Indiana Long Term Care Transformation Stakeholder Workgroup Meeting 2

Monday, November 6, 2017, 9:00 am - 1:00 pm

Indiana Government Center South, Conference Room 1 & 2

Agenda

Welcome and Introductions (9:00 am – 9:15 am)

October Stakeholder Meeting Review and HEA 1493 Report Check-in (9:15 am – 9:45 am)

Moving to Action & Parameters of Initial Design (9:45 am – 10:00 am)

Discussion Topics (10:00 am – 12:50 am)

- Case Management: What do you expect from an HCBS Waiver Case Manager? How does that differ from A&D's current Case Management definition? (45 minutes)
- Break (10 minutes)
- Supported Services in a Residential Congregate Setting: What does this look like? What services are included? How would DA phase in this approach? (35 minutes)
- Secure Memory Care in Nursing Facilities vs Assisted Living: What are the characteristics that a "community" setting must have? (50 minutes)
- Person-Centered Foundations: What are the goals for person-centered foundations and participant direction under the 1915(c) renewal? What are the long term goals? (30 minutes)

Next Steps and Wrap-Up (12:50 pm – 1:00 pm)

Phased Approach to Long-Term Care Transformation – Summary

The table below organizes the action steps from the HEA 1493 report into three phases for Indiana's long-term care transformation efforts. The action steps are listed in order by phase with all action steps in Phase 1 appearing first, followed by those in Phase 2 and 3, and ending with the ongoing action steps that span across all three phases. Action steps that span across multiple phases include additional detail on the main goals within each phase.

#	Action Step	Stakeholder Priority	Phase 1 1915(c) Renewal July 2018	Phase 2 Preparing for Broader Redesign Efforts (2018)	Phase 3 Implementation of New Medicaid Authority (2019)
1	**New Medicaid service option for support services in congregate settings, i.e. housing with services as described in IC 12-10-15. (p. 26)**	•	• Remove Licensure Requirements Supported Services Option Dementia/Memory Care Services	• Explore Memory Care Add-On	• Supported Services Option in Alternate Settings
2	**Enhance the current dementia care or specialty care competencies. (p. 26)**	•	•		
7	**Increase the use of the healthcare coordination service on the A&D waiver. (p. 35)**	•	• Define level of coordination needed between CM and RNs Identify PCP Offices	• Develop training materials for scope of service Market availability of service	
8	**Raise the standards for case managers and the expectations for levels of coordination between care providers. (p. 38)**	•	•		
9	**Expand the use of consumer-directed care and structured family care. (p. 40)**	•	• Explore expansion of participant-directed options		• Develop written resources and training
11	**Explore ways to create more universal waiver programs – children's services waiver; roll TBI into existing waivers. (p. 42)**	•	• Transition TBI into A&D/CIH as appropriate		• Create children's services waiver and amend A&D waiver to 22+
3	**Create a State Plan on special needs housing. (p. 28-29)**	•		•	

#	Action Step	Stakeholder Priority	Phase 1 1915(c) Renewal July 2018	Phase 2 Preparing for Broader Redesign Efforts (2018)	Phase 3 Implementation of New Medicaid Authority (2019)
6	**Align understanding of scope of practice regulations. (p. 35)**	•		•	
10	**Convene a workgroup to review overlap in process, clarify roles, identify changes to the oversight process, or organizational structures. (p. 41)**			•	
16	**Implement an options counseling trigger for individuals staying longer in nursing facilities. (p. 58)**			•	
20	**Build partnership with Indiana 211 for community resources and I&A support. (p. 61)**			•	
21	**Expand functionality of the INconnect Alliance website. (p. 61)**			•	
23	**Create a comprehensive resource site for family caregivers, including links to training resources. (p. 62)**			•	
24	**Pursue FMAP and MAC reimbursement for ADRC functions. (p. 62)**			• Provide additional training on MAC reimbursement Explore options counseling as State Plan service	• Implement options counseling as State Plan service based on Phase 2 exploration
17	**Train medical staff and discharge planners to educate individuals about all LTSS options. (p. 58)**			• Train discharge planners, connect with OC	• Train medical staff
4	**Combine the waiver service and State Plan home health prior authorization processes. (p. 34)**				•

#	Action Step	Stakeholder Priority	Phase 1 1915(c) Renewal July 2018	Phase 2 Preparing for Broader Redesign Efforts (2018)	Phase 3 Implementation of New Medicaid Authority (2019)
5	Review the use of Medicare home health hours as part of the State Plan home health prior authorization process. (p. 34)				•
12	Develop a Medicaid HCBS program focused on at risk individuals not yet at nursing facility level of care. (p. 44)	•			•
13	Select and implement an evidence based caregiver assessment tool and new caregiver support services. (p. 45)	•			•
15	Establish a more streamlined process that allows persons to access HCBS while the financial eligibility determination process is occurring. (p. 53)				•
18	Amend Indiana's State Plan to add services such as targeted case management and other transition supports. (p. 61)	•			•
22	Strengthen designation requirements for INconnect Alliance members/ADRCs. (p. 62)				•
14	Maintain more than adequate approval levels to assure that all those who qualify can access A&D Medicaid waiver services. (p. 45)		• Ongoing	• Ongoing	• Ongoing
19	Continue marketing and branding of INconnect Alliance brand. (p. 61)		• Ongoing	• Ongoing	• Ongoing

CMS Final Rule for Home and Community Based Services[i]

The Centers for Medicare & Medicaid Services (CMS) released a rule for Home and Community Based Services (HCBS) settings in March 2014. The HCBS Settings Final Rule is intended to encourage person-centered, safe, quality services funded through 1915(c) and 1915(k) waivers and 1915(i) state plan amendments. The rule features two key provisions: Person-Centered Planning and Settings Requirements. CMS requires all settings be compliant with the provisions by March 2022.[ii]

Person-Centered Planning

Person-centered planning increases a person's input into the service planning process and identifies areas a service plan should address. The goal is to ensure that people have control over the lives they have chosen and are able to live the lives they want. A person-centered plan:

- Is driven by the individual and includes people chosen by the individual;
- Provides necessary information and support to the individual to help them direct the process;
- Occurs at the times/locations that are convenient for the individual;
- Reflects cultural competency and uses plain language;
- Includes strategies for solving disagreement;
- Offers the individual choices regarding services and supports they receive; and
- Provides a method to request plan updates.

Home and Community Based Services (HCBS) Settings Requirements

The HCBS Settings Requirements ensure people have opportunities to be fully integrated into their communities and increase protections for people wherever they receive services. In general, all HCBS settings must have the following characteristics:[iii]

- **Integration with the Community**: HCBS must be integrated within and support access to the greater community to the same degree as individuals not receiving Medicaid HCBS.
- **Choice**: States must provide individuals the option of receiving care in a setting that is not provider-owned. Settings must be selected by the individual from options that include non-disability specific settings and options for a private unit in a residential setting.
- **Rights**: HCBS providers must ensure individuals are provided privacy, dignity, respect, and freedom from restraint and coercion.
- **Autonomy**: the setting must optimize individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.

Non-Residential Settings

Under the final rule, non-residential settings must:

- Integrate with the Community, including the ability to seek employment and work in competitive integrated settings;
- Allow for Informed Choice;
- Respect Participant Rights; and
- Maximize Independence.

Residential Settings

Under the rule, settings owned or controlled by providers need to have a legally enforceable, written agreement and follow the same landlord tenant law responsibilities/protections from eviction that apply to all rental agreements in their geographic area. Key characteristics residential settings must have include:

- Privacy in living/sleeping unit
- Choice of roommates
- Units with lockable entrance doors
- Freedom to furnish and decorate
- Freedom and support to control activities, schedules, and visitors at any time
- Ability to have access to food any time
- Be physically accessible to the individual

Modifications to these requirements are allowed when supported by a specific assessed need. They require proper documentation and the individual's informed consent.

[i] Guidance extracted from: "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers." https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

[ii] CMS Informational Bulletin: "Extension of Transition Period for Compliance with Home and Community-Based Settings Criteria." https://www.medicaid.gov/federal-policy-guidance/downloads/cib050917.pdf

[iii] CMS Training: Monitoring Compliance with the Home and Community-Based Settings Requirements, March 9, 2016: https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-monitoring-slides.pdf

Current IAC 455, Case Management Definition and Provider Qualifications

Definition

"Case management services" or "CMS" means a comprehensive service comprised of, but not limited to, the following:

(1) Assessment of an individual to determine the individual's:
    (A) functional impairment level; and
    (B) corresponding need for services.
(2) Development of a care plan addressing an eligible individual's needs.
(3) Supervision of the implementation of appropriate and available services for an eligible individual.
(4) Advocacy on behalf of an eligible individual's interests.
(5) Monitoring the quality of community and home care services provided to an eligible individual.
(6) Reassessment of the care plan to determine the continuing need and effectiveness of the community and home care services provided to an eligible individual under this article.
(7) Provision of information and referral services to individuals in need of community and home care services.

Provider Requirements

455 IAC 2-17-1 Information concerning an individual

A provider of CMS shall have the following information about an individual receiving CMS:

(1) The needs and wants of an individual, including the following:
    (A) Health.
    (B) Welfare.
    (C) Wishes for self-directed care.
(2) The array of services available to an individual whether the services are available under this article or are otherwise available.
(3) The availability of funding for an individual.

455 IAC 2-17-2 Training and orientation

a. To become an approved case manager, the person shall do the following:
    (1) Meet all the necessary qualifications.
    (2) Attend the required case manager orientation training.
b. To maintain DDARS approval to provide CMS under this article, a provider shall complete the designated training requirements.
c. If DDARS or its designee identifies a problem with a case manager's provision of services, training on the topics shall be prescribed by DDARS.

455 IAC 2-17-3 Contact information

A provider of CMS shall give the individual or the individual's legal representative, if applicable, clear instructions for contacting the provider, including contact information for nonbusiness hours.

455 IAC 2-17-4 Distribution of information

a. A provider of CMS shall ensure that:
    (1) the individual and their legal representative, if applicable; and
    (2) all other providers of services to the individual, regardless of whether the services are provided under this article; have copies of relevant documentation, including information on

individual rights, an individual's plan of care, how to file complaints with DDARS, and requesting appeals concerning issues and disputes relating to the services provided to the individual.

b. A provider of case management shall submit and receive communication and documentation through DDARS' designated software system within the prescribed time frame.

455 IAC 2-17-5 Availability of providers

a. A provider of CMS shall provide the:
   (1) individual; or
   (2) individual's legal representative upon request; with a current list of providers approved under this article, including a complete description of services offered by each provider from a generated pick list.

455 IAC 2-17-6 Plan of care progress

a. (a) A provider of case management shall do the following:
   (1) Ascertain and document the:
      (A) quality;
      (B) timeliness; and
      (C) appropriateness; of the care, services, and products delivered to an individual.
   (2) Analyze and update the documentation at least every ninety (90) days, unless otherwise specified.
b. The documentation required under this section shall include an appropriate assessment of the identified needs in the individual's plan of care.
c. A provider of CMS shall assess and monitor the services and outcomes established for the individual in the individual's plan of care to ensure the health and welfare of the individual, including, but not limited to, the following:
   (1) Providing follow-up on identified problems.
   (2) Acting immediately to resolve critical issues and crises in accordance with this article.
   (3) If concerns with services or outcomes are identified, addressing the concerns.
d. A provider of CMS who is attempting to resolve a dispute shall follow the dispute resolution procedure in 455 IAC 2-9-3.
e. A provider of CMS shall specify the amount of contact required with an individual in an approved plan of care.

Service Requirements

455 IAC 2-19-1 Coordination of services and plan of care

a. As follows, the case manager shall create a plan of care for the individual that shall:
   (1) Consist of a formal description of goals, objectives, and strategies, including the following:
      (A) Desired outcomes.
      (B) Persons responsible for implementation.
   (2) Be designed to enhance independence.
b. The provider shall assess the appropriateness of an individual's goals at least once every ninety (90) days as described in 455 IAC 2-17-6.
c. All entities responsible for providing service to an individual shall do the following:
   (1) Coordinate the services provided to an individual.
   (2) Share documentation regarding the individual's well-being, as required by the individual's care plan.

New IAC 455, Case Management Definition and Provider Qualifications[1]

Definitions

"Case management" means a comprehensive service including, but not limited to, the following:

(1) Assessing an individual to determine:
  (A) Functional impairment level; and
  (B) Need for services.
(2) Assisting participants in the establishment of a person-centered service plan.
(3) Monitoring service delivery to participants.
(4) Advocating for participants.
(5) Ensuring the quality of home and community-based services (HCBS) for participants.
(6) Reassessing participant service plans at least every ninety (90) days or more often if needed to determine the continuing need and effectiveness of services.

"Case Manager" means

(1) A person or entity that provides case management services;
(2) For the Medicaid waiver, a Medicaid-enrolled individual or company certified by DA; and
(3) For non-waiver programs, an entity with an Area Agency on Aging (AAA).

Service Requirements (Activities)

Case management services are services furnished to assist individuals in a community setting or transitioning to a community setting in gaining access to needed services and supports. Assistance provided includes, but is not limited to:

(1) Comprehensive assessment;
(2) Periodic reassessment;
(3) Development of a person center support plan; services plan?
(4) Referral and related activities to help the individual access needed services; and
(5) Monitoring and follow up activities.

Provider Requirements (Standards)

All providers of a case management service must:

(1) Comply with the conflict of interest standards contained in 42 CFR 441.730(b) and
(2) Refrain from providing another service under this article unless a designated ADRC or AAA with an expressly granted written waiver from DA.
(3) Ensure each case manager has:
  (A) a bachelor's degree in nursing, social work, psychology, sociology, counseling, health or human services, or gerontology; or
  (B) a bachelor's degree in any field with a minimum of two (2) year's full-time direct service experience with the elderly or disabled (this experience must include assessment, person-centered service plan development, and monitoring); or
  (C) an advanced degree in a related field and one (1) year experience; or
  (D) a registered nurse license with one (1) year of experience in human services.

[1] From Draft Provider Rule 455 IAC 2.1 (to replace 455 IAC 2 on HCBS, including provider qualifications; provider approvals; standards and requirements for home and community-based services providers; compliance monitoring; protecting participants for home and community-based services funded through the Division of Aging, including nursing facility level of care Medicaid waivers services.)

(E) Alternatively these requirements may be waived by DA upon demonstration of meeting approved core competencies through the use of a DA approved assessment tool and training.

Service Coordination and Collaboration

The case manager is the only entity authorized to coordinate services for the participant and providers must collaborate with the participant's case manager

Provider Responsibilities (Training and Timeframes)

Case management providers must:

(1) Ensure new case manager complete the State's required case manager orientation training before providing case management services.

(2) Ensure that all case managers complete a minimum of twenty (20) hours of training per calendar year and all required core competency trainings. Hours will be pro-rated for the first year for newly-hired case managers.

(3) Ensure that case managers, at a minimum:

(A) Follow up on identified issues.

(B) Immediately address critical issues.

(C) Address any concerns with services or outcomes.

(D) File and follow up on incident reports.

(E) Coordinate services;

(F) Share information on the participant's well-being as required by the participant's person-centered plan;

(G) Collaborate with the participant's other providers; and

(H) Collaborate with other authorized entities.

(4) Ensure that assessments, person centered support plans, case notes, level of care reviews, and other actions are data entered in DA's case management system within seven (7) calendar days of the action.

(A) A case manager must document in the case management system:

(1) Contacts regarding the participant and their services. These would include, but not be limited to, contacts with:

i. Participant or a legal representative;

ii. Participant's providers;

iii. Potential providers;

iv. Individuals the participant has identified as part of the person centered planning process.

(2) Any issues which must be reported, including, but not limited to:

i. unusual incidents affecting the participant's health and welfare; or

ii. Resolutions of issues and incidents.

(5) Issue to the participants, their legal representatives, and their service providers:

(A) LOC decisions;

(B) person-centered service plans;

(C) instructions for filing complaints;

(D) instructions for filing appeals;

(E) instructions for reporting abuse, neglect, and exploitation;

(F) a copy of the Participant rights and responsibilities.

(6) Assist the participant in developing a person-centered service plan that includes:

(A) goals,
(B) participant's assessed needs and desired outcomes, and
(C) units of service designed to achieve needs and maximize independence.

(7) At a minimum of every ninety (90) days, the case manager, using the DA's monitoring tool, must review service deliverables as determined by the person-centered plan, to determine if participant's assessed needs are being addressed and assess whether the participant is satisfied that the services meet their needs and goals.
    (A) The case manager must conduct the first face-to-face assessment with the participant in the home.
    (B) The case manager must conduct at least two of the four required 90-day assessments in the home.
(8) As necessary, the case manager will assist the participant with updating the person-centered service plan.
(9) The case manager must complete all assessment and evaluations as required by the service and program, including any level of service assessments.

When requested by participant, a case manager must generate through the DA's electronic case management database, a current list of certified providers and a description of the services they offer for the participant or legal representative.

Case managers shall not authorize others to perform case management duties on their behalf unless the individual or entity has been certified as a case manager pursuant to this article.

(1) The participant must be informed and agree with the change.
(2) Non-case management service providers may not circumvent or assume the role and tasks of the case manager.

State Examples of Housing and Supported Services

Supported Services in Provider-Owned Congregate Settings

State	Medicaid Waiver Service Definition and Food Service/Home Delivered Meals Guidance	Room and Board Definition
MN	Minnesota's assisted living service is called customized living, provided in housing with services establishments. All housing with services establishments in Minnesota must register with the state (similar to Indiana) and they are only required to provide two meals a day.[i] Customized living services include individualized supports that the person and his/her team choose and design specifically to meet his/her needs. The services include: • Arranging for or providing transportation • Assisting the person with personal funds • Assisting the person with setting up meetings or appointments • Home care aide tasks • Home management tasks including laundry and meal prep • Socialization • Up to 24-hour supervision and oversight • Help with personal care or mobility • Help with medication • Delegated nursing tasks as ordered by a physician and described in the plan • Active behavioral, mental health or cognitive support which requires: o Support needs that an appropriate professional has assessed o A plan to implement and monitor the support o Feedback on the efficacy of the support o Training for staff that is specific to the person's needs.[ii] Food Service Provisions: Includes all food preparation and service of a meal for the participant done simultaneously with food preparation for other participants. This includes but is not limited, preparing specialized diets, cutting up food and buttering bread. Tray delivery is also covered when required by the participant. Raw food costs are not covered under congregate meal prep within customized living.[iii] Home Delivered Meals Guidance: Home delivered meals are not covered for enrollees who live in settings licensed for foster care or board and lodge (but does not prohibit home delivered meals in housing with services establishments). No more than one meal per day will be paid for under HDM by the waiver.[iv]	Room and Board: Room and board, or raw food (groceries), and rent, while a recipient receives customized living services, are paid by the recipient's income, which may include Supplemental Security Income. If the recipient has inadequate income for room and board or rent charges, he or she may be eligible for a Group Residential Housing (GRH) payment to the provider.[v]

State	Medicaid Waiver Service Definition and Food Service/Home Delivered Meals Guidance	Room and Board Definition
IA	"Assisted living" or "program" means provision of housing with services, which may include but are not limited to: • Health-related care, personal care, and assistance with instrumental activities of daily living, to three or more tenants in a physical structure which provides a homelike environment. "Assisted living" also Includes: • Encouragement of family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence • The provision of housing and assistance with instrumental activities of daily living only if personal care or health-related care is also included • Includes 24 hours per day response staff to meet scheduled and unscheduled or unpredictable needs in a manner that promotes maximum dignity and independence and provides supervision, safety, and security.[vi] • Unanticipated and unscheduled personal care and supportive services that are provided to waiver participants who reside in a homelike, non-institutional setting. Food Service Provisions: Facilities must provide hot meals at least once a day or coordinate with other community providers to make arrangements for the availability of meals. Home Delivered Meals Guidance: Individuals can receive home delivered meals while in Assisted Living facilities. Services, however, are monitored by the case manager to prevent any duplication.	Because the Medicaid waiver program pays only for the costs of personal and medical services, the cost of rent and board are paid by the tenant. Innovative funding sources that can be used to cover the "board" portion of assisted living can include OAA funds, food stamps, or direct payment from the tenant.[vii] Paying for Room and Board: Iowa provides an optional state supplement based on allowable costs of residential care, plus PNA that is retained by the resident, minus the federal SSI payment. Family supplementation is permitted.
OH	Assisted living services include: • Personal care • Supportive services (homemaker and chore) • 24 hour on site response capability • Social and recreational programming • Nonmedical transportation • Coordination of the provision of three meals a day and snacks. Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management including medication administration, and the delivery of part-time intermittent nursing and skilled nursing up to the maximum allowed in Ohio Administrative Code (OAC) Rule 3701:17-59 and 3701-17-59.1., when not available through a third party.	Paying for Room and Board: Room and board capped at SSI minus a PNA. The state does not address family supplementation.[x]

State	Medicaid Waiver Service Definition and Food Service/Home Delivered Meals Guidance	Room and Board Definition
	The scope of the service does not include 24 hour skilled care, one on one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications or over the counter medications. Food Service Provisions: Residential care facilities may choose not to provide meals; or to provide 1-3 meals. Facilities that do not provide meals must ensure that each resident unit is appropriately and safely equipped with facility-maintained food storage and preparation appliances. Facility prepared meals must provide the recommended daily allowances.[viii] Ohio's Assisted Living waiver specifies that the assisted living service includes the coordination of the provision of three meals a day and snacks.[ix]	
TN	Assisted Facilities Have to Provide: • Food preparation, serving, and cleaning up after meals ("raw" food costs are excluded); • Laundry Services • Protective care • Safety when in the facility • The ability and readiness to intervene if crises arise • Room and board • Non-medical living assistance with activities of daily living Food Service Provisions: Assisted living facilities must provide at least three meals constituting an acceptable and/or prescribed diet per day. There shall be no more than fourteen (14) hours between the evening and morning meals.[xi]	Examples of costs that are considered to be room and board which are not covered under the CHOICES program (1115 waiver) include rent, mortgage payments, title insurance, mortgage insurance; property and casualty insurance; property taxes; utilities, resident phone, cable TV, etc.; building and/or grounds maintenance; residents' "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals may be covered under the SWW); household supplies and equipment necessary for the room and board of the individual; and; furnishings used by the individual (does not include office furnishings).[xii] Paying for Room and Board Medicaid policy limits the amount that assisted care living facilities can charge for room and board to 80 percent of the maximum personal needs allowance (PNA). The CHOICES program sets the PNA at 300 percent of the federal Supplemental Security Income (SSI) rate. Family supplementation is permitted up to the maximum allowable charges for room and board.

Supported Services in Participant-Controlled Subsidized Settings

State	Program Description	Service Delivery Model
MD	The mission of the Congregate Housing Services Program is to provide support services and State subsidies to eligible residents of low and moderate income senior housing who, due to advanced age or chronic health conditions, need daily help with activities such as meals, housekeeping, and personal services.[xiii] To be eligible to be a participant and receive congregate housing services, an individual shall: • Be 62 years old or older; • Be physically or mentally impaired; • Need assistance with one or more of the essential activities of daily living; • Need one or more of the congregate housing services available in the facility; and • Be able to function in the facility if provided with those services.[xiv]	A provider shall elect to participate in either the Standard Congregate Housing Services Plan or the Individualized Congregate Housing Services Plan. Mandatory services include: • Meals o Standard Congregate Housing Services Plan provides at least two meals/day o Individualized Congregate Housing Services Plan provides at least one meal/day • Minimum of 1.5 hours/week of housekeeping and laundry o Bed linens must be changed and laundry services provided weekly o An Individualized Congregate Housing Services Plan can offer service packages that provide 3, 6, or 9 hours per week of any combination of personal assistance services and weekly housekeeping and laundry services. • Personal Assistance Services o If a participant needs and wants personal assistance services, a Standard Congregate Housing Services Plan provider shall provide the services. o An Individualized Congregate Housing Services Plan provider shall offer at least one service package that includes at least 3 hours of service weekly. • Service Management o A Standard Congregate Housing Services Plan provider shall provide service management as part of the services provided to participants. o An Individualized Congregate Housing Services Program provider shall offer at least one service package that includes service management. Optional services include: • Assistance with IADLs • Assistance with arrangements for regular health care appointments; • A service to escort a participant to a health care appointment; • Meal delivery to a participant's apartment, for a nominal fee if participant elects not to participate in congregate meal program and provider has sufficient staff • Opportunities for individual or group activities in accordance with participants' interests, abilities, and needs; • Assistance with completing and submitting benefit applications; • Assistance with securing additional services needed; • Subject to the prior approval of the Department and in accordance with §G of this regulation, medication reminders or administration; and • Other services participants may need if a provider has an adequate number of staff with the qualifications necessary to provide the proposed services.[xv]

State	Program Description	Service Delivery Model
LA	Louisiana achieved national recognition as the country's first cross disabilities Permanent Supportive Housing (PSH) program. It serves individuals with developmental or adult on-set disabilities and addresses both physical disabilities and those related to behavioral health. The program's success is based on the inclusion of services that are: • Flexible and responsive to the needs of the individual • Available when needed by PSH tenants • Accessible where the tenant lives People who are residing in a State of Louisiana Permanent Supportive Housing unit or who are linked for the State of Louisiana Permanent Supportive Housing selection process are a priority group for the 1915(c) Community Choices Waiver (Age 21+, NF LOC)	Community Choices Waiver services that are delivered in PSH settings include: • Support Coordination (SC) • Transition Intensive Support Coordination(TISC) • Transition Service • Personal Assistance Services • Adult Day Health Care (ADHC) • Environmental Accessibility Adaptations(EAA) • Assisted Devices and Medical Supplies • Skilled Maintenance Therapy Services • Nursing Services • Home Delivered Meals • Caregiver Temporary Support Services • Monitored In-Home Caregiving[xvi] Services covered under 1915(c) Community Choices Waiver that will enable participants transitioning from an institution to secure their own housing and prepare to receive waiver services in their own home or other community setting: • Housing Stabilization services: o Assist participants to maintain their own housing as set forth in the approved plan of care for each participant. • Housing Transition/Crisis services o Assist participants transitioning from an institution to their own housing o These services are provided while the participant is in an institution and preparing to exit the institution[xvii]
OR	Housing with Services, LLC was formed by a group of nine non-profit organizations to address social determinants of health, including housing instability, food insecurity, and social isolation among low-income adults living in publicly subsidized housing in Portland, Oregon. The HWS team included 3 housing providers, 1 health plan, 2 mental health care providers, and 3 community-based service providers.[xviii] Housing with Services is an emerging model of community-based care. This is not a licensed health care setting, though some residents receive health services in their apartment. Residents live independently and may choose whether or not to engage in any offered services.	Service delivery model consists of: • A centralized care navigation team works onsite across the 11 housing properties with assistance from culturally specific care navigators, when needed. • Resident service coordinators work in each of the 11 housing properties, either full-time or part-time. • Partner agencies (including LLC members) provide targeted services to the properties or have agreed to formal communication and/or coordination channels. All residents eligible for HWS-sponsored social events and service coordination. Services included: • Home care • Case management • Benefits/insurance access • Information and referral

State	Program Description	Service Delivery Model
	Program Goals: • Promote optimal use of health and social services by: improving access to health and social services, and reducing health care costs associated with emergency department use and other high-cost health services • Improve access to long-term supports and services, and delay nursing home admissions • Improve housing stability • Improve resident quality of life	• Healthcare services (physical health, mental health, dental health, medication management) • Mental health services • Isolation intervention • Monitoring services • Outreach • Transportation • Nutrition[xix, xx]

[i] http://www.health.state.mn.us/divs/fpc/profinfo/lic/fpc926_1.pdf
[ii] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_001787
[iii] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6790H-ENG/
[iv] https://www.revisor.mn.gov/statutes/?id=144D.01
[v] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_056766#cls
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[xix] http://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Housing%20with%20Services%20Evaluation%20-%20Executive%20Summary%20and%20Report.pdf
[xx] http://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Housing%20with%20Services%20Year%201%20Evaluation.pdf

Current IAC 455, Article 3: Assisted Living Medicaid Waiver Services

Facility Requirements

(a) Each facility at which assisted living Medicaid waiver services are provided shall meet the following requirements:

(1) Maintain a current residential care facility license as required by IC 16-28 and 410 IAC 16.2-5.
(2) Comply with the requirements of IC 12-10-15.
(3) Provide assisted living Medicaid waiver service recipients with individual residential living units that include the following:
    (A) A bedroom.
    (B) A private bath.
    (C) A substantial living area.
    (D) A kitchenette that contains:
        i. a refrigerator;
        ii. a food preparation area; and
        iii. a microwave or stovetop for hot food preparation.

(b) If a facility was in operation prior to July 1, 2001, and was in compliance with the requirements of IC 12-10-15-7 on June 30, 2001, individual living units provided to recipients shall have a minimum of one hundred sixty (160) square feet of livable floor space including closets and counters, but excluding space occupied by the bathroom.

(c) If a facility was in operation prior to the effective date of this rule and was licensed under 410 IAC 16.2-5, individual living units provided to recipients shall contain the following:

(1) A substantial living area of at least one hundred sixty (160) square feet of livable floor space, including closets and counter space, but excluding space occupied by the bathroom.
(2) A sleeping area, not necessarily designated as a separate bedroom from the living area.
(3) A semiprivate bath or shower.
(4) A kitchenette that contains:
    (A) a refrigerator;
    (B) a food preparation area; and
    (C) a microwave. and
(5) Access to a stovetop/oven for hot food preparation in the common area.

(d) All other facilities shall provide recipients with individual living units meeting the following additional requirements:

(1) Contain a minimum of two hundred twenty (220) square feet of livable space including closets and counters, but excluding space occupied by the bathroom.
(2) Contain a bath that is wheelchair accessible. Fifty percent (50%) of the units available to recipients shall have a roll-in shower. and
(3) Contain individual thermostats.

(e) Residential units provided to recipients must be single units unless the recipient chooses to live in dual-occupied unit and the recipient and the other occupant consent to the arrangement.

(f) Residential units provided to recipients shall be able to be locked at the discretion of the recipient, unless a physician or a mental health professional certifies in writing that the recipient is cognitively impaired so as to be a danger to self or others if given the opportunity to lock the door. This subsection does not apply if this requirement conflicts with applicable fire codes.

Assisted Living Medicaid waiver services

(a) The provider shall provide the following assisted living Medicaid waiver services:

(1) Personal care services.
(2) Homemaker services.
(3) Chore services.
(4) Attendant care services, including supportive services.
(5) Companion services.
(6) Medication oversight services, as permitted by state law. and
(7) Therapeutic, social, and recreational programming.

(b) Assisted living Medicaid waiver services shall be provided to a recipient as outlined in a recipient's plan of care, as developed by the recipient's case manager and interdisciplinary team, as follows:

(1) The provider shall provide the intensity and level of services as outlined in the recipient's plan of care. The intensity and level of services shall range from level 1 for recipients who are the least impaired and require the least intense level of services to level 3 for the most severely impaired recipients who require the most intense level of services.
(2) Should a recipient require more intense assisted living Medicaid waiver services (a higher level of services) than the provider is approved to provide, or require services more intense than level 3, the provider shall assist the recipient in transferring to a more appropriate setting and shall observe all discharge requirements of 410 IAC 16.2-5.

(c) The initial plan of care must be approved by the office of Medicaid policy and planning prior to the initiation of assisted living Medicaid waiver services. It must be updated at least every ninety (90) days and annually or when the recipient experiences a significant change per 410 IAC 16.2-1.1-70.

(d) Provider staff shall provide information to the recipient's interdisciplinary team, as requested by the recipient's interdisciplinary team. If requested by a recipient and/or recipient's case manager, appropriate provider staff shall serve on a recipient's interdisciplinary team.

(e) All direct care shall be provided by personnel specified in IC 16-28-13-1.

(f) As appropriate, services shall be provided to recipients in their own living units.

(g) The physical environment and the delivery of assisted living Medicaid waiver services shall be designed to enhance autonomy in ways which reflect personal and social values of dignity, privacy, independence, individuality, choice, and decision making of recipients. The provider shall provide services in a manner that:

(1) makes the services available in a homelike environment for recipients with a range of needs and preferences;
(2) facilitates aging in place by providing flexible services in an environment that accommodates and supports the recipient's individuality; and
(3) supports negotiated risk, which includes the recipient's right to take responsibility for the risks associated with decision making.

(h) If requested by a recipient, the provider will assist a recipient and a recipient's case manager in obtaining, arranging, and coordinating services outlined in a recipient's plan of care that are not assisted living Medicaid waiver services.

(i) Should other entities furnish care directly, or under arrangement with the provider, that care shall supplement the care provided by the provider but may not supplant it.

Levels of service; level of service assessment/evaluation tool; provider enrollment

(a) Assisted living Medicaid waiver services will be provided and paid according to three (3) levels of service, with level one (1) being the least impaired and level three (3) the most impaired/dependent. No assisted living Medicaid waiver services may be provided that meet the skilled level of care as defined in 405 IAC 1-3-1.

(b) The impairment level assessment tool for assisted living Medicaid waiver services will be based on the point system definitions designated on the level of service assessment form and will be documented on forms prescribed by the division.

General service standards

(a) A provider shall provide assisted living Medicaid waiver services only to persons approved by the office of Medicaid policy and planning to receive assisted living Medicaid waiver services.

(b) A provider shall:

(1) promote the ability of recipients to have control over their time, space, and lifestyle to the extent that the health, safety, and well-being of other recipients is not disturbed;
(2) promote the recipient's right to exercise decision making and self-determination to the fullest extent possible;
(3) provide services for recipients in a manner and in an environment that encourages maintenance or enhancement of each recipient's quality of life and promotes the recipient's:
    (A) privacy;
    (B) dignity;
    (C) choice;
    (D) independence;
    (E) individuality; and
    (F) decision making ability; and
(4) provide a safe, clean, and comfortable homelike environment allowing recipients to use their personal belongings to the extent possible.

(c) The provider shall complete a service plan within thirty (30) days of move-in or the recipient's receipt of assisted living Medicaid waiver services.

(d) The provider shall ensure the service plan:

(1) includes recognition of the recipient's capabilities and choices and defines the division of responsibility in the implementation of services;
(2) addresses, at a minimum, the following elements:
    (A) assessed health care needs;
    (B) social needs and preferences;
    (C) personal care tasks; and
    (D) limited nursing and medication services, if applicable, including frequency of service and level of assistance;

(3) is signed and approved by:
    (A) the recipient;
    (B) the provider;
    (C) the licensed nurse;
    (D) the case manager; and
(4) includes the date the plan was approved.

(e) The service plan shall support the principles of dignity, privacy, and choice in decision making, individuality, and independence.

(f) The provider shall provide the recipient, case manager, and area agency on aging with a copy of the service plan and place a copy in the recipient's record.

(g) The provider shall update the plan when there are changes in the services the recipient needs and wants to receive. At a minimum, the provider shall review the service plan every ninety (90) days for assisted living recipients.

Negotiated risk plan appropriate to level of service

(a) If deemed appropriate and determined to be necessary by a recipient's interdisciplinary team, the provider shall establish a negotiated risk plan with a recipient.

(b) The negotiated risk plan shall address unusual situations in which a recipient's assertion of a right, preference, or behavior exposes the recipient or someone else to a real and substantial risk of injury.

(c) The negotiated risk plan shall identify and accommodate a recipient's need in a way that is acceptable to both the provider and the recipient.

(d) A negotiated risk plan shall include:

(1) an explanation of the cause(s) of concern;
(2) the possible negative consequences to the recipient and/or others;
(3) a description of the recipient's preferences;
(4) possible alternatives or interventions to minimize the potential risks associated with the recipient's preference/action;
(5) a description of the assisted living Medicaid waiver services the provider will provide to accommodate the recipient's choice or minimize the potential risk and services others [sic., other] entities will provide to accommodate the recipient's choice or minimize the potential risk; and
(6) the final agreement, if any, reached by all involved parties.

(e) The provider shall involve the recipient and the recipient's interdisciplinary team in developing, implementing, and reviewing a negotiated risk plan.

(f) The provider shall review a negotiated risk plan with a recipient and a recipient's team at least quarterly.

Recipient records

(a) An individual recipient record shall be developed and kept current and available on the premises for each recipient receiving assisted living Medicaid waiver services. In addition to the requirements of 410 IAC 16.2-5-8.1, a recipient's record shall include the following:

(1) Plan of care.
(2) Negotiated risk agreement, if any. and
(3) A written report of all significant incidents relating to the health or safety of a recipient including:
    (A) how and when the incident occurred;
    (B) who was involved;
    (C) what action was taken by provider staff; and
    (D) the outcome to the recipient.

(b) Recipient records shall be readily available to all of the following:

(1) Caregivers.
(2) Representatives of the office of Medicaid policy and planning.
(3) Division.
(4) Recipients.
(5) Recipient's authorized representatives.
(6) A recipient's case manager.
(7) Interdisciplinary team members.
(8) The ombudsman, as provided for by IC 12-10-13. and (9) Other legally authorized persons.

(c) Records shall be kept for the time period required by 410 IAC 16.2-5-8.1 or a minimum of three (3) years, whichever is longer.

(d) If a recipient is transferred, discharged or the provider otherwise ceases to provide services, the recipient's records shall be transferred with the recipient pursuant to 410 IAC 16.2-5-8.1.

Administration

The provider shall do the following:

(1) Comply with all requirements of this article.
(2) Ensure all provider staff are knowledgeable about applicable recipient rights.
(3) Not require a recipient to sign any admission contract or agreement that purports to waive any rights of the recipient.
(4) Develop and implement a complaint procedure and process which is responsive to recipient's complaints to assist in resolving agreement disputes between recipients and the provider.
(5) Adopt procedures for securing and recording complaints and endorsements filed by:
    (A) recipients;
    (B) recipients' designated representatives; and
    (C) recipients' family members.
(6) Post in a place and manner clearly visible to recipients and visitors the Indiana state department of health, state and local ombudsman toll-free complaint telephone numbers and telephone numbers for contacting a case manager through the local area agency on aging.
(7) Comply with all federal and state statutory and regulatory requirements regarding nondiscrimination in all aspects of the provider's operation.
(8) Encourage recipients and the recipient council, if there is one, to provide input to the facility about recipients' preferences for food choices, taking into account the cultural and religious needs of recipients.
(9) Ensure all instances of:
    (A) suspected abuse;

(B) neglect;
(C) exploitation; or
(D) abandonment; are reported to the adult protective services program, as required in IC 12-10-3-9 and 455 IAC 1-2-10, and to the local law enforcement agency.

(10) Not have any sexual contact with any recipient and shall ensure that provider staff and students not have sexual contact with any recipient.

(11) Permit the office of Medicaid policy and planning, the division, the ombudsman, and other state representatives to enter the facility without prior notification in order to monitor the provider's compliance with this article and to conduct complaint investigations, including, but not limited to:
(A) observing and interviewing recipients; and
(B) accessing recipient records

Payment for room and board

Each recipient is responsible for payment of the room and board services. The provider shall charge recipients room and board rates that are no higher than the SSI rate current at the time room and board services are provided, less the amount of the personal needs allowance for room and board for Medicaid eligible individuals.

New IAC 455, Housing with Services Definition and Provider Qualifications[1]

Service Requirements (Rule 5)

Housing with services is available in provider owned or controlled settings in which the housing provider is also the service provider.

Housing with services include, but are not limited to, the following:

- Attendant care services;
- Companion services;
- Homemaker services, including laundry and housekeeping services
- Preparing, serving, and cleaning up after meals
- 24-hour on-site response capability to meet unanticipated and unscheduled resident needs and to provide supervision, safety and security.
- Transportation for community activities that are therapeutic in nature or assist with maintaining natural supports;
- Personal emergency response system;
- Participant-focused activities appropriate to the needs, preferences, age, and condition of the individual resident;
- Assistance with correspondence and bill-paying, if requested by the resident;
- Medication oversight as permitted under state law;

Room and Board (Rule 6)

Room and board definition: "Room and board" means the provision of:

1) meals and
2) housing accommodations for rent or purchase, including living space.

Room and board stipulations:

- Any Medicaid per diem does not include payment for room and board.
- Providers may charge residents room and board up to the current maximum Federal Supplemental Security Income (SSI) after ensuring that the participants retain the PNA when calculating room and board rates.
- Participants are responsible for paying room and board directly to the provider.

Provider Qualifications and Requirements in Provider Owned or Controlled Settings (Rule 7)

If services will be provided in a provider owned or provider controlled setting, a person must:

(1) provide copies of the following:

(A) Setting floor plan;
(B) Corporate, partnership, and ownership structure;
(C) Staffing plan;
(D) Documentation in support of compliance with fire prevention and building rule commission;
(E) Documentation in support of compliance with state sanitary code certificates and permits;

[1] From Draft Provider Rule 455 IAC 2.1 (to replace 455 IAC 2 on HCBS, including provider qualifications; provider approvals; standards and requirements for home and community-based services providers; compliance monitoring; protecting participants for home and community-based services funded through the Division of Aging, including nursing facility level of care Medicaid waivers services.)

(F) Completed self-survey; and

(2) Submit to an on-site survey to ensure compliance and assess experience of consumers.

If services will be provided in a provider owned or provider controlled residential setting, a person must also:

(3) Provide a copy of their residency agreement that addresses eviction procedures and is consistent with or comparable to applicable State and local landlord tenant laws. The residency agreement must:

(A) Designate a specific physical place that is owned, rented or occupied by the individual receiving services;

(B) Ensure the individual has all the same rights, responsibilities, and protections from eviction as tenants under the Indiana Residential landlord-tenant statute as defined in IC 32-31-2.9-2;

(C) Provide the individual at least a 90-day notice of an intent not to renew the residency agreement;

(D) Provide for a set rent payment for the duration of the residency agreement; and

(E) Be for a time period of not less than six months.

(4) Ensure apartments have:

(A) A minimum of 220 square feet of living space including closets, excluding the bathroom. Residential settings limited to serving 4 or fewer participants are exempted from this requirement.

(B) Privacy in sleeping or living unit;

(C) Access to the following in accordance with the participant's person-centered service plan:

(1) A bedroom or sleeping area in the case of a studio apartment;

(2) A private bathroom with toilet, sink, and shower;

(3) A living area;

(4) A kitchen area that contains:

i. a refrigerator;

ii. a food preparation area;

iii. a sink; and

iv. a microwave or stovetop for hot food preparation; and

(5) The ability to control the temperature of their living unit.

(6) Residential settings limited to serving four (4) or fewer participants are exempted from this clause.

(D) Develop, implement, and disclose to potential and current residents its pet policy, if pets are permitted in the setting

Provider Responsibilities in Provider Owned or Controlled Settings (Rule 8)

If services are provided in a provider owned or provider controlled setting, the provider must also:

(1) Continue to comply with

(A) Local fire prevention and building rule commission

(B) State sanitary code certificates and permits

(2) Notify the DA of any planned changes to the physical layout of the setting that include remodeling, renovation, rehabilitation, or reconstruction. On-site survey required if physical changes have been made to the setting that affect or could affect the usability of building in any manner for participants.

(3) Ensure required participant rights contained in rule 11 of this article;

(4) Ensure that any modifications to participant rights for reasons of health or safety are
    (A) Supported by an assessed specific need,
    (B) Justified in the participant's person-centered support plan and the provider's service plan; and
    (C) Agreed to by the participant and their legal guardian.

If services are provided in a provider owned or provider controlled residential setting, the provider must also:

(1) Ensure required participant rights in rule 11 or this article;
(2) Ensure that any modifications to participant rights for reasons of health or safety are
    (A) Supported by an assessed specific need,
    (B) Justified in the participant's person-centered support plan and the provider's service plan; and
    (C) Agreed to by the participant and their legal guardian.
(3) Maintain individual written safety procedure and evacuation plans that meet the needs of each participant.

Participant Rights (Rule 11)

HCBS participants have the right to:

(1) Privacy, dignity, and self-respect;
(2) Autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact;
(3) Choice regarding their services and who provides them;
(4) Choice regarding the setting in which they receive services from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options must be identified and documented in the person–centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board; and
(5) The following same degree as individuals not receiving HCBS:
    (A) Opportunities to seek employment and work in competitive integrated settings to the same degree of access as individuals not receiving HCBS;
    (B) Engage in community life;
    (C) Control their personal resources, and
    (D) Receive services in the community.
(6) Participants receiving services in provider owned or provider controlled settings also have the right to:
    (A) Freedom from coercion, restraint, and seclusion.
    (B) The right to independently enter and exit the community and without interference or restrictions when desired;
    (C) Autonomy to control their own schedule and to choose whether to participate in community activities.
(7) Participants residing in a provider owned or provider controlled residential setting also have the right to:
    (A) A legally enforceable residency agreement which addresses eviction procedures and is consistent with or comparable to applicable State and local landlord tenant laws
    (B) A lockable living unit with only staff identified in the person-centered support plan having access;
    (C) A private living unit that is physically accessible to the resident;

(D) Choice of roommates, if desired;
(E) The ability to have visitors when they choose in accordance with their residency agreement;
(F) Access to food at all times;
(G) Decorate or furnish their living unit as they choose within the terms of the residency agreement;
(H) Opportunity to participate in activities and received services in the community.

b. (b) The case manager must provide the participant with information about their rights prior to the start of services.
c. (c) The case manager monitors for any depravation of rights at least every 90 days through
    (1) Observations;
    (2) Participant interview; and
    (3) Input from others identified by the participant as part of the person centered planning process.

CMS HCBS Settings Rule: Considerations for Dementia and Secure Memory Care[1]

Wandering or Exit-Seeking Behavior – Person-Centered Planning and Community Integration

Many individuals living with dementia and other conditions have a heightened risk of unsafe wandering or exit-seeking behavior. Person-centered planning, staff training and care delivery are core components of provider operations to meet HCBS requirements while responding to unsafe wandering and exit-seeking in an individualized manner. All settings must facilitate and optimize individuals to live according to daily routines and rituals, pursue their interests and maximize opportunities for engagement with the broader community. Person-centered plan must address the individual's preferences in regards to community integration and reflect clinical and support needs.

- Person-centered plans should be developed with the individuals and their representatives (as appropriate) in order to know and understand their conditions, needs, and history and use this knowledge to create strategies to assure that individuals are free to interact with others and the community in the most integrated way possible and still prevent injury for those who wander or exit-seek unsafely. Person-centered planning includes assessing patterns, frequency and triggers for behavior, creating baseline information to develop plans to address unsafe wandering behavior, and periodically reassessing in order to update the plan.
- Education and training for provider staff should cover the most common types, stages and impacts of conditions that lead to wandering behavior. Understanding past situations that led to instances of unsafe wandering and strategies for identifying and handling behavioral expressions of need or distress that would lead to unsafe wandering or exit-seeking are key to person-centered delivery.
- Community engagement desires of the individual should be assessed during initial planning. Document important factors of the community to the individual, record preferences as well as transportation needs, provide opportunities to engage with others in the setting, ensure visitors are not restricted, ensure individuals can connect to communities virtually, and ensure opportunities to visit and go out with family and friends.

Memory Care Units with Controlled-Egress

Any setting using controlled-egress should assess an individual that exhibits wandering and document choices about safety measures in their person-centered plan. Settings should be able to demonstrate how they make determinations and accommodations for those not at risk. The person-centered plan must document the individual's understanding of the safety features, choices for prevention of unsafe wandering or exit-seeking, consent, services and supports to promote participation in desired activities, and options that were explored before modifying plan. The plan must be reviewed at least annually to determine if it needs revision, and restriction is reassessed over time, with all other options taking priority.

Promising Practices

- Staffing: ensure adequate training for person-centered planning and unsafe wandering, support individuals to move about freely with staff, ensure adequate staffing for activities outside of facilities, ensure staff regularly escorts individuals to locations and activities outside of the setting, and provide flexible supervision to allow support from resident to resident.
- Activity: prevent under-stimulation by offering activities that engage individuals, provide a wellness program, support mobility through engaging activities, develop daily meaningful activities and minimize passive entertainment, make available easily accessible activities, encourage interaction with others, and ensure family and friends have unrestricted access to individual.
- Environmental: eliminate overstimulation, create pictures on wall that can be sensory in nature, manage shift changes so individuals do not see significant numbers of staff coming and going, use signage to orient individuals, disguise exit doors, use unobtrusive technological solutions, include lockable doors on room unless the person-centered plan documents that this would be unsafe, ensure unrestricted access to secure outdoor spaces, identify quiet, public spaces for individuals, enable people to leave premises when they are not at risk of being unsafe, use tools and technology to monitor activities, ensure that individuals carry identification, create a lost-person plan for emergencies and evaluate each instance of lost-persons and revise person-centered plan of said individual.

[1] Adapted from "FAQs concerning Medicaid Beneficiaries in Home and Community-Based Settings who Exhibit Unsafe Wandering or Exit-Seeking Behavior," CMS, December 15, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/faq121516.pdf