Once we have that information we will know whether there needs to be a budget action. We just don't have the information to decide right now.

What will be the process for emergency right suspension [, restrictive intervention,] and emergency control procedures? Not having an outlet for these will severely restrict a provider's ability to serve many individuals. Under the current regulation, emergency right suspension -- rights suspensions are used when [imminently] necessary to protect the health and safety of the person, others or property. This is a DD [rule]. I think we should clarify this. An [] emergency control procedure is used in order to keep the person receiving services and others safe. These measures usually involve self-defense or defense of others and that means you can use them even when the individual does not consent. If you are using it just to protect property and you don't have self-defense [or] . . . defense of others [then] we would have to check on whether defense of property is legal to do something. We don't read the rule, the federal [rule], as preventing appropriate use of these so long as you follow the procedures in the current regulation. On restrictive procedures, there is no emergency restrictive procedures so you would just follow the same process as usual for getting a regular restrictive procedure which includes getting informed consent and other items required for your behavioral individual service and support plan.

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And that is in the IDD system.

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And then get whatever additional documentation you need under items 39.

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We had a question about how we said in [the] FAQ how we're not planning to change procedures [relating to human rights committees (HRCs)] which is also an IDD entity. [Wherever] notice [] has historically been required, the notice now is just a prelude to informed consent. Does this mean suspensions [may still occur short term in emergency situations while teams confer and work to achieve consent]? Yes, [Indiscernible-muffled].

Does the department [expect that we continue to follow all due process for suspensions of rights and restrictive procedures] in addition to the due process outlined here. A related question is what does the right to due process look like to the individual? Yes, that's what we expect and all the existing and settings final rule applies. If you are already following due process rules, continue to follow those procedures and also get informed consent and the -- whatever other documentation may be required . . . under item 29. Keep in mind there is a pretty fair amount of overlap between what we have already [been] requiring in the IDD world and the new requirements. It is ought -- not always a ton of more information.

The due process for restrictive procedures and suspension of rights will be the same moving forward and if they are the same what separates these two modifications? The answer is the more we learn about the federal rules, the more we're starting to think there should be a single streamlined process for everything whether it is what we used to call a restrictive procedure, rights suspension or any other kind of modification to someone's rights. We are studying this and we may end up having to update the crosswalk where we set up what our roadmap is for making bigger regulatory changes to make everything consistent and simple. We are starting to think there are too many similar terms out there for similar things and there should be a more streamlined process. The exact details of that have not been decided. We think for the foreseeable future that human rights committees will continue to play their current role which is some kind of involvement or oversight to make sure people -- that any restriction makes sense for people.

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What is the expected time line for the [BUS] to be ready for input of our documentation? You can start inputting documentation relating to the rights modifications -- you can start doing that now. Just use the log note field which we mentioned in item 31. You can check -- sorry. We will check on the timing and the development of dedicated fields for rights modifications. I think we just got this question at the last minute, so we still have to check on the timing. If you are ready to roll now, just use the log note field --.

There is a question about without the ability to limit certain rights when someone removes consent, for example limiting access to sharps, chemicals, fire starting

materials and so on, it could become dangerous to serve individuals. The department says we may choose to terminate an individual in that case but we must allow time for the person to find a new provider. How do we help the person and the providers stay safe in the time it is taking the person to find a new provider without being able to limit access to the dangerous items? We had a question for this provider which is how are you currently handling the situation if there is not already rights [suspension] in place? We wanted to know -- if the provider is on the line you can unmute yourself with \*6 and let us know what you currently do.

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If this is a person you've never seen -- who you have never seen this kind of challenging behavior and you have no way of knowing they will all of a sudden pull a knife on the provider or start a fire, then we would expect what we have done in the situation in the past. You would have to impose an emergency control procedure where you basically would have to do a restraint. If the person is going to start a fire right there you would restrain them and then you would be removing that fire starting material by way of an emergency rights suspension and we have all kinds of prescriptive rules about how to do that. That is how I know it is [done] now [Indiscernible - multiple speakers].

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If we received consent to limit access to sharps but then somewhere in the FAQ it says the person can choose to remove consent without any due process. They can say I remove my consent that you can restrict my access to sharps and then that person no longer has that restriction and can access sharps. That's obviously a dangerous situation if we have to give two weeks notice and we cannot limit access to those sharps. Even if you can say you can limit in the moment, it is still a risky situation.

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Right now haven't you typically handled those by way of the rights suspension right now and if the person -- you don't have informed consent with the rights suspension, you have noticed. How have you handled that where you have a suspension and they say forget it, I'm going to go ahead and find a knife somewhere. Then you deal with that in an emergency situation and you might then decide to terminate services to that person and the problem becomes how does a person get served in the interim during the 15-day period where you are serving them notice to terminate service to them. That becomes another issue. [Indiscernible - multiple speakers]

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This is Jody. I think also part of the question is there are currently through rights suspensions many processes that are pro-active. There might be a bag search protocol coming back and forth from a worksite where they have more access to things or something like that that enables us to ensure that there are not fire-setting materials or individuals with the recent history of attempting to start a fire or a recent attempt at attempting to utilize a sharp as a weapon. Those are the instances specifically that I think we are looking for more guidance around because how are we then asking a true health and safety situation if you are no longer doing things proactively and all you can do is during an emergency control procedure while that individual has a knife or is attempting to start a fire, intervened? I'm concerned about the health and safety

potential risk for a handful of individuals served and I don't find giving notice to be an appropriate response.

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Jody, I'm confused because the example you gave, absolutely right on as far as there are proactive steps you take but in this case, you have a known dangerous behavior so you would in your rights modifications that you are still able to do, you would have the bag searches still contained in that rights modification. [Indiscernible - low volume]

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It says in the FAQ that the person can remove consent at any time.

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Yes, they could do that exact same thing with a rights suspension. You don't get informed consent for a rights suspension, you just give notice you will do these bag searches but they can say any time you are not going to search my bag and pull out a sharp. You follow the same approach in terms of having that proactive approach in the rights modification where you include that you are still going to do a bag search and they might not ever sign that informed consent to do that [and] if they don't sign it, then you might choose not to continue to serve them.

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What about the example of lopping -- locking of sharps? The person background but in the future, we would get informed consent that we are locking them up and then the person says one day I no longer want to give informed consent. I should have the right to access these sharps and can you unlock them. I'm removing my informed consent?

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I think to summarize what Lori was saying and what we're trying to say is if you know there is an issue, I think you all get this. If you know there is a situation you want to build that in advance and get their consent and put it in with the right documentation. If they agree to it and then revoke consent and say I don't agree anymore to this consent, in that case they are not consenting and they have revoked, you don't have permission to do what you were doing but you may still have permission under emergency control procedures or emergency rights suspensions to do what you need to do to keep that person and yourself and others in the community safe. That is a different source of authority to keep doing the thing you are doing if you really think there is a safety issue.

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Honestly clearly, we have to flush this out as Leah said earlier. We need to provide more detailed guidance because this is evolving. Just like when you asked if we would be creating a form for informed consent. We have the pieces that you would likely need to include just like we have the things that CMS says one has to do with the rights modification. We still need to flesh out how that will work and particularly in these emergency situations. For the time being, you would employ our existing [rules] around emergency control procedures and emergency rights suspension. You still would've had to follow that getting the upfront informed consent to follow that set of processes that makes sense.

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I think we will have to add more to our answer here when we publish something.

In the current environment finding providers to respond to RFPs is very difficult. What happens if we were to provide notice to an individual who has retracted his or her informed consent and no other provider will serve the individual? We again have a question for this provider which is how are you currently handling that kind of situation [where] no other provider is willing to step in. -- If they are on the phone? If you said something, you are still on mute. There is no change in the policy for that. That is the answer.

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I think the question is going back to the fact that if you can no longer keep the individual safe because they have revoked their consent but you still have an obligation to serve them, there are instances in the community where all of us are serving an individual that isn't getting picked up for longer than our typical notice would require. In those instances where we have lost the ability to provide the consent, I definitely hear what you are saying with the emergency control procedure but a lot of the current suspensions that individuals have in place, if they are revoked they are -- there is still imminent health and safety issue concerns that could come up where you cannot guarantee the safety of an individual [in] services. I think that is a fundamental difference. Right now we can do it because we have the ability to provide [suspensions] but if we have somebody who has been deemed that they are incompetent to stand trial, so they don't have court orders in place specifically but they still have a criminal re-since path and we cannot put in place those pre-active matters because the individual simply will not consent, how do we keep them in the community safe?

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That still goes back to the same issue that the person with the rights suspension that could be dangerous can at any point walk out of your services and say I don't care that there is a rights suspension in place, I'm going to go ahead and do these dangerous things. You are powerless to do anything so you serve notice and unfortunately the community and the person and provider are at risk during the interim period of time until another provider picks them up. I think that has always been an existing problem. The element of informed consent versus providing notice and imposing upon them does generate an additional challenge for us all. We will work on flushing out the details of that response more.

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It's a good question and it's difficult because the federal rule is changing something but even the feds have acknowledged it's in a -- if it is an emergent situation you are still going to look to the emergency control procedure or the emergency rights suspension if you have an imminent risk that people are going to be hurt or the individual will hurt himself. Those are still in place.

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I'm sorry. One last question and I promise I will stop asking questions. I just heard you say emergency rights suspension. Is there any federal guidance around the potential link of an emergency rights suspension. --?

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No, there is not. I think we will have to do some thinking around -- if you want to do something for two weeks, is that whole time [an] emergency situation? I think we have

to think about that. We're taking notes here and we will have to get back to you with more.

We are concerned about not being able to utilize a control procedure to ensure [a] person[s] safety and are even more concerned [with] the FAQ on self-defense if warranted. The state has traditionally prohibited [self-defense] when supporting a need for safety, how will this change how we keep people safe? We think it's an invitation to harm people. The answer here, as we said in a written response to item 14, restraints and restrictive interventions can be used under certain conditions. If you have to do that, you need to do advance planning and get the individuals consent and documented and these requirements are new compared to the current IDD [regs] for safety and emergency control procedures as well as the regulations for many other waivers.

What do you do if you don't have consent? The response to item 32 says when the provider no longer has consent they may be able to take actions justified as self-defense or defense of others. In this context when we are talking about self-defense we are talking about . . . that [as] a reason for intervention. What is giving you a legal right to intervene here and do something to someone? We're not talking about any particular method or technique like how you intervene and what physical movement you are going to make. The bottom line is if a particular method is not allowable under the current rules, it is not allowable under the FAQ. If it is already allowable, under the FAQ it is still allowable as long as you have a justification like self-defense or defense of others. Lori wants to clarify.

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I think what may have thrown off our response to this is the [term] of -- self-defense. We don't use that term in IDD. We frown on that term and if you are thinking about crisis intervention kinds of techniques like CPI, the focus on those obviously are about teaching behavior as a communication and de-escalation and using an escort or physical restraint, never putting your hands on a person. That is still the case and expectations of how our rules are written. We have very prescriptive rules around the use of physical restraint. What we're really talking about is we are not telling you if you should use [Indiscernible] or can or cannot use something. We are also saying our safety control procedure and emergency control procedures rules are still in force and [if] the person is in imminent danger, you have to do something to keep them safe. That is not a self-defense, that is a protection for that individual and we would expect that you will physically stop them from running out into traffic. That has not changed. Our rules currently do not forbid restraints nor do the settings rules [forbid] restraint, rather that you have to use the rules as prescribed and you have to protect people and you can only use restraints in order to protect the individual and other -- others and to de-escalate in the recent -- least restrictive way. I don't know if that helps clarify.

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It's Leslie, how are you?

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Good.

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If I ask a clarifying question, we understand [Indiscernible]. What we are reading in your responses to the FAQ is if we are going to implement a safety control procedure that we have to get informed consent go along with that. I think that is where everyone is struggling is when a person's safety is an imminent harm and we don't typically ask permission, how are we supposed to get that informed consent? The second part of that is when you talk about the emergency control procedure, in rule it says if there is an anticipated need for a restraint following that we have to develop a safety control procedure. That is where a lot of these are coming from.

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I guess I would say that I think it is okay and it would be good practice to say to the individual . . . that we know you have this propensity towards this dangerous behavior of running into traffic or we know you have a tendency to strike out at your peers that you live or work with. And we have a responsibility to keep your peers safe, therefore, we are asking for your informed consent in the event of that because we have a very prescribed way we are going to do this safety control procedure with you and we are going to use this specific intervention technique. I think it is absolutely appropriate to ask for conformed -- informed consent and we have to get it for the use of behavioral [ISSP] where that is the ultimate and restrictive procedure so why would it not be appropriate to get informed consent for that? So if that person or their guardian does not consent to that, I as a provider would say I'm not sure I would be well-equipped to serve this individual who is dangerous and could hurt the people he or she lives with if I'm not able in the last resort to use this safety control procedure.

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Does that make sense?

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Yes, I think it does but I think it goes contrary to stop the person from running up the street if they are going to get hit by a car.

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[Well] that would be an [] emergency control procedure if it is not a known behavior. [But] if it then becomes a known behavior then I have to have safety controls. I think there are follow-up questions that need to go along with this in terms of how much -- I think there are follow-up questions.

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We definitely are taking notes feverishly here and we will probably [give] this one hard [thought] and have more detailed responses.

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Thank you, Lori.

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There was another question -- and we are trying to wrap up by 12:30 PM. We are near the end of the questions. There is a large training component to this work for both the providers and case management agency. Will there be a baseline standard training put out by the department or . . . CDPHE? [HCPF has presented seven trainings on the rule. Please see the HCBS Settings Final Rule website.] Please take a look at the slide deck[s].

The next question, relates to different timelines for providers and case management agencies to come into compliance and I think the [gist] of this question, we probably answered when we talked about the extension for case management agencies and providers to get all of the rights modifications either cleaned up and get consent to what you didn't have consent for or to eliminate the modification by May 31, 2019.

There is another question about CCBs and providers have meetings and may want additional information and so we do use a lot of channels of communication to try to reach all of you. Some of us on this team have been on calls. There is a quarterly [Indiscernible] IDD provider call. There are a lot of ways we send out information and I think the best way, if you are a provider or case management agency [and] you have some question about am I doing this right? And you have not already had a site visit, you can request a site visit and [CDPHE] will be happy to schedule one with you and provide on-site guidance and review your documents with you and help understand what you need to do in your personal case and we hope that is helpful and you will take us up on our offer. That is the last question that was submitted before the calls. Are there any final questions . . . while we have time?

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This is Tiffany with Developmental Pathways. As we are talking about the rights restrictions and suspensions, you haven't talked about what a case management agency is supposed to do when all providers have been refused to serve a person who will not sign an [ ] informed consent and what the possible ramifications are for that individual and for the community. It feels like we are looking at putting people in regional centers or waiting until they commit a crime and then intervening and having court orders. We are at a loss as a case management agency when a provider [Indiscernible] but if there are no providers, that's a big problem. I don't want to belabor the point, so if you want to say we need to think about this, that's fine. I just want to call out that case management agencies are responsible for finding services and it feels like there might not be options for people who really do have some serious dangerous behaviors.

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Duly noted. This seems to be the crux of the issue here relative to that change of informed consent [for a rights] suspension. I would love to chat with a few of you guys off-line, namely the three of you -- Jody, Leslie and Tiffany. I would love to set up a conference call with you guys.

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I would love that.

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If you guys would be willing to send me your email and you know my . . . email, I will set up a conference call as soon as I'm able with you and I think we can have a focused conversation about this because I hear the urgency around this effect -- affecting capacity and the health and safety of a particular vulnerable set of our population. That would be great.

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Thanks, Lori.

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You bet.

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Lori, this is Michelle with the SOMB. Could I please be included in that conference call?

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Absolutely. That would be wonderful. Thank you so much. A thank you. --

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Thank you.

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Any other folks with questions?

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[Indiscernible-muffled] we are looking at branching out into doing work with the [Indiscernible] program. When they are not in a host home and are in their own apartment and they have a guardian because they don't make good decisions, with those restrictions still need to be -- with that still need to be done -- I forgot we call them.

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Yes, I want to make sure we understood the question. There is an individual who is receiving [CDASS] in their home?

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Right. In their own home.

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[Indiscernible - multiple speakers] They were court ordered into the state mental health services and then they moved from the institutional setting into the community and there were restrictions that came with them that were set up by the mental health system. In that situation with that -- he passed away [REDACTED] but we always -- that was in his risk mitigation plan but I don't know if we ever really did those formal types of things. In that situation where they have a guardian and a contract for them to live in the community and there were mostly environmental types of restrictions. We mostly set up his home [Indiscernible-muffled]. Moving forward if we work with someone like that, with those rights restrictions need to be done based on the requirements in the mental health system?

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If we are talking about a person who is receiving [CDASS] in their own home, the answer is twofold. Yes, the settings rule applies everywhere. CMS [Indiscernible - multiple speakers] That applies wherever services are rendered and wherever people are receiving [HCBS] live. If there are restrictions whether they are court ordered or agreed to some -- through other meetings, they should be in their person-centered plan. The second part of my answer is as an enforcement approach that we are taking as a state [Indiscernible], we are presuming that people in their own home -- that is compliant with the settings rule. We're not doing site visits the way that [Indiscernible - multiple speakers] And are [not] doing provider transition plans. You should do it and when we get around to checking if you have done that is in the course of the normal cycle of [CDPHE] site visits and whatever else you have been visited for.

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The reason I'm asking now is our organization is looking at working with you guys [Indiscernible-muffled]. I was curious because I don't know if we will ever get another

intensive client the way [REDACTED] was. [Indiscernible] I pretty much coordinated the environmental controls. He had a camera in his living room and he was aware. He knew that they were there.

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I'm going to stop you [here].

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I'm just wondering, everyone would need to do a rights restriction plan . . . --

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Yes, per the settings [rule]. We are out of time here. Thank you so much to everyone who submitted questions in advance or asked questions today. It's very helpful for us and for all of you. That's all we had for today and we will try to start putting more of this online as we get the recording and transcripts for those who missed it. Thank you for joining us. You can all disconnect. [Event Concluded]