PRESENTATION

# Special Webinar for Case Managers and Supervisors

# HCBS and IBL Updates

## Home and Community-Based Services

## Individually-Based Limitations

TrainingUnit.ServicesSupports@odhsoha.oregon.gov

May 1, 2024

Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

# Agenda

- HCBS and IBL Basics
- The IBL Process
- New SPA requirement
- Q and A with policy
- Additional tools

# What is HCBS?

Home and Community-Based Services (HCBS) are services that are provided in an individual's home or in a community setting.

# What is the HCBS Settings Rule?

The HCBS Settings Rule provides federal requirements to ensure that people receiving services in the community have the same freedoms and rights as people not receiving services.

# Rights Included in the HCBS Settings Rule

- Opportunities for employment
- Engagement in community life
- Control of personal resources
- Live in a setting selected by the individual
- A person-centered service plan
- Privacy, dignity and respect
- Freedom from coercion
- Freedom from restraint
- Choice of services and provider

# Provider Owned, Controlled, or Operated Settings

A setting where an individual receives services that is owned, operated or controlled by the provider:

- Adult Foster Homes
- Residential Care Facilities
- Assisted Living Facilities
- PACE
- Adult Day Centers
- Specialized Living

## Additional Requirements for Provider Owned, Controlled or Operated Settings

- Lease or residency agreement
- Physically accessible setting
- Decorate/Furnish own room
- Access to food at any time
- Privacy (including a locking door)
- Choice regarding roommates
- Control of schedules and activities
- Visitors at any time

# What is an IBL?

Individually-based Limitation:
An agreement between a resident (or resident's representative) and a provider to modify a right based on a moderate risk of health or safety.

## Which rights can be modified?

- Access to food at any time
- Control of schedules and activities
- Decorate/Furnish own room
- Freedom from restraint
- Privacy (including a locking door)
- Roommate choice
- Visitors at any time

## In what circumstances can a right be modified?

- There is a moderate health or safety issue to the individual or others
- The resident is trying to execute the right
- Other options are not available or have not been successful
- The resident or representative consents to the IBL

# Informed Consent

- The resident (or representative) must understand the request
- The provider cannot limit the right without consent
- The resident can revoke the consent at anytime

# Who determines ability to consent?

## Qualified Healthcare Professionals:

A qualified healthcare professional who knows the individual must determine if the person can consent to MAiD

- Physician
- Physician's Assistant
- Nurse Practitioner
- Qualified Mental Health Professional
- Psychiatrist

## An IBL is not …

- Permanent
- For the provider's convenience
- Transferable between facilities
- Requested proactively
- Applied universally

# The IBL Process

## For Case Managers

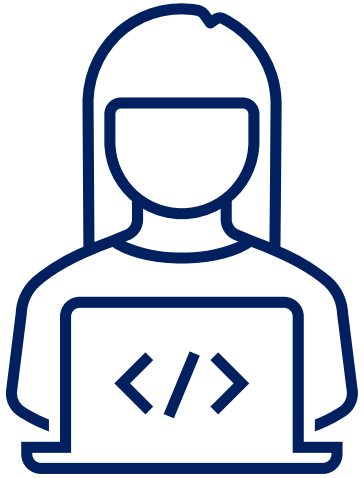
Bellina, a Sunrise Adult Foster Home resident, enjoys daily walks outside. Over the past year, she has struggled with balance and has had an increase in falls, especially on uneven ground. Despite her physical therapist and long-term community care nurse feeling she is not safe to walk outside without using her walker, Bellina adamantly will not use it.

However, Bellina is willing to walk with a staff member, even if she needs to wait until one is available.

The provider submits an IBL request to limit Bellina's right to control her schedule and activity regarding her daily walks.

## Provider Submits Request

The provider completes and sends the IBL Request Form (0556) to the consumer's case manager.



## Narrate

"Request for proposed HCBS IBL received via email today from AFH provider Dianne Chandler, for limit to schedule and activities. This CM will narrate outcome after review."

# Review

- There is a moderate health or safety risk to the individual or others.
- The IBL is proportionate to the risk and is not for the provider's convenience.
- Includes less restrictive methods tried that failed.
- Describes how and who will measure the effectiveness of the IBL.
- Request expires in less than one year.
- The resident has initialed and signed the form.

# Individual Consent to HCBS Limitation(s)

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Date printed: 02/17/24 Individual's birthdate: 05/22/40

Individual's name: Bellina Batista

Provider's name: Diane Chandler (Sunrise Adult Foster Home) Private pay? No

Provider address: 2700 Mango Lane, Peach City, OR 95999

**Individually-Based Limitations to the Rules for individuals receiving Home and Community-Based Services (HCBS) in a provider-owned, controlled or operated residential setting:**

This form is to be completed when there is an Individually-Based Limitation(s) to the HCBS rule requirements proposed in a provider-owned, controlled or operated residential setting.

**Select the appropriate limitation(s) from the list below by providing the requested start and end dates for the limitation(s). These dates cannot exceed one (1) year.**

| Rights that may be limited | Requested start date | Requested end date |
|---|---|---|
| Access to food at any time | | |
| Choice of roommate in shared units | | |
| Control own schedule and activities | 5/13/24 | 5/12/25 |
| Freedom from restraint | | |
| Furnish and decorate bedroom or living unit | | |
| Privacy — Lockable doors | | |
| Visitors at any time | | |

1. Describe the Individually-Based Limitation to the Rule. (*Who proposed this limitation? What is it? When is it implemented? How often? By whom? How is the limitation*

| | | |
|---|---|---|
| Privacy — Lockable doors | | |
| Visitors at any time | | |

1. Describe the Individually-Based Limitation to the Rule. (*Who proposed this limitation? What is it? When is it implemented? How often? By whom? How is the limitation proportional to the risk?, etc.*)

I am requesting a limitation regarding Bellina's control of her schedule and activities, specifically her daily walks outside. She usually goes for one or two walks a day at various times. Depending on when she feels like going on a walk, she might have to wait up to an hour for someone to be free to accompany her.

2. Describe the reason/need for the Individually-Based Limitation, including assessment activities conducted to determine the need. (*What health or safety risk is being addressed? Assessment tool, outreach, consultation, etc.*)

She's had several falls recently, particularly on uneven ground when she's not using her walker. She will not agree to use her walker, but will agree to wait for a staff to walk with her. Bellina has participated in PT, and had a nurse consultation. Both feel it is unsafe for Bellina to walk without her walker unless someone is with her.

3. Describe what positive supports and strategies were tried prior to the decision to implement the Individually-Based Limitation. (*Include documentation of positive interventions used prior to the limitation; documentation of less intrusive methods tried,*

her walker. She will not agree to use her walker, but will agree to wait for a staff to walk with her. Bellina has participated in PT, and had a nurse consultation. Both feel it is unsafe for Bellina to walk without her walker unless someone is with her.

3. Describe what positive supports and strategies were tried prior to the decision to implement the Individually-Based Limitation. (*Include documentation of positive interventions used prior to the limitation; documentation of less intrusive methods tried, but which did not work, etc.*)

Bellina attended PT to try to get more stable. We took her to look at different walker options but she refuses to try them at this time. The nurse consultant came and to provide education and fall prevention tips, which has improved her safety when she is indoors on even ground. We also tried to make outdoor walking a group activity, only a few residents showed interest, and eventually, all except Bellina declined participation.

4. Describe how this Individually-Based Limitation is the most appropriate option and benefits the individual. (*Why/how does implementing the limitation make sense for the individual's personal situation?*)

Bellina will be able to continue to take her walks with a significantly less chance of falling since a staff member will be with her to help steady her when she loses her balance or needs to step over a curb.

5. Describe how the effectiveness of the Individually-Based Limitation will be measured

falling since a staff member will be with her to help steady her when she loses her balance or needs to step over a curb.

5. Describe how the effectiveness of the Individually-Based Limitation will be measured. *(Including ongoing assessment and/or data collection and frequency of measurement.)*

Staff will document Bellina's frequency of walks, and any falls she still has when walking outside.

6. Describe the plan for monitoring the safety, effectiveness, and continued need for the limitation. (*Who is responsible to monitor? How frequently? How is the ongoing need for continued use of the limitation to be determined? Etc.*)

Staff will continue to monitor her safety when walking and document any changes in her stability. We will also check in with her weekly to see if the new arrangement is working, and offer to help her feel more comfortable using a walker.

## Decision summary and signature section

Select appropriate limitation(s) below by including start and end dates, as applicable. Indicate whether the individual consents, or does not consent, to the limitation(s). Please request the individual, or legal representative/guardian (*if applicable*), initial each limitation to ensure the individual's wishes are accurately reflected.

**I understand I am <u>not</u> required to consent to any proposed limitation(s).**

| Rights that may be limited | Start date | End date | Consent? | Individual's initials |
|---|---|---|---|---|
| Access to food at any time | | | ○Yes ○No | |
| Choice of roommate in shared units | | | ○Yes ○No | |
| Control own schedule and activities | 05/13/24 | 05/12/25 | ◉Yes ○No | BLB |
| Freedom from restraint | | | ○Yes ○No | |
| Furnish and decorate bedroom or living unit | | | ○Yes ○No | |
| Privacy — Lockable doors | | | ○Yes ○No | |
| Visitors at any time | | | ○Yes ○No | |

**If the individual <u>does not</u> agree or consent to a limitation, it will <u>not</u> be put in place.**

**A copy of this document will be provided to the individual.**

### Individual statement

**If the individual does not agree or consent to a limitation, it will not be put in place.**

**A copy of this document will be provided to the individual.**

## Individual statement

I have read the above information, or it has been provided to me in a format I can understand. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. Where Individually-Based Limitations were discussed, I was given additional options. It was made clear to me that I do not have to agree or consent to any limitations. I agree to the sharing of this information with my care team, when applicable.

Individual, or legal representative/guardian (*if applicable*), please review that your wishes to consent or **not to** consent are accurately captured in the box you have initialed, above. Then print your name, sign and date below.

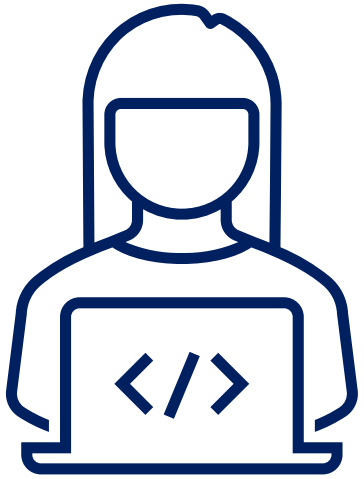
Bellina Batista
Print name

Bellina L Batista
Signature

5/13/2024
Date signed

## Staff with Supervisor

- Staff all requests with your supervisor until further notice
- Supervisors will staff IBLs with HCBS Policy if they are unsure whether to approve



# Narrate

"IBL request from AFH provider Diane Chandler reviewed and appears complete. Request staffed with my supervisor, Tim Raven, who agrees the IBL is complete and appropriate. Message left with Bellina to discuss her understanding and possible consent to the IBL."

# Review with Consumer (Representative)

- Read the information on the IBL request
- To the best of your ability, determine if the consumer understands the limitation
- Encourage and answer the consumer's questions
- Confirm the consumer has not been coerced into giving consent
- Sign the case manager statement on page three of the IBL form if appropriate

**Feedback from the individual:**

I understand I will sometimes need to wait for someone to be available to go with me on my walks.

## Statement by the person centered service plan coordinator or witness

I have accurately read the information to the above named individual, and to the best of my ability made sure that the individual understands the documented Individually-Based Limitation(s).

I confirm that the individual was given an opportunity to ask questions about the Individually-Based Limitation(s), and all the questions have been answered accurately and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and when consent has been given, it is done freely and voluntarily.

## Statement by the person centered service plan coordinator or witness

I have accurately read the information to the above named individual, and to the best of my ability made sure that the individual understands the documented Individually-Based Limitation(s).

I confirm that the individual was given an opportunity to ask questions about the Individually-Based Limitation(s), and all the questions have been answered accurately and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and when consent has been given, it is done freely and voluntarily.

APD/AAA case manager or private-pay witness, please sign and date below:

Joelle Eidelman
Print name

971-111-2222
Phone number

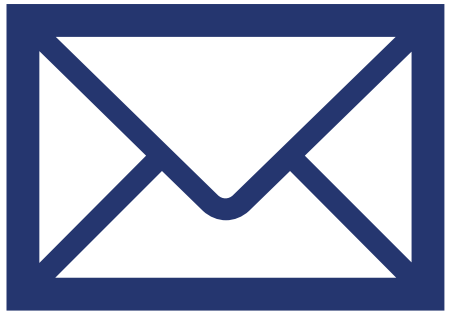
Joelle Eidelman
Signature

05/14/2024
Date signed

Check the appropriate box for your role:

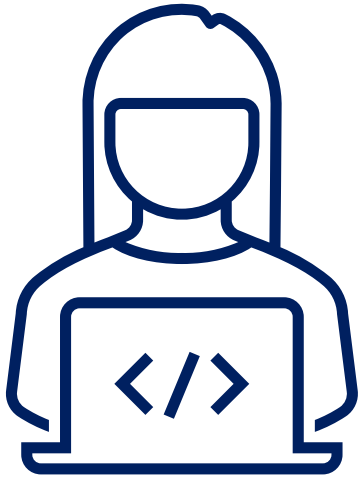
[X] APD/AAA case manager [ ] Private-pay witness

You can get this document in other languages, large print, braille or a format you prefer. Contact APD Medicaid Services and Supports Team at 503-945-6412 or email hcbs.oregon@dhsoha.state.or.us. We accept all relay calls or you can dial 711.



# Send Notices

- Add IBL to the SPA portion of the SPAN
- Mail the signed IBL to the consumer (representative) and provider, and the new SPA for signatures
- Upload to electronic file



# Narrate

"**Direct Contact**: This CM talked with Bellina on the phone and reviewed the IBL request regarding the control of her own schedule and activities. Bellina understands and consents to limiting control of her own schedule and activities. SPA sent to Bellina and AFH provider for signatures. Copy of signed IBL also sent to Bellina and AFH provider Diane Chandler."

Every Friday night, Alan hosts movie night with his grandkids. Many residents complain about the noise when they come over. The facility administrator requests an IBL to limit Alan’s right to have his grandkids over in the evening for the well-being of the other residents.

# Individual Consent to HCBS Limitation(s)

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Date printed: 05/01/24 Individual's birthdate: 12/03/46

Individual's name: Alan Reinfer

Provider's name: South Shores Assisted Living Facility Private pay? No

Provider address: 423 Pumpkin Hill, Peach City, OR 95999

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| Access to food at any time | | |
| Choice of roommate in shared units | | |
| Control own schedule and activities | | |
| Freedom from restraint | | |
| Furnish and decorate bedroom or living unit | | |
| Privacy — Lockable doors | | |
| Visitors at any time | 5/1/24 | |

1. Describe the Individually-Based Limitation to the Rule. *(Who proposed this limitation?*

| | | |
|---|---|---|
| Furnish and decorate bedroom or living unit | | |
| Privacy — Lockable doors | | |
| Visitors at any time | 5/1/24 | |

1. Describe the Individually-Based Limitation to the Rule. (*Who proposed this limitation? What is it? When is it implemented? How often? By whom? How is the limitation proportional to the risk?, etc.*)

Alan's grandchildren tend to run and yell, disturbing other residents. The request is for Alan to restrict his grandchildren's visits prior to 5 PM, accommodating times when other residents are busy with other activities.

2. Describe the reason/need for the Individually-Based Limitation, including assessment activities conducted to determine the need. (*What health or safety risk is being addressed? Assessment tool, outreach, consultation, etc.*)

I have a documented history of complaints from other residents following an evening when Alan's grandkids visit. The visits are negatively effecting the other residents well-being.

3. Describe what positive supports and strategies were tried prior to the decision to implement the Individually-Based Limitation. (*Include documentation of positive interventions used prior to the limitation; documentation of less intrusive methods tried, but which did not work, etc.*)

well-being.

3. Describe what positive supports and strategies were tried prior to the decision to implement the Individually-Based Limitation. (*Include documentation of positive interventions used prior to the limitation; documentation of less intrusive methods tried, but which did not work, etc.*)

I have visited with Alan several times and asked that he respect the privacy of the other residents. Although, the grandkids are no longer running up and down the halls, they continue to yell and run in the apartment disturbing the neighbors on the side and below the apartment.

4. Describe how this Individually-Based Limitation is the most appropriate option and benefits the individual. (*Why/how does implementing the limitation make sense for the individual's personal situation?*)

The limitation will improve Alan's relationship with the other neighbors.

5. Describe how the effectiveness of the Individually-Based Limitation will be measured. (*Including ongoing assessment and/or data collection and frequency of measurement.*)

Ongoing monitoring of noise or other complaints from residents.

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Ongoing monitoring of noise or other complaints from residents.

6. Describe the plan for monitoring the safety, effectiveness, and continued need for the limitation. (*Who is responsible to monitor? How frequently? How is the ongoing need for continued use of the limitation to be determined? Etc.*)

Not applicable.

## Denying an IBL that is not complete or appropriate

- Notify the provider the outcome and reason for denying
- Narrate the outcome and conversation with the provider
- Upload request to electronic file

## No Consent?

- Consumer or rep marks and initials “no” and signs page 3 of request
- Send a copy to the consumer (representative) and provider
- Upload to electronic file
- Narrate

Print | Save | Reset

## Decision summary and signature section

Select appropriate limitation(s) below by including start and end dates, as applicable. Indicate whether the individual consents, or does not consent, to the limitation(s). Please request the individual, or legal representative/guardian (*if applicable*), initial each limitation to ensure the individual's wishes are accurately reflected.

**I understand I am <u>not</u> required to consent to any proposed limitation(s).**

| Rights that may be limited | Start date | End date | Consent? | Individual's initials |
|---|---|---|---|---|
| Access to food at any time | | | ○ Yes ○ No | |
| Choice of roommate in shared units | | | ○ Yes ○ No | |
| Control own schedule and activities | | | ○ Yes ○ No | |
| Freedom from restraint | | | ○ Yes ○ No | |
| Furnish and decorate bedroom or living unit | | | ○ Yes ○ No | |
| Privacy — Lockable doors | | | ○ Yes ○ No | |
| Visitors at any time | 04/08/24 | 03/31/25 | ○ Yes ◉ No | DG |

**If the individual <u>does not</u> agree or consent to a limitation, it will <u>not</u> be put in place.**

**A copy of this document will be provided to the individual.**

## Individual statement

I have read the above information, or it has been provided to me in a format I can understand. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. Where Individually-Based Limitations

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## Individual statement

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Individual, or legal representative/guardian (*if applicable*), please review that your wishes to consent or **not to** consent are accurately captured in the box you have initialed, above. Then print your name, sign and date below.

Denny Green

Print name

Denny Green

Signature

4/10/2024

Date signed

# The SPA

Save | Print | Reset

**Print:** ○ Entire notice ◉ Service plan agreement only **Print**

## Service Plan Agreement

**Consumer:** Sonia Jones **Prime:** 1ABCDE

Based upon our discussion, you have been given the choice and you agree to receive monthly ADL and IADL services and supports as follows:

Case manager: Select "Waivered Case Management Services" unless the consumer is in a NF, on PACE or is MAGI eligible.

| | |
|---|---|
| ☒ Waivered Case Management Services | ☐ Nursing Facility |
| ☐ Independent Choices Program | ☐ PACE Program |
| ☐ Homecare Worker* | ☐ Natural Support |
| ☐ In-Home Care Agency* | ☐ Long-Term Care Community Nursing |
| ☐ Home Delivered Meals | ☐ Emergency Response System |
| ☐ Adult Day Services | ☒ Community Based Care |
| ☐ Specialized Living | ☐ Limitation(s) to your HCBS Rights |
| ☒ Other: Sunrise Adult Foster Home | |

**Your provider may be authorized additional and reasonable mileage reimbursement if they need to take their own vehicle to shop on your behalf.*

The service plan is intended to address your needs identified in the assessment including how much assistance is needed and the type of provider(s) you have selected. If you think the service plan does not meet your needs, please discuss with your case manager. You have the right to appeal if you continue to disagree with the assessment or service plan.

**Signing your service plan means you have received and reviewed the provided information. It is important for you to sign this page and return it to the case manager as soon as possible.**

☐ Please check this box if you believe this service plan does **NOT** meet your needs or you **disagree** with the assessment or service plan.

Consumer signature _____ Date _____

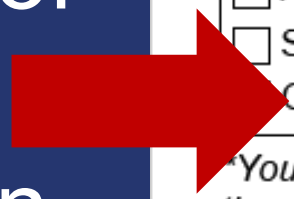
Consumer representative signature _____ Date _____

Provider signature _____ Date _____

Case manager signature _____ Date _____

# New Requirement:

Include the name of the facility for all consumers living in a CBC facility or an Adult Foster Home.



**Service Plan Agreement**

**Consumer:** Sonia Jones **Prime:** 1ABCDE

Based upon our discussion, you have been given the choice and you agree to receive monthly ADL and IADL services and supports as follows:

Case manager: Select "Waivered Case Management Services" unless the consumer is in a NF, on PACE or is MAGI eligible.

| | |
|---|---|
| ☒ Waivered Case Management Services | ☐ Nursing Facility |
| ☐ Independent Choices Program | ☐ PACE Program |
| ☐ Homecare Worker* | ☐ Natural Support |
| ☐ In-Home Care Agency* | ☐ Long-Term Care Community Nursing |
| ☐ Home Delivered Meals | ☐ Emergency Response System |
| ☐ Adult Day Services | ☒ Community Based Care |
| ☐ Specialized Living | ☐ Limitation(s) to your HCBS Rights |

☐ Other: Sunrise Adult Foster Home

*Your provider may be authorized additional and reasonable mileage reimbursement if they need to take their own vehicle to shop on your behalf.*

The service plan is intended to address your needs identified in the assessment including how much assistance is needed and the type of provider(s) you have selected. If you think the service plan does not meet your needs, please discuss with your case manager. You have the right to appeal if you continue to disagree with the assessment or service plan.

**Signing your service plan means you have received and reviewed the provided information. It is important for you to sign this page and return it to the case manager as soon as possible.**

☐ Please check this box if you believe this service plan does **NOT** meet your needs or you **disagree** with the assessment or service plan.

Consumer signature _____ Date _____

# IBL SPA Requirement:

- Select “Limitations”

**Consumer:** Sonia Jones **Prime:** 1ABCDE

Based upon our discussion, you have been given the choice and you agree to receive monthly ADL and IADL services and supports as follows:

Case manager: Select “Waivered Case Management Services” unless the consumer is in a NF, on PACE or is MAGI eligible.

| | |
|---|---|
| ☒ Waivered Case Management Services | ☐ Nursing Facility |
| ☐ Independent Choices Program | ☐ PACE Program |
| ☐ Homecare Worker* | ☐ Natural Support |
| ☐ In-Home Care Agency* | ☐ Long-Term Care Community Nursing |
| ☐ Home Delivered Meals | ☐ Emergency Response System |
| ☐ Adult Day Services | ☒ Community Based Care |
| ☐ Specialized Living | ☐ Limitation(s) to your HCBS Rights |
| ☒ Other: Sunrise Adult Foster Home | |

**Your provider may be authorized additional and reasonable mileage reimbursement if they need to take their own vehicle to shop on your behalf.*

The service plan is intended to address your needs identified in the assessment including how much assistance is needed and the type of provider(s) you have selected. If you think the service plan does not meet your needs, please discuss with your case manager. You have the right to appeal if you continue to disagree with the assessment or service plan.

**Signing your service plan means you have received and reviewed the provided information. It is important for you to sign this page and return it to the case manager as soon as possible.**

☐ Please check this box if you believe this service plan does **NOT** meet your needs or you **disagree** with the assessment or service plan.

Consumer signature _____ Date _____

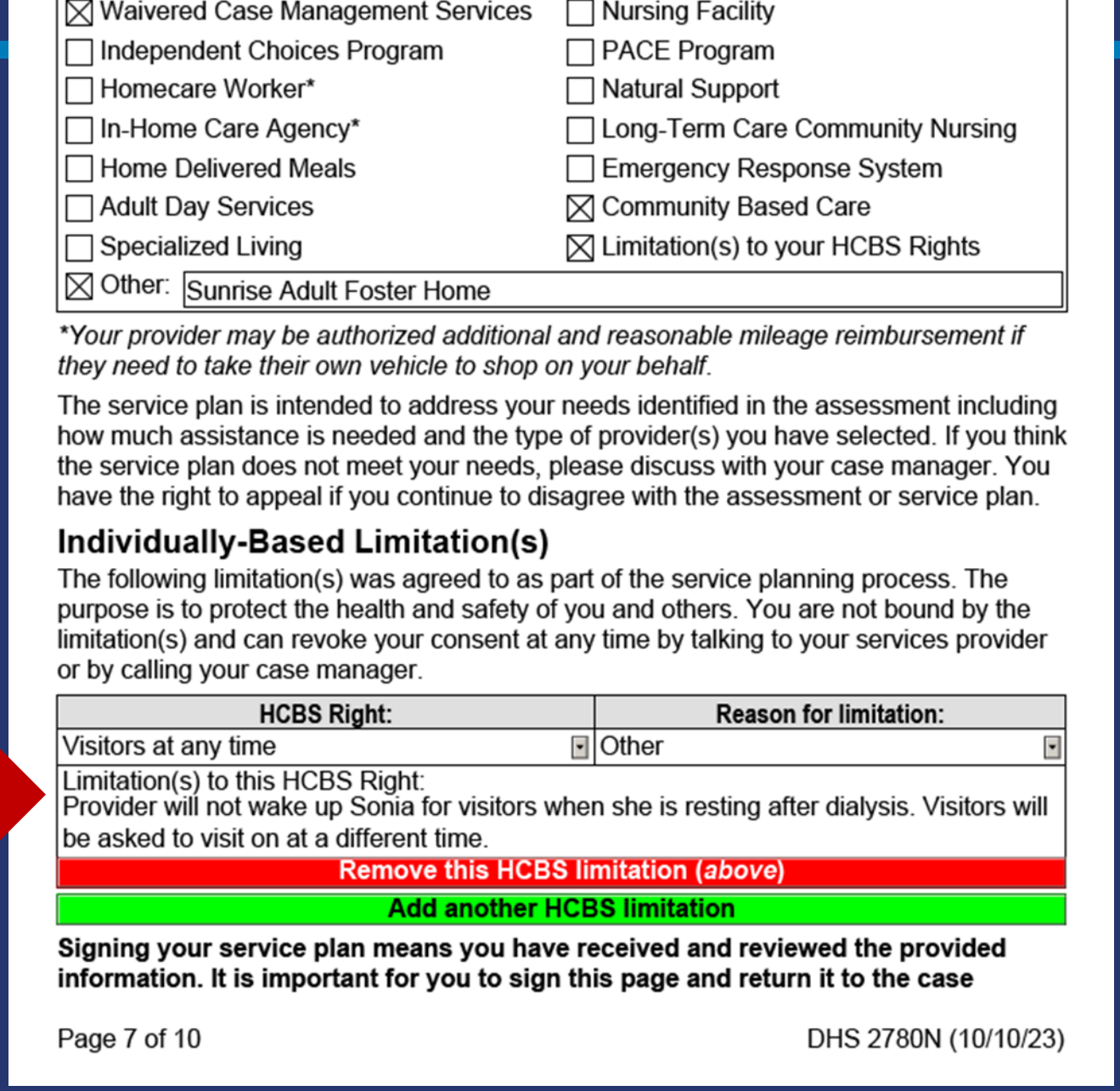
Consumer representative signature _____ Date _____

Provider signature _____ Date _____

Case manager signature _____ Date _____

# IBL SPA Requirement:

- Select “Limitations”
- Choose the right that is being limited
- Choose the reason for the limitation
- Describe the limitation



☒ Waivered Case Management Services
☐ Independent Choices Program
☐ Homecare Worker*
☐ In-Home Care Agency*
☐ Home Delivered Meals
☐ Adult Day Services
☐ Specialized Living
☒ Other: Sunrise Adult Foster Home

☐ Nursing Facility
☐ PACE Program
☐ Natural Support
☐ Long-Term Care Community Nursing
☐ Emergency Response System
☒ Community Based Care
☒ Limitation(s) to your HCBS Rights

*Your provider may be authorized additional and reasonable mileage reimbursement if they need to take their own vehicle to shop on your behalf.*

The service plan is intended to address your needs identified in the assessment including how much assistance is needed and the type of provider(s) you have selected. If you think the service plan does not meet your needs, please discuss with your case manager. You have the right to appeal if you continue to disagree with the assessment or service plan.

**Individually-Based Limitation(s)**

The following limitation(s) was agreed to as part of the service planning process. The purpose is to protect the health and safety of you and others. You are not bound by the limitation(s) and can revoke your consent at any time by talking to your services provider or by calling your case manager.

| HCBS Right: | Reason for limitation: |
|---|---|
| Visitors at any time | Other |
| Limitation(s) to this HCBS Right: Provider will not wake up Sonia for visitors when she is resting after dialysis. Visitors will be asked to visit on at a different time. | |

Remove this HCBS limitation (*above*)

Add another HCBS limitation

**Signing your service plan means you have received and reviewed the provided information. It is important for you to sign this page and return it to the case**

Page 7 of 10 DHS 2780N (10/10/23)

# Questions and Answers

I thought we were already doing IBLs? What changed?

- In 2023, we failed a CMS audit.
- IBL requirements are no longer limited to those with cognitive needs.
- Discontinued use of the OA Screening Tool

**Assessment Type:**
Title XIX

**Review Date:**
10/31/2024

**Status:**
Completed

**Asessment by:**
Training4, Train4

Referrals

IBL [illegible]ning

Plan Summary

Model

| APD-In Home | 10/01/2023 | 11/02/2024 |
|---|---|---|

**Hours Segments**

| Hours # | Begin Date | End Date | Status | Alwd |
|---|---|---|---|---|
| 1 | 10/01/2023 | 11/02/2024 | Pending | 26 |

**Plans For APD-In Home Benefit** ( Read C

| Plan # | Begin Date | End Date | Status |
|---|---|---|---|
| 1 | 10/01/2023 | 11/02/2024 | Pending |

**Services For Plan #1**

| Row # | Services | Provider Name | Begin Date | |
|---|---|---|---|---|
| 1 | In-Home Care HK (Agency | ADDUS HEALTHCARE | 10/01/2023 | 11 |
| 2 | Home Delivered Meals (OI | TO BE SELECTED | 10/01/2023 | 11 |

Provider Search | Needs Association | View/Assign Hours

# What should I do if I think an IBL is needed but the provider does not?

- Talk with the provider and consumer
- Contact Licensing if the provider fails to execute an IBL
- Report abuse concerns (including restraints) to APS and Licensing

How long does a case manager have to respond to an IBL request?

- Try to respond within one business day.

- We encourage local offices to develop a plan for covering requests when a case manager is out of the office.

Since memory care facilities are often secured, do all residents need an IBL?

Only residents who try to leave a secured facility require an IBL for control of schedule and activities.

# Does a resident have to revoke consent in writing?

- An individual may revoke consent at anytime.
- The case manager will issue a new SPA.
- The resident’s care plan must be updated with a new IBL Request form.

# What are my responsibilities after an IBL is in place?

- Continue to monitor through direct/indirect contacts
- Discuss possible changes with the consumer and provider
- IBLs are valid for a maximum of one year

# Tools and Resources

- Case Manager IBL Checklist
- Flow charts
- IBL Narration Template
- Recording of this webinar
- Q and A document
- Oregon’s HCBS website
- Workday transcript instructions

# Contacts

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