

Provider Training Series

Chapter 45, Section 13

Standards for Home and Community-Based Waiver Services (Module #4)

Wyoming Department of Health

Division of Healthcare Financing

DD Waiver Provider Training Series



Welcome to the Wyoming Department of Health, Division of Healthcare Financing (Division), Developmental Disabilities Section Provider Training Series for Chapter 45 of the Department of Health's Medicaid Rules (Rules). These rules govern the home and community based Comprehensive and Supports Waivers, hereinafter referred to as the DD Waivers.

Chapter 45, Section 15(d) states that all persons qualified to provide waiver services shall complete training in specific areas prior to delivering services. Although some provider organizations may choose to develop their own training modules, individuals who complete all of the Series training modules and associated training summaries will be in compliance with this specific requirement. Please note that there are provider training requirements established throughout Chapter 45, and it is the responsibility of providers to ensure they meet **all** training requirements prior to delivering waiver services.

This module covers Section 13, which addresses standards for home and community-based waiver services.

Purpose of This Training



To familiarize providers with home and community based services and service setting requirements and standards that must be met during the provision of waiver services.

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Training Agenda

- ▶ Review of federal authorities
- ▶ Home and community-based service (HCBS) settings
- ▶ Provider owned and operated settings
- ▶ Standards of HCBS providers
- ▶ Required policies and procedures

At the end of the module addressing standards for home and community-based waiver services, the following topics will have been introduced and explained.

- A review of the federal authorities that govern the DD Waivers;
- The characteristics of settings that are considered home and community-based in nature;
- An explanation of provider owned and operated settings, and the difference between these settings and personal residences;
- The standards that home and community-based waiver providers must meet, including inspections, emergency plans, and participant rights and freedoms; and
- Policies and procedures that are required, including policies related to conflicts of interest.

Please note that, for the purpose of these trainings, providers include provider staff and case managers, unless there is a specific need to make a distinction.

Choice



Freedom to make choices is a human right. Laws protect people's right to decide how to spend their money, make their own health care decisions, work for a living, and have relationships with friends and family.

Home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives. Whether the choices are related to big decisions such as who provides their services, where they live, or what they want for their future, or small decisions such as with whom they spend time, what and when they eat, and how they spend their day, having choice is paramount to human dignity.

You will see that the philosophy of participant choice is infused throughout this Section. Facilitating individual choice is a crucial part of being a DD Waiver provider.

Federal Authorities



42 C.F.R., Part 441, Subpart G establishes the federal requirements for home and community-based waiver services.

The DD Waivers are governed by the Code of Federal Regulations (CFR) Title 42, which establishes federal requirements for home and community-based waiver programs, including requirements related to person-centered planning, characteristics of authorized service settings, provider compliance, and assurances that the state must meet in order to administer waiver services. The full rule can be found at <https://ecfr.io/Title-42/sp42.4.441.g>.

Standards and Regulations of Home and Community-Based Services

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- ▶ Defines the philosophy of the DD Waiver programs.
- ▶ Establishes basic guarantees, and assures participants have choice in their lives.
- ▶ Holds providers who control settings to a high standard.
- ▶ Requires compliance in order to receive funding for waiver programs.

The Wyoming Department of Health's Medicaid Rules align with the federal requirements for home and community-based services. Rules and regulations are important as they have the full force and effect of law. But the purpose of these rules and regulations is about the people that the services ultimately impact.

Having agreed upon standards enables the Division to define the person-centered philosophy of the DD Waiver programs, and how we translate those philosophies into practice.

The regulations require providers of home and community-based services to ensure that participants:

- Have full access to their community;
- Have the freedom to make their own choices;
- Have interactions with whom they want, when they want; and
- Experience privacy, dignity and respect in their life.

Providers that deliver services in settings that they control need to be held to a very high standard to ensure that the participants receiving those services continue to have the rights and responsibilities that other community members have.

As mentioned in earlier trainings, the DD Waivers are funded with state and federal monies. In order to receive the federal portion of the funding, which accounts for 50% of the budget, the

DD waivers must be in compliance with the federal regulations.

Home and Community-Based Service Settings



Home and community-based settings are those that fulfill the requirements to receive Medicaid funding for home and community based services.

When we talk about home and community-based services, we are talking about the actual services that are being provided. Community support, respite, and companion are all examples of home and community-based services. Home and community based service **settings** are the settings in which the services are provided. In order for a setting to be home and community-based, it must meet specific state and federal requirements as well.

Goals of the Home and Community Based Settings Rule

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- ▶ Defines characteristics of settings that are community-based, as opposed to those that may have the qualities of an institution.
- ▶ Ensures that HCBS settings offer people with disabilities access to the broader community and facilitate relationships with others.
- ▶ Ensures that HCBS settings offer people with disabilities control over daily decisions.

In 2014, the Centers for Medicare and Medicaid Services (CMS) issued guidance regarding home and community-based service settings. CMS recognized that the effort to deinstitutionalize individuals with intellectual and developmental disabilities was a necessary and important movement, but that further steps needed to be taken in order to support individuals in the community. One step was to provide clear definitions and regulation regarding the types of settings that truly uphold the goals of home and community-based programs, which would then qualify for federal funding for home and community-based services.

CMS identified goals it aimed to achieve as part of the 2014 guidance. In addition to clearly defining the characteristics of settings that would be considered home and community-based in nature, CMS wanted to ensure that the settings supported people with disabilities to integrate into their respective communities, develop and maintain relationships with others, and control decisions within their daily lives.

Settings That Are NOT Home and Community-Based

- ▶ Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- ▶ Located in a building on the grounds of, or immediately adjacent to, a public institution; or
- ▶ Has the effect of isolating individuals receiving HCBS from the broader community of individuals not receiving HCBS.

Chapter 45, Section 13(c)

CMS has defined settings that are not considered home and community-based in nature. These settings include:

- Any setting that is located in a building that is also publicly or privately operated facility and provides inpatient institutional treatment;
- Any setting that is in a building on the grounds of, or immediately adjacent to, a public institution; or
- Any other setting that has the effect of isolating individuals receiving home and community-based services from people who don't receive home and community-based services. Requiring participants to spend their free time with roommates in a group home rather than participating in community activities with friend from work is an example of how participants could be isolated.

This definition from CMS has been adopted in Section 13(c).

Settings That ARE Home and Community-Based

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- ▶ Assists participant to achieve success and support full access to the greater community;
- ▶ Is selected by the individual from options including non-disability specific settings;
- ▶ Assists participant to advocate for him or herself, and participate in lifelong learning opportunities;
- ▶ Ensures individual's rights of privacy, dignity, respect, and freedom from coercion and restraint;
- ▶ Ensures, but does not regiment, individual initiative, autonomy, and independence in making life choices, including daily activities, recreational activities, physical environment, and with whom to interact;
- ▶ Facilitates individual choice regarding services and supports and who provides them; and
- ▶ Encourages individuals to have visitors of their choosing at any time.

Chapter 45, Section 13(b)

CMS has also established characteristics of settings that **are** considered home and community-based in nature.

- In order for a setting to be considered home and community-based, it must be integrated and support full community access.
- It must be selected by the participant, who had other options from which to choose, including settings that are not disability specific.
- The services received in the setting must facilitate opportunities for participants to advocate for themselves and participate in lifelong learning.
- When the participant is in the setting, their rights to privacy, dignity, respect, and freedom from coercion and restraint must be ensured.
- While in the setting, participants must have autonomy and independence in making life choices, including those related to daily and recreational activities, physical environment, with whom they interact, the services and supports they receive, and who provides those supports and services.
- Participants should be encouraged to have visitors when they choose. Providers and participants should work together to identify how participants can have visitors in a way that does not infringe on the rights of others, and considers the wishes and needs of everyone in the home.

This guidance has been adopted in Section 13(b).

Provider Owned or Operated Settings

Certified waiver providers offering direct care services to participants in a provider owned or operated service setting shall meet all applicable federal, state, city, county, and tribal health and safety code requirements. A service setting includes the provider's home, if services are routinely provided in that setting.

Chapter 45, Section 13(a)

Section 13(a) establishes that certified waiver providers offering direct care services to participants in a provider owned or operated service setting shall meet all applicable federal, state, city, county, and tribal health and safety code requirements. Overall, Section 13 establishes certain requirements for provider owned or operated settings as well.

So, what is a provider owned or operated service setting?

Types of Provider Owned or Operated Settings

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- ▶ Property is owned by the provider.
- ▶ Property is co-owned by the provider and another party.
- ▶ Property is leased or owned by the participant, who has a roommate who is paid to deliver HCBS for that person.
- ▶ There is a direct or indirect financial relationship between the property owner and the provider.

Provider owned and operated settings can take many forms.

Settings that are owned or co-owned by the provider are pretty easily identified. However, there are other situations that are a little more difficult to classify.

If a participant has a roommate who is paid to provide waiver services to them, this would be a provider operated setting, even if the property is leased or owned by the participant. Let's use the example of Bill and Ted. Bill is an employee of ABC Services. ABC Services is listed on Ted's individualized plan of care (IPC) as the Community Living Services provider. Bill, as the employee of ABC, lives with Ted and provides these services. Even though both Bill and Ted are leaseholders and pay rent on the apartment, the setting is considered to be provider operated because Ted receives services from Bill.

If the property in which services are being provided is owned by a person who has a direct or indirect financial relationship with the provider, the property would be considered provider operated. As an example, if the provider is married to the property owner, this would be an indirect financial relationship. If a provider is unsure if a financial relationship exists, it would be best to err on the side of caution and presume that it does.

Provider owned and operated settings are not considered bad or undesirable...these settings just need to adhere to some additional standards, which will be addressed in next section of

this training.

Private Residences

What they are:

- ▶ Participant or family member privately owns or leases the home.
- ▶ Participant lives independently or with family, friends, or roommates, and the friends or roommates don't receive payment for providing services to the individual in the home.
- ▶ A provider does not handle or receive funds from participant for rental payments.
- ▶ A provider or provider staff member is not listed on the lease.

How to support participants:

- ▶ Ensure the IPC services support access to the greater community.
- ▶ Provide support to participants, family members, and providers to understand the goal and intention of HCBS.
- ▶ For case managers, conduct regular home visits.

Private residences, as identified on this slide, are not considered provider owned or operated settings. These include:

- Residences that are owned or leased by the participant or family member, or residences in which the participant lives independently or with others who do not get paid to provide waiver services;
- Residences for which the provider does not receive payment, even if the payment is a "pass-through" from the participant to the provider to the landlord; and
- Residences that don't have the provider or a staff member who works for the provider listed on the lease.

When a participant lives in a private residence, the services that providers deliver must still be home and community-based in nature. Ensuring that the participant's IPC upholds that philosophy is critical. Providers should educate the participant and family members, as necessary, on the goals and intentions of home and community-based services. Additionally, case managers have a responsibility to conduct home visits to ensure that participants are in an environment that meets their needs and is comfortable for them, and to have genuine exchanges about their services, their living situation, and their lives.

Private residences are not subject to requirements of provider owned or operated service settings.

HCBS Setting Standards



Providers delivering home and community-based services in provider operated settings must meet specific standards.

Providers who deliver services in provider owned or operated settings are subject to a higher level of scrutiny due to the level of control the provider has over these settings. These settings must comply with the federal and state regulations established for home and community-based services settings.

If a provider does not intend to deliver services in a setting they own or operate, the provider must sign a “No Services In a Provider Operated Setting” form, which can be found on the [Forms and Documents Library](#) page of the Division website, under the *Certification Forms* tab. If this changes, the provider must notify the Division and come into compliance with the home and community-based services setting standards. Failure to notify the Division and be in compliance with the home and community-based services setting standards could result in the Division recovering Medicaid payments that the provider has received.

Inspections of Service Settings by an Outside Entity

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- ▶ Must occur at least once every twenty-four (24) months.
- ▶ Must verify that all areas are free of fire and safety hazards and any other significant health or safety concerns.
- ▶ Must result in a written report that describes items inspected and recommendations to address deficiencies.
- ▶ Provider must remediate deficiencies within thirty (30) days.
- ▶ External inspections are required on all new locations.

Section 13(e) established that provider owned or operated settings are subject to an inspection from an outside entity, or what is often called an external inspection, at least once every 24 months. Outside entities include fire marshals, certified or licensed home or building inspectors, or appropriate contractors inspecting a part of the setting within the scope of the contractor's license.

The outside inspector must verify that all areas inspected are free from fire and safety hazards, and are free from any other significant concerns to the participant's health or safety.

The purpose of this inspection is to ensure that the setting is safe, and to avoid large scale hazards from sneaking up on the provider and interrupting services. As an example, wiring may not be something that a provider will notice; however, an occasional inspection may identify damaged wiring before it causes an electrical fire that puts everyone in the setting in danger.

Once the inspection is complete, the inspector must generate a written report. The report should contain the items and areas inspected, as well as any deficiencies found. Providers are responsible for ensuring that the report is complete and addresses the requirements outlined in Rule. The provider then has 30 calendar days to remediate the deficiencies. If deficiencies cannot be remediated within 30 days, the provider should refer to Section 13(e)(v) for further guidance.

The Division has the right to require that the setting undergo additional external inspections if there has been a modification to the setting or the setting appears to be unsafe.

New locations are affected by this provision of rule. Before a new location can be used for service provision, the following steps must occur:

- The provider must notify the Division at least 30 calendar days before the new service location is used;
- An external inspection must be conducted on the new service location;
- All deficiencies identified in the external inspection must be remediated; and
- The Division must review the external inspection and verify that all deficiencies have been remediated.

An **Outside Entities Inspection Requirements** tool is available on the [Forms and Documents Library](#) page of the Division website, under the *Certification Forms* tab. This tool includes information on the external inspection requirements, as well as a simple reporting tool that can be used by the outside inspector.

Emergency Plans - What is Required?

- ▶ Fires;
 - ▶ Bomb threats;
 - ▶ Natural disasters;
 - ▶ Power and other utility failures;
 - ▶ Medical emergencies;
 - ▶ Missing persons;
 - ▶ Provider incapacity;
 - ▶ Safety during violent or other threatening situations;
 - ▶ Staffing shortages due to other emergency situations;
 - ▶ Vehicle emergencies;
 - ▶ How providers will care for participants while caring for children under 12 or others who need support, if applicable; and
 - ▶ A contingency plan that assures a continuation of essential services.
- Chapter 45, Section 13(g)(i) - (ii)*

Section 13(g) addresses emergency plans. Providers delivering services in a provider owned or operated setting are required to have emergency plans to address many of the “what ifs” that can and do happen. Emergency plans must be specific to the setting, outlined in writing, and be available for participants and staff members to refer to, when needed. The purpose of these plans is to ensure that participants and providers know what to do if an emergency arises, so it is critical that the plans address the specific concerns related to the setting. If providers have a solid plan in place, there is no need to figure things out in the middle of a crisis, and there is less chance of the emergency developing into something worse.

The following emergency plans must be developed, adopted, and followed as necessary.

- Fires.
- Bomb threats.
- Natural disasters, including earthquakes, blizzards, floods, tornadoes, wildfires, and any other natural disasters that would or could logically occur in your area.
- Power and other utility failures. Developing a plan for a power failure is fairly easy, but think about other utilities that are in use. What happens if the setting doesn’t have running water or the sewer line is plugged for several days? What if the setting has a furnace that runs on natural gas and gas service is interrupted? Providers should think through these scenarios and have plans to address these emergencies.
- Medical emergencies. Providers often have names for the locations, such as The Pine

- Street House, or simply Headquarters. It is important to include a reminder of the actual address of the location in your plan for medical emergencies.
- Provider incapacity. A plan for provider incapacity is extremely important. What if tragedy strikes and an independent provider or provider staff member who works one on one with a participant is incapacitated or dies? The plan should address how the provider will address the safety of the participant or participants in such an event. The plan should be developed keeping considerations such as the participant's ability to call for help, or the risk of the person being without supervision or support for any length of time, in mind.
- Safety during violent or other threatening situations.
- Staffing shortages due to other emergency situations. When emergencies require staff to respond to one or two individuals, but there are other participants receiving services in that setting, it can result in an immediate staffing shortage. How does the provider assure that the needs of all individuals are met? This should be addressed in a plan for staffing shortages due to other emergency situations.
- Vehicle emergencies, including vehicle breakdown and traffic accidents.
- In limited circumstances, providers may offer services in their home while also caring for their own children. In this situation, the provider needs to develop a plan that outlines how they will care for the participant and children under the age of 12.
- Finally, each provider should have a contingency plan that assures a continuation of essential services. In our post COVID-19 world, we all understand that unprecedented emergencies can occur. Providers should have a contingency plan in the event that an unforeseen emergency arises.

Emergency Plans - Reviewing the Plans

- ▶ Review with all staff and participants.
- ▶ Review every twelve (12) months.
- ▶ Review on routine shifts.
- ▶ Document concerns and follow-up conducted.
- ▶ Provide evidence of one fire drill, including evacuation of the premises

Chapter 45, Section 13(g)(iii)

It is extremely important for providers to have emergency plans. However, the plans are not really useful if the people impacted by the plans aren't aware of their existence, or don't know how to follow them.

Section 13(g)(iii) establishes the provider's responsibility to review emergency plans with staff members and the participants they serve. The plans should be reviewed at least once every 12 months. The plans should be reviewed on routine shifts to ensure that everyone working in the setting has the opportunity to review the plans and ask questions. These reviews, including the date, the time of the shift, who attended, and concerns and follow-up, must be documented.

So what do we mean when we say that emergency plans must be reviewed? Reviewing a plan means that the participants and staff members have been made aware of the information that is in the plan, either through reading or discussion, and have had the opportunity to ask questions and seek clarification on the plan. It is not necessary to conduct a drill for each emergency plan. It is typical for new participants to begin receiving services in a setting, or new staff members to be hired to provide services in a setting. As these changes occur, providers should ensure that the emergency plans are reviewed with people who are new to the setting to ensure they are aware of what to do in an emergency.

When the plans are reviewed, there may be specific concerns identified. For example, Ted is a participant who lives in a group home with three other individuals. Ted refuses to leave the

house during fire drills. The provider cannot, and should not, force Ted to leave during the fire drill. The provider can talk to Ted about the importance of leaving, and discuss strategies for his future participation with the plan of care team. However, if there is a fire, the provider needs to have a plan in place for making sure that Ted evacuates safely. This plan, as well as how the provider should work with Ted during drills, should be included in the emergency plan. The plan should be updated if a specific strategy is found to be successful in encouraging Ted to evacuate, or if Ted decides to participate on a regular basis.

The provider must conduct an annual fire drill, including evacuation of the premises, on each shift. When performing these drills the provider should, to the extent possible, lessen the impact that this drill will have on participants. For example, if the drill needs to occur for the overnight shift, it might be best to conduct the drill on a Friday night if participant's don't typically have to get up and go to work the next morning. Or try for right at the end of the overnight shift, at perhaps 5:30am, and then have a delicious breakfast of waffles and bacon to celebrate the successful drill.

Food

- ▶ Participants must have access to food at all times.
- ▶ Providers must offer nutritious meals and snacks.
- ▶ Providers must meet standards for storing raw and prepared food.
- ▶ Providers must meet standards for serving food.

During Module #2, we reviewed the rights of participants receiving services, including their right to freedom and support to have access to food at any time. This is reestablished in Section 13(h)(i).

Providers delivering community living and day services in provider owned settings must provide nutritious meal and snack options. Providers cannot require a regimented meal schedule, unless a meal schedule is included as part of a rights restriction, so these meal and snack options must be available at the time the participant chooses. Just consider your own life and eating schedule. Sometimes we are hungry at 5:00pm, and sometimes we aren't hungry until 8:00pm. And sometimes we like to eat in front of the TV rather than at the kitchen table.

Section 13(h) takes a deeper dive into food, and provides specific guidance on storing food. Section 13(h)(ii) states that raw and prepared food, if removed from a container or package in which it was originally packaged, shall be stored in clean, covered, dated, and labeled containers. Fruit and vegetables may remain unmarked unless they have been partially prepared or used.

So why have these strict standards? There tend to be several people living, working, and receiving services in community living and day service settings. By labeling and dating containers, it is easy to identify what and how old the contents are. This labeling and storage is critical to ensuring that participants who ultimately eat the food don't end up eating something

that could make them sick.

Section 13(h)(iii) requires that all food must be served in a clean and sanitary manner. This is just good common sense, but it is also a rule.

Cleanliness and Maintenance

- ▶ Floors
- ▶ Walls
- ▶ Doors, windows, and other exits
- ▶ Restrooms
- ▶ Overall condition of the service setting

Several subsections of Section 13(h) are related to the importance of keeping service settings clean and well maintained. For example:

- Floors should be free of tripping hazards;
- Walls should be free of holes or visible water damage;
- Windows should not be broken;
- The setting should be free of rodents, insects, and other pests;
- Restrooms should have soap, towels, and trash receptacles; and
- Overall, everything should look, smell, and be clean.

The Division has developed a Provider On-Site Safety Standards tool to guide providers in some specific items to consider, which can be found on the [Forms and Documents Library](#) page of the Division website, under the *References/Tools* tab.

Using Technology for Service Delivery



- ▶ Video monitoring is prohibited in bedrooms and bathrooms.
- ▶ Other forms of remote monitoring or support must be documented in the IPC of all participants affected.
- ▶ Consent must be obtained from all participants affected.

The use of technology has become a more commonplace component of providing services in many healthcare industries. Section 13(h)(xi) addresses some basic rules regarding technology.

First and foremost, video monitoring is prohibited in bedrooms and bathrooms. These areas are places where people expect to be afforded a level of privacy. If a camera is located outside, the provider must ensure that it is not pointed toward the interior of the setting, especially toward bedrooms or bathrooms. If an audio monitor is used, it must be addressed as a rights restriction in the participant's IPC.

The Division does offer remote support as a supervision option for community living services if participants meet certain criteria. However, if remote support is going to be used, it must be documented in the participants plan. If the participant lives with a roommate who is also a waiver participant, and the remote support technology will impact the roommate in any way, that roommate must give consent to allow the use of remote support and it must be written into the roommate's plan of care as well.

More information on remote support can be found on the [Service Definitions and Rates](#) page of the Division website.

Transportation

- ▶ Comply with applicable federal, state, county, and city laws and requirements.
- ▶ Maintain vehicles in good repair.
- ▶ Keep and replenish first aid supplies in vehicles.
- ▶ Conduct quarterly self inspections.

Section 13(l) establishes that any provider that transports participants during the provision of waiver services must comply with all federal, state, county, and city laws, including those related to the licensing of drivers and the vehicle registration and insurance. Drivers must obey traffic laws...again, just common sense, but also a rule.

Vehicles that are used to transport participants must be in good repair. Section 13(l)(iii) requires that providers conduct a quarterly self-inspection of the vehicle, or have the vehicle inspected by a mechanic. This requirement is in place to ensure that the vehicle is operational, safe, and in good repair. During day to day driving, you may not notice little things that are slowly deteriorating, but a quarterly inspection, conducted by you or a mechanic, is a great way to identify problems that could cause an extreme hazard if they malfunction while you are driving down the highway at 65 miles an hour. This is a great time to check oil levels, tire pressure, and windshield wiper fluid.

Providers must keep a first aid kit in the vehicle. Be sure to replace any items that are used, and check it regularly...perhaps during the quarterly vehicle inspection...to ensure it is well stocked and that items have not expired.

Employment Services

Providers of Supported Employment Services shall ensure that participants are:

- ▶ Involved in making informed employment decisions;
- ▶ Linked to services and community resources;
- ▶ Given information on local job opportunities; and
- ▶ Regularly assessed on their satisfaction with employment services.

Chapter 45, Section 13(m)

If you are a DD Waiver provider of employment services, you have a responsibility to ensure that participants are making informed decisions regarding their employment. You must link participants to the community resources and services that are available, and make sure that they have accurate and current information on local job opportunities. It is important that you regularly evaluate their satisfaction with the employment services you are providing, and make adjustments based on their preferences.

If you don't provide employment services, but support a participant who has a job, it is critical that you support that individual in being as successful as they can be. For example, if you provide community living services, you can provide support by ensuring work clothing is clean, providing transportation to work, and talking with them about their work day.

Providers shall ensure that all participants residing in a provider owned or operated service setting have the following:

Chapter 45, Section 13(h)(xiv)

Section 13(h)(xiv) establishes additional rights and freedoms to which participants who **live** in provider owned or operated settings are entitled.

Additional Rights

- ▶ Freedom to support and control schedules and activities;
- ▶ Freedom to access the community;
- ▶ Freedom to furnish and decorate sleeping and living units within the lease or other agreement; and
- ▶ The right to a private bedroom and individual bed.

Typically, participants who live in provider owned or operated settings are adults. One of the best things about being an adult is having the freedom to make decisions about life. Even if a participant has restrictions on certain rights, they should have the freedom to make as many decisions about their own life as they can. Providers should support participants in making decisions about their daily schedule and activities, decorating their home in the style they want, and participating in their community. These freedoms are an essential part of home and community-based services.

Unless the participant is married or has specifically requested alternate arrangements, they should have their own room and their own bed.

Leases

- ▶ Must be signed by the participant and legally authorized representative, when applicable.
- ▶ Must allow the same responsibilities and protections from eviction that all tenants have under landlord/tenant laws. *(W.S. 1-21-1201 through 1-21-1211)*
- ▶ Participant must not be asked to leave the residence on a regular basis to accommodate the provider.

Every participant living in a provider owned or operated setting must have a lease.

Leases serve as a legal protection for all parties named within the lease. Leases outline what is expected from a tenant, and what protections the tenant has in return. These requirements help to protect the tenant and the landlord in case a dispute arises. Leases also help to ensure that participants have choice in their residence, with the ability to give notice and vacate the premises.

The State of Wyoming has specific laws regarding the rights of landlords and tenants. Leases between landlords of provider owned or operated settings and participants must comply with these laws. Leases must be signed by the participant and legally authorized representative, when applicable.

One approach that providers of community living services use to deliver services is having the participant live with a provider, or the provider and their family. In this model, the participant must still have a lease in place. The participant cannot be asked to leave their home on a regular basis to accommodate the provider's schedule. As an example, if the provider has a regular book club meeting at their home, they cannot require the participant to leave during this time.

The Comprehensive and Supports Waiver Service Index, which is incorporated into rule by

reference, states that participants who receive community living services shall have one primary residence. Therefore, the participant must have a lease for the residence in question if the residence is in a provider owned or operated setting. The provider cannot require the participant to leave the residence for the convenience of the provider.

Security and Access

Participants must have:

- ▶ Access to appropriate egress;
- ▶ A lockable entrance;
- ▶ A secure place for personal belongings;
- ▶ A key or other type of access for the home, bedroom, and any locked storage, with only appropriate staff members having keys.



Feeling safe and secure is a basic human need. Section 13(h)(xiv) addresses several areas related to the security of participants and their belongings.

Participants must be able to evacuate their home in the case of an emergency. They must have access to a door or window from which they can exit. As an example, if a participant has a room in the basement, they must be able to exit from the basement window in the case of a fire that blocks the stairway to the upper floor.

The provider owned or operated residence is the participant's home. The home, bedroom, and any other storage areas that hold a participant's belongings must have locking mechanisms for the purpose of security, and the participant should have a key to those locks. If the participant has difficulty manipulating a key, there may be other options, such as a keypad or key card. Even if the participant has difficulty with a key, this is their home, and they should have a bedroom and belongings that are secure. The participant should have the opportunity to be in possession of the keys. Any restriction of this right must be outlined in the IPC and meet the requirements of Chapter 45, Section 4.

Providers may have keys, based on the participant's individual circumstances, but those keys should be limited to only those staff members who need them.

Remember, in most cases, the setting is a place where the provider works. However, the

setting is also the place where the participant lives. Think of your own home. Would it be acceptable for people who work in your home to just walk in? People who don't live in a home typically knock before entering. Please remember that the place where you work is someone's home, and demonstrate courtesy by knocking before you enter.

Emergency Placements

- ▶ Shall be limited to one week.
 - ▶ Participant may request additional placement on a week-by-week basis.
 - ▶ Provider must notify the Division if placement lasts longer than one month.
- ▶ Participant shall be permitted to transition to permanent housing.
- ▶ Accommodations shall meet health and safety needs and allow for personal privacy and immediate egress.

In rare circumstances, a provider may be asked to provide temporary placement for a participant who has lost their primary caregiver. This request will typically come from the participant, a legally authorized representative, or a case manager. If a provider agrees to provide temporary services, they must ensure that the accommodations meet the needs of the participant, allow for personal privacy, and have necessary access to egress so they can evacuate in the case of an emergency.

Emergency placements must be limited to one week, although the participant may request additional time on a week to week basis. Temporary providers are just that...temporary. Once the emergency situation is addressed, the case manager is responsible for ensuring that the participant has choice in a new permanent provider and home.

Medical Evaluations

Unless otherwise directed by the participant's licensed medical professional, or it is otherwise indicated in the individualized plan of care, community living service providers shall ensure each participant receives a medical evaluation every twelve (12) months.

Chapter 45, Section 13(j)

Community living service providers are responsible for ensuring that participants receive a medical evaluation at least once every 12 months, unless the participant's licensed medical professional directs otherwise. If a participant refuses to attend annual medical appointments, this refusal, along with the strategies that the provider and plan of care team have implemented to encourage the participant to receive medical care, should be documented in the IPC.

Required Policies and Procedures



Section 13 requires providers to develop and implement written policies to address the health, welfare, and rights of DD Waiver participants.

Section 13 requires providers to develop and implement written policies to address the health, welfare, and rights of DD Waiver participants.

Smoking, Pets, and Weapons

- ▶ Smoking policy, if occupants or visitors of the home smoke.
- ▶ Pet policy, if occupants or visitors have pets.
- ▶ Weapons policy, if occupants or visitors have weapons in the home.

Chapter 45, Section 13(h)(xv)

Section 13(h)(xv) establishes that providers must have policies related to smoking, pets, and weapons if these are on the premises of a provider owned or operated setting. The smoking policy must assure the protection of the participant's health, the pet policy must assure that pets have necessary vaccines, and the weapons policy must assure that weapons that are owned by the provider are locked up or inaccessible to the participant, and that ammunition is stored separately.

Conflicts of Interest

- ▶ Provider must identify, in writing, potential conflicts of interest among employees, other service providers on the participant's plan, and relatives to the participant or legally authorized representative.
- ▶ Provider must address how the conflict of interest will be mitigated.
- ▶ Provider must share this information with potential participants and legally authorized representatives.

Chapter 45, Section 13(k)

A conflict of interest occurs when someone has loyalties to more than one person or organization, and those loyalties pull the person in multiple directions. Providers must identify conflicts of interest and be open and honest about how they will address the needs of everyone involved in these situations.

Providers should have a conflict of interest policy. The policy should include how the provider will identify and avoid potential risks that result from conflicts of interest. Not every conflict of interest can be completely avoided or resolved, but providers should do their best to make sure the impact of such conflicts can be managed and decreased, and that they are open and transparent about their efforts to do so.

Any conflicts of interest among employees, other service providers listed on the participant's IPC, or relatives of the participant or legally authorized representative must be shared with potential participant's and legally authorized representatives before the provider is selected to deliver services.

Please note that case managers have extensive standards that must be met in relation to conflicts of interest. These standards will be addressed in Module #6, and can be found in Chapter 45, Section 5(b)(ii) of the Department of Health's Medicaid Rules.

Beware of Unintended Rights Restrictions



Beware of unintended rights restrictions related to food, personal belongings, visitors, communication, and privacy.

During the day-to-day efforts to provide services, providers need to be careful not to inadvertently impose limitations on the rights of participants. Providers can encourage participants to make what most would consider to be good choices, but they cannot put arbitrary limitations on choices...even if the choice is viewed as a bad choice, or creates an inconvenient situation for the provider.

As we discussed in Module #2 - Rights of Participants Receiving Waiver Services, there must be a specific reason for imposing a rights restriction, and that reason can never be for the convenience of the provider or the legally authorized representative, or just because the legally authorized representative feels it would be in the best interest of the participant.

Restrictions on Food

Settings that include any restriction to a participant's right to food, or a non-regimented meal schedule imposed by a provider, shall be ordered by the participant's attending medical professional with evidence in the individualized plan of care that details the assessed need for the order and the protocols that shall be followed.

Chapter 45, Section 13(n)

Food related restrictions cannot be imposed unless the restriction has been ordered by the participant's medical professional and meets the requirements of Chapter 45, Section 4(h). A participant can be encouraged to eat dinner with their roommates, but has the ultimate choice of what, where, and when to eat. Limiting what the participant eats (*"You don't need another soda. You've already had one."*), when the participant eats (*"It's late. You don't need a snack."*) is prohibited.

Other Rights Restrictions

A participant's right to visitors, communication, privacy, or other standard in this Section may only be restricted as documented in the individualized plan of care with the restriction being time-limited and following the requirements listed in Chapter 45, Section 4.

Chapter 45, Section 13(o)

All rights of participants, including those related to visitors, communication, privacy, and others outlined in this and other sections of Chapter 45, must be honored unless a restriction on a right is specifically listed in the participant's IPC and meets the requirements of Section 4(h).

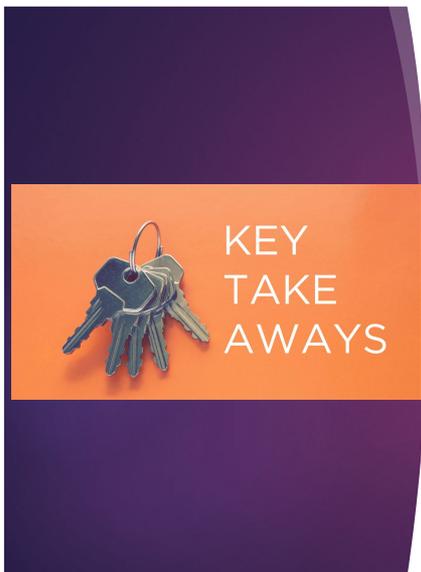
This can be challenging in residences where more than one person lives. Although roommates can establish some common courtesy rules, providers cannot impose rules that would be considered unreasonable to adults without disabilities. As an example, roommates may determine that music should be turned down after 10:00pm, but providers cannot dictate that music must be turned off after 10:00pm.

It is also important to remember that providers may need to be creative in identifying ways to promote the health and safety of participants without restricting their rights. As an example, Sally wants to sit on the porch in the sun. Sally's skin is very sensitive and it is over 80 degrees outside, so this is certainly a potential safety concern. The provider, in an effort to keep Sally safe, encourages her to come inside, but Sally refuses. After 30 minutes, Sally's skin is red and dry, and Sally is showing signs of heat stroke, but Sally still refuses to come inside. The provider feels they have no choice but to pick Sally up and take her inside. The provider has now violated Sally's rights, has performed an unauthorized restraint, and has potentially damaged their relationship with Sally.

Providers need to be creative in finding solutions to help participants stay safe without violating

their rights. In the prior example, there were several things the provider could have done to minimize the risk to Sally's health. They could have brought out an umbrella and ice water. They could have ensured Sally had plenty of sunscreen. Most importantly, they could have talked to Sally about why it was important for her to be out in the sun, so they could better understand what Sally's behavior was communicating. Once the provider understands why the participant is doing something, they can work with the participant to determine if there is a safer way for them to get what they want.

Finally, it is important to remember that any restriction on a person's right to privacy must be included as a rights restriction in the participant's plan of care. Waiting outside of the restroom while a participant is inside is not a rights restriction. However, if a provider goes into the bathroom to support the participant, except for emergency purposes, the participant's right to privacy may have been violated and should be discussed with the plan of care team as a possible rights restriction that should be addressed in the IPC.



1. There are specific requirements that must be met in order for a setting to be considered home and community-based.
2. Participants are entitled to the same rights and protections when receiving HCBS as any adult who does not receive HCBS.
3. Providers are required to have certain policies and emergency plans to facilitate the welfare of participants.

Before you complete this training, we'd like to review some of the key takeaways:

1. There are specific requirements that must be met in order for a setting to be considered home and community-based. Providers must ensure that they meet these requirements when delivering waiver services.
2. Participants are entitled to the same rights and protections when receiving HCBS as any person who does not receive HCBS, including access to food, visitors, and their community.
3. Providers are required to have certain policies and emergency plans to facilitate the welfare of participants. Remember, having policies and plans is the first step. The second step is following the policies and plans, and making sure that participants and staff members are knowledgeable of the policies and plans.

Questions???

Contact your Provider or Participant Support Specialist

<https://health.wyo.gov/healthcarefin/dd/contacts-and-important-links/>

This ends the training on the standards for home and community-based waiver services that has been conducted by the Division of Healthcare Financing, Developmental Disabilities Section. If you have questions related to the information in this training, please contact your Provider or Participant Support Specialist. Contact information can be found by clicking on the link provided in the slide.

Please be sure to complete a summary of this training so that you can demonstrate that you received training on the standards for home and community based waiver services.