

CART Provided by A La CARTe Connection

This rough edit transcript, which may contain missing, misspelled or paraphrased words, is only provided for your immediate review and is not certified as verbatim and is not to be cited in any way.

1-19-17

Oregon ISP

Captioner standing by.

[Audio line is silent]

>> The broadcast is now starting. All attendees are in "listen-only" mode.

>> Well good morning and welcome to our webinar "individually based limitations Oregon ISP." This webinar is presented by Oregon Training & Consultation (OTAC) under contract with the state office of developmental disability services. My name is Alan Lytle OTAC's Program Director for Oregon ISP and I'm here with Danelle Moore one of our lead trainers. Hi Danelle.

>> Hey everybody. So happy to be here and thanks for joining us today.

>> Something new and exciting for today. Our webinar today is being live captioned. If you would like to access the live captioning link will be provided in the webinar control panel and it's also in the reminder email you got prior to the event. We have Rose Herrera who is with the state of Oregon Department of Human Services. She specializes and HCBS which we'll hear more about today and works with federal medicare policy and Oregon rules and policies. So good morning Rose. Nice to have you here with us.

>> Good morning.

>> Thanks for being with us on this -- I was going to say chilly morning but gosh it's not so chilly as it was last week. Right?

>> Oh no. It's improving quite a bit.

>> Now we're back to enjoying our more typical rain. So I hope everybody has been defrosting for those affected by the snow and ice over the last couple of weeks. We wanted to get a sense first off, Rose has quite a presentation for us today and we wanted to get a sense of who is here and in what settings do you provide or receive services. So I'm going to launch this poll. There's a poll coming up on your screen right now and it asks in what set dogs you provide or receive services. Go ahead and check all that apply on your screen. Do you provide in home services either through the CDDP or brokerage or receive services in that case or residential services, 24 hour supported living or through the state operated stabilization and crisis unit. Residential settings, foster care. How about employment services and/or day support services in and those of you who provide case management through the CDDP or brokerage also any of you who may be state or regional staff. Let us know that. We're really interested to know what settings are impacted. Looks like 90 percent of you have responded to this poll and Rose let's take a look at who -- who's responded. It looks like the majority of folks. 44 percent provide or receive services in a residential setting. Specifically 24 hour, supported living or stabilization and crisis unit. And it looks like another 30 percent of participants, 31 percent actually provide employment services and/or day supports and 30 percent of you provide case management through the CDDP or brokerage. That's useful information and it helps us as we're proceeding through the session. And thank you for taking a moment to respond. We're curious one other question.

What's your role in contributing to the development of an ISP? And in this case we'll ask you to choose one. Are you a person receiving services or a family member? Are you a CDDP services coordinator or brokerage personal agent? How about a provider? A 24 hour program, a provider in a foster care setting or anybody else? Anybody else? Yeah thanks for taking time to respond. I see already 90 percent of respondents or 90 percent of our attendees have already responded. Now we're up to 93. Great. Let's take a look at the results of that Rose. It looks like -- looks like 35 % for the majority. Thirty-five % of folks are provider of services in 24 hour programs. Followed by CDDP services coordinators or brokerage personal agent at 31 % and others are also here. We're glad everybody else is here. Rose how does the attendance compare to other similar presentations that you've given?

>> I would say it's rather similar. Today's presentation is highly focused on residential service settings; individual based limitations are specific to the residential service settings.

>> Excellent. Well Rose I'm excited to see the contents you have for us. I'm going to get out of your way and we look forward to hearing what you have for us.

>> Okay sounds good. I want to thank you all for being here today and taking time out. I did have the pleasure of going around to most counties in the state. I still have a few with our weather issues that I have to come visit. I will say today's training is kind of a condensed version of what I've presented so far. So for those that have participated in previous trainings this information is going to be repetitive however you might still find it helpful and my goal is to focus quite a bit of time on presenting information to you all but really having a large section of time at the end of today's presentation to also answer questions. I'm sure there's a lot of burning

questions as people are starting to apply these concepts. Initially we'll start with an introduction overview of these concepts and we'll kind of talk about what are those limitations and from there like I said some of these concepts will develop into questions for you all. So I'm going to go ahead and get started. The first question of course is what are Individually Based Limitations. There's strategies that restrict an individual from enjoying specific home freedoms. When we think about this it's an intervention, a barrier put in place typically from a care giver. So what are HCBS freedoms? They apply to anybody in any setting when they're receiving our Medicaid programs that we offer through our services. The slide here is going to be talking about those freedoms that anyone should be enjoying when they're receiving services whether it's in home, employment or day services or services in residential settings among others. So these freedoms are really focused on people having lives like everybody else. So when we talk about experiences we want to make sure that people have integration, people have that opportunity to have that life in their community and that there aren't things done differently or extraordinary for people with disabilities but again how we bring supports to people living the lives they would like to lead. So the HCBS freedoms in a summary basically we're supporting people so they can have jobs in the community. They can control their individual resources and exercise choice and self direction and people are treated with dignity and respect. This is not new stuff. In Oregon we're good at focusing on what's important to the individual. So a lot of these overlying concepts that are part of the new federal Medicaid rule we're putting into place are not new to us and Oregon established self direction and choice. I think this helps us fine tune things and makes us aware of key elements of things we do naturally and even if we talk about

limitations I think our field is strong and we do things naturally and we don't always call out what we're doing as something as exceptional or something we think about because it does come naturally to us so some of these are intentional or making sure we document some of those great skills and strategies that we're applying when we support people successfully. So when we look at residential settings the federal CMS highlighted a section of rules that they apply specifically to what they call provider owned control operated residential settings. The individuals live in the provider's home. There's some type of relationship between who that service provider and that home setting is and who owns or controls or has an interest in that property. And typically in Oregon in our programs we're looking at fosters homes, 24 hour program settings or group homes. We have a whole array of arrangements for supported living but essentially when there is a relationship between the provider and that property of supported living that also would be provided opened controlled or operated and it's not on the list here but living facilities fall under this as well. We have seen an increase in a number of individuals as people are aging choosing assisted living facilities. That's sometimes a common thing as they age and need extra assistance. These provider owned controlled or operated settings rules are specific to residential settings. And really we said we want to make sure people have lives like everybody else. When you live in the community and you're in a community home your home is your home regardless if you own or rent that home individually or receive some type of maybe shared care in a setting such as a foster home or 24 hour home. We looked at drawing out characteristics or things that people typically enjoy as a freedom in a private home setting and how do we make sure that's also available to people when they're living in the home with their

provider. So these freedoms that they have in residential settings the first is rather straight forward. The setting is physically accessible to the individual. Really this means the home accommodates the individual. So if somebody has mobility issues for example does that person have access to be able to get around in parts of that home? If you have somebody who is utilizing a wheelchair for mobility it probably would not make sense for them to live in a split level home unless there was a lift system that allows access to the common areas of the home. So how is that home accommodating that individual? And the next is there's a residency agreement in place for each individual address protections for individual and the eviction and appeal process. As we looked at this and if we look at the actual CFR, code of federal regulations, that federal law they talk about individuals living in settings where there's a rental or lease agreement or there's a residency agreement. In Oregon in our statute landlord -- 24 hour home foster care home are specifically exempted from landlord tenant law. So that part of the statute language doesn't apply but we need to make sure there are similar protections in place for individuals. So we fall under the residency agreement requirement. Basically what this means and is that we wanted to make sure people have security in their housing which means people understand what are reasons they can be kicked out. How long do I have to find a new place to live and do I have a voice if I don't agree with the decision making or why I'm being kicked out. Essentially we have those concepts in our rules like now. When you look at our exit language in the 24 hour rule and foster care rule they're very similar and they identify what conditions, what reasons can someone be given a notice. They have that 30 day notice time frame and there's an appeal process when individuals disagree. So we've taken care of that but the element we

need to address as we implement these federal rules is that written agreement. That was a challenge for us because individuals that we support don't often read our rules. So although we have these protections in place they're not often communicated to the individual. This residency agreement really does help us communicate those protections to the individual. In foster care you're also going to see some of those previous concepts that were house rules for example that really are more appropriate in a residency agreement. When you have a provider who has a policy about something like smoking or pets those are typical things you're going to find if you were going to represent a home or apartment in the community. So they really found that appropriate in the residency agreement. So residency agreement is required for each residential setting. We actually do have templates available as an option for providers to use. Those are posted on the HCBS page and later on in this presentation there's actually a link to the HCBS page that includes various versions of that residency agreement which providers may use as a tool if they would like. Then we go to each individual privacy in his or her unit/bedroom. Privacy has been something that's in Oregon law already. This again just really makes sure are we always honoring privacy to the best that we can. Additionally we got federal guidance that helped us put a perspective on privacy. If we think about privacy we probably all have a fairly common concept of what privacy means. But in reality privacy really looks different depending on a person and their needs. If someone needs assistance in the restroom someone coming in to support is not necessarily violating their privacy. If you have somebody who did not need support and someone comes in it's easily a violation of privacy. We have to think about physical support needs and behavioral and make sure when we are providing support as do

we honor privacy as much as possible but realize the support needs are going to impact how privacy looks individually. And now we're going to focus on the 6 here and this is going to be the focus for Individually Based Limitations. So these 6 are the concepts that are somewhat new in our Oregon system and we do have tools and resources if there are safety issues related to these. The first is bedrooms have lockable doors with the individual and staff having keys. For you are system this was something new. We even had laws that said don't put locks on doors and now we're saying go ahead and do that. But for us I think the helpful thing is that we had APD and our mental health program at the stable because these rules apply to their residential settings as well and they've had bedroom door locks available for a long time for individuals and it really isn't a big issue. It's people having the opportunity to control their space. Hey I need private time or you know what, I would like to have my belongings here so nobody can help their selves to my areas. Individuals have a choice of roommates. So when we talk about the bedroom. Okay I see questions to slow down. I will apologize. That's my own habit. I grew up in a large family and we learned how to talk fast and loud. Slowing down. Sorry guys. So in shared bedrooms we do talk about individuals having a choice in roommates and we were talking about shared bedroom roommates so we can't throw the house mates off the island but if I'm sharing that intimate space of the bedroom I should have a say. I shouldn't come home and a new person landed themselves in my room. I really should be part of that process where we look at, hey, Rose there's something new who would like to move into this room. We think she's a good fit and here's why. Here are things you might have in common. Then I can raise objections or concerns and be part of that process and that's really what we want to

see. Again the provider has the right to decide who is going to live in the home. So I can't just meet a new friend on the side of the road and decide I'm going to move them in and share my space. It is up to the provider to decide who will be a resident in the home. Then we go to individuals have freedom to decorate their bedroom. The bedroom is where you need to be surrounded in an environment. Individuals should be able to put things on their wall or, you know, decorate their bedroom in a way they would like. Maybe there's going to be personal items or furnishings that are very important. Perhaps there's a chest of drawers or dresser or item from that person's family that's important to them. If they would like to bring that piece of furniture into the home they should be able to have that opportunity to do that.

Now at the same time when we think about living spaces there's elements of safety as well and the provider has a property interest in that room as well. So that residency agreement is a great tool to identify if there's going to be issues such as if the individual would like to paint with glitter paint. Maybe that's going to be a problem. Kind of hard to paint over or what type of nails or things can be hung on the walls or whether or not water beds are accepted. Often residency agreements have language about exits or safety issues such as excessive clutter and things like that as well and that's entirely reasonable and within standards you would commonly find if you were to rent or lease somewhere in the community. And then we move on to individuals may have visitors of their choice at any time. We said hey have visiting hours, put them on the wall and now we're saying don't do that at all. Really that marks the trend when we talk about community based support even hospitals move away from visiting hours. Really when someone is living at their home and we want people to feel proud of where they live and feel comfortable enough to have

guests over and share their space with other people. Now when people live with other individuals in a home their spaces impact other people. The providers can address safety if a specific guest is unsafe they can definitely respond and say I'm sorry this is not safe for this home right now. We have to make those calls sometimes. But overall again people should feel comfortable to have guests and not be restricted to a social life from 2:00 to 4:00 on a Sunday afternoon. Then we have individuals have the freedom and support to control their personal schedule. So again we want people to have a lot of self direction and choice in their daily life. And have that flexibility. Now it doesn't mean that providers can't have an operating schedule bus that works for a lot of people and you've got to start somewhere so we need to make sure we have flexibility for people to self direct their days as well. If you have a household of people up nice, bright and early but I'm not a morning person I shouldn't have to choose between breakfast and sleeping in. Instead it might be I have repeated breakfast but I have the flexibility. I have a job opportunity but it's a swing shift which is different from how the house is operated. I have that planning and flexibility to support that community job at that alternate schedule if I need. This rule really came from our senior population when people were in assisted living facilities. Based on the large structure and how they operate they had rigid schedules in a lot of environments and what would happen is people felt they had to choose having their basic needs met and social opportunities and community opportunities. If I went out for coffee and ran late and I missed lunch I, I missed lunch. If I want to do an afternoon activity and it runs over time I miss dinner and I'm choosing between an activity and dinner. People have to choose between things like meals which are an essential and a social opportunity often

they're going to be staying home because that builds a lot of anxiety and people become isolated. So we need to make sure people have flexibility. Again when we think about the people to have self direction there are components that we have to be a cognitive surrogate about. If you think about impulses we have, desired activities we usually have a cognoscente process that goes along with that. So if I'm sitting at home and see a movie premier I don't bolt off my couch and head to the theater to see the movie. I process and think when does it come out. Can I afford that or do I need to wait until after payday? Is there a day that's more optimal? So we want to respond when people have buyers impulses and help them process when that can happen. We don't need to magically create every opportunity when there's an impulse or desire to do something. So we need to engage and help people understand when things can happen. Then the last one is individuals have the freedom and support to have access to personal food at any time. Our rules are staying the same around what providers are expected to provide in regards to meals. Individuals living in foster care and 24 hour pay room and board and that board is 3 meals and two snacks. How we would expect the providers are honoring tasteful preferences of individuals and I mean within reason. I can have a preference for lobster every meal but it's not a reasonable accommodation to expect lobster being served in the typical meal. But at the same time if I hate liver and onions I shouldn't have to eat that because it's served on Wednesdays. I should have a reasonable alternative. This one focuses on the personal food piece. So what we need to look at is if individuals need support to acquire -- maybe they need help with budgeting, maybe they need help making transactions in stores, to acquire that personal food then to have access. So I have my food items. Now do I have access to them?

Are they stored in a place that I can get to them easily? Is there a way that I can help identify which things are mine? I'm eating just my items maybe my bin has my name on it and I know where to go versus helping myself to the pantry and having other people's food. So we think about these rules. There are things we really enjoy in our everyday lives when we think about typical community living experiences. If we're hungry we eat something, if we want to do an activity we do it or plan when we can and that's what we want to extend to people who are supported in 24 hour and foster care and supportive living environments. But we have a couple ways we can approach things. As we think about these rules and think yeah that's a great idea we also probably think about the support these people have and certainly their safety concerns as well. So we can approach these in a couple different ways. We can be reactive meaning we're responding to something bad that happened and it's like oh, no, stop. Or we can think about instead how do we introduce to somebody a positive way to enjoy these freedoms and that's what we want to focus on when we think about these HCBS freedoms someone has. Now if you think about potential safety issues and food comes up a lot. An individual might have really poor choices around food where if you gave them money and the door to the candy store they would blow their money on candy and be sick. That's probably not an optimal thing for the person. There can be health implications. Our thought can be okay we will tell Rose she can't have her money freely to spend at the candy store. How effective is that when we think about skill building and autonomy and independence and self direction? When someone tells me I can't do something that's exactly what I want to do. Now if someone suggests things to me that's an entirely different thing as well. When you think about when you tell

somebody they can't do something you're also kind of doing a great disservice to them because their introduction to this concept of freedom is what they can't do. And even if I want to do the right thing maybe I'm not optional. I would like to make healthy and good choices. How easy is it for me to choose something different other than the picture in my head what I can't do because that's how this was introduced to me? So we want to think how do we create opportunity. So if Rose wants to have some snack food maybe instead of setting her up by giving her money and saying go forward and we'll see how that goes for you we can say you know what Rose. We think you should have some snacks. Sometimes when we've been at the store there's disagreements about what I'm purchasing for meals because I have to make sure I serve healthy food and what you would like so you can use some of your money for those snacks. Let's talk about how much money you think you would want to spend on snacks maybe each week. And so again you must take \$10 to the store this week and if there are certain things you want to buy, great. If you buy one big bag of it are you going to be tempted and eat it all at one time or do you want to buy the package with individual portions so you know when to stop and you can enjoy the snacks through the week? So there's a lot of opportunity for suggestions and skill building and supporting someone in enjoying their freedom and that's what we want to think about. Although fear comes up because we care about people and we're concerned for their safety how do we turn that into here's a successful opportunity to enjoy this freedom. So I really want people and teams to think about how do we introduce these concepts in a healthy way. How do we give people opportunities? You know if we're concerned about the types of visitors somebody might have because of that unsafe person they might meet instead of saying well you

can't have these people over, instead what's the underlying issue? You need to help support the individual to learn about boundaries and maybe help them build skills on how to kind of have a radar system as far as safety and people they meet. Are there social opportunities we can help create where this person might be more likely to be exposed to people in a reciprocal relationship rather than someone that wants to take advantage of them? So again thinking about opportunities. How do we create positive resources for people? The person centered planning focuses on what's important to the individual. Yes -- you can have visitors. Let's talk about what works best for you. It's important that you keep your job. And it's also really important that you get along with your house mates. So let's identify are there a couple nights during the week that are the best time to bring somebody over? Again we're not telling Danelle she can't bring people over or blow off work but we're guiding her. When we engage Danelle we're talking about when your friends come over how can you be a good host. We share that responsibility and talk about how to be respectful to others and potential outcomes. Like Danelle you work on Mondays. If you brought your friend over in Monday you would be missing work. What do you think your employer would think about that? What might happen? Is there another time to do something different? So we want to engage people and help them problem solve and identify what would be the outcomes if I choose different paths. If we talk about limitations there are going to be times where we do need to put restrictions in place because health and safety is a risk. We always want to focus on the positive and proactive first. I always challenge people if you feel like you want to say don't you can't to somebody, instead how about you say absolutely, let's talk about the best ways this can happen. But that's not always going to work.

So we are going to consider limitations but only if there's an active threat that requires intervention. So we don't want to think of, you know, some day there's a full moon and the stars align this bad thing might happen so we will tell this person no today. What we really want to do is think about this is an active issue right now. We know this is going to happen and we have to intervene and there's no other way for us to intervene other than saying no, stop, don't you can't to that person. These are the areas we talk about limitations. So again we're speaking specifically to residential service settings. Foster care, 24 hour and some supportive living. And it's in regards to these 6 areas that we have listed here on the screen. The lockable bedroom door, choice of bedroom roommate, access to personal food, control of schedule, visitors at any time and decorating bedroom. Now individuals might have things that look like a limit or a restriction in other areas of their life or other ways they're supported and their ISP plan is going to address those. The federal rule we know specifically calls these characteristics out for residential service settings. So we do that here and have a formal process that we're applying. We also might see similar supports such as maybe access to food or visitors for someone living in another environment like an in home environment and they can have a support again these rules are specific to a residential setting. So someone like in an in home plan their ISP and Risk Management Plan is going to be addressing some of those structures and strategies that might be in place. They're applying these 6 concepts specifically when an individual lives in a foster care, 24 hour or some supported living setting. So we can only put a limitation Individually Based Limitations or these 6. Again people can have supports or strategies and limits in other areas but to call it an IBL it's going to be these 6 in that residential setting then we have to follow required

process which includes specific documentation that the feds require. These are the requirements. These requirements come straight from the federal CFR, the code of federal regulation and what we did in Oregon was we took that federal language and basically cut and pasted it into Oregon rule. So the requirements at a minimum are the need. Why are we doing this limitation? Positive interventions used prior including what has been tried and didn't work. Again why are we doing this level of restriction on somebody? Try in a positive proactive way instead and that didn't work. Why? Why not? A description of the limitation. What does it look like? What are we doing? Is it we're securing all food and when that person wants food access we have certain conditions in place like there has to be somebody supervising, maybe the food texture is modified or the quantity measured or individual bites are given out so we know they're swallowing safely. We need a plan for regular collection after review of data to measure the effectiveness. If we're going to tell somebody you can't do something or stop you from enjoying something that pretty much everybody else in the community can enjoy we need to take it seriously and have some way of looking at how do we know it's working. We shouldn't be telling somebody they can't do something or stop them from doing something if it has no impact. So we need to come up with a way that we can measure this makes a difference for somebody. We have time limits. So if we have that plan for measuring, how often are we checking back? Is it still necessary? Again if it doesn't have effectiveness we shouldn't be doing it but also sometimes people need an intervention but then that more healthy behavior becomes more of a habit and we don't need somebody stopping anymore because we really kind of changed our ways a bit. We need consent from the individual or the guardian to put a limitation in

place and we always have to assure that limitation we're putting in place will not cause harm.

>> There's a couple questions here Rose that I thought this would be a good time to pause Anus a couple of these great questions that people are asking. So the first one is actually related to this slide here. Let's see if -- there's lots of questions coming in. Do you have a data collection form available? Is there one for that data collection or people building them themselves?

>> We do not have a specific data collection plan at this point. But we really looked at with this requirement is again we think about people are probably already pretty much doing what they need to. It's a matter of formalizing. So we wanted to be less prescriptive and let people look at what are you already doing. For example often people might have a behavior support plan if they have safety issues and behavioral issues to the point where they're warranting a limitation. Is there a way to utilize the data collection in that behavioral support? I had a provider at one of the trainings I did and she said I make notes on my calendar and I check with the service Coordinator. We want people to have that flexibility so we did not create a template. It's really up to the team to say what measure will tell us what's effective.

>> Great. Here's another one. This person is asking if somebody is saying I don't want a locked door knob, he says he doesn't want locking door knobs; he would not like to have it. How would you deal with that situation?

>> One of the things we have to have when we talk about a limitation is

there has to be a need. So when it comes to the locks since that question has come up specifically fairly often, our default expectation is a lock will be installed. If an individual has a health and safety issue that's directly related to that lock such as a health or safety will be increased by the presence of a lock a limitation could be put in place and no lock installed but the individual has choice not to use the lock if they don't want it but we want to make sure they're available to the individual and when we look to the federal criteria and guidance there wasn't an opt out option. The only exception was through an individually based limitation and for that to be satisfied we have to tie into a direct health and safety list.

>> So we think about the planning process. Naturally we talk about risks in situations when we enter into the person centered planning process which is ongoing. We look at the Risk Identification Tool where we identify the risk and have a Risk Management Plan and address how we're addressing risk. That's the key place we will say, oh, how are we supporting this individual? It actually looks like a limitation. Our newest ISP which I believe is coming out this spring will actually have a couple questions that specifically indicate is there a limitation, is one proposed and accepted or is one proposed but not accepted? And that really helps us rethink to make sure if there's a support that we're implementing to keep someone safe and it looks like a limitation we go ahead and add this process. So we have an individual consent to limitations form that we do have to complete and attach to the end of the ISP if there's a limitation that's indicated. So right now the time line is we actually started rolling this Individually Based

Limitations process and we expect March 1, 2017 effective ISPs or later. If there's a support or restriction that looks like an individually based limitation we should see this formal process in place. So we're planning now for those ISPs coming up. We do want to go ahead and apply this process. And we're really looking at as you're entering into that let's say March 1 ISP or later is there existing support we're doing or existing strategy that's a limitation? We need to go ahead and incorporate the formal process and makes sure we have what the feds require. Once we've done that if something new comes up, maybe they have a new medical condition that affects their diet. We go ahead and call it out at that time and add that limitation. We would be using an ISP change form to indicate that update and we're going to go ahead and add that new limitation. We're not waiting for that next ISP year. We are going to draft them as they come up once someone has had their ISP. March 1, 2017 through February 28, 2018 we have a transition period. As an individual's ISP comes due that's kind of what the switch date is for making sure the formal limitations are captured in that person's plan. So again when we have a limitation we have to use the individual convenient sent to limitations form. That's a required form. There's our web link. It gives us that form. There's also power points from the trainings I have done so far that help explain both how you consider something a limitation and the process for completing that form. There's also a PowerPoint with examples that kind of walk you through some key areas --

[Sound stopped]

Those resources are now available online. So now you see this is a copy of our form we have. Again that form is available online. You will indicate the individual's information. That includes their name, phone number, provider's name and individual's address and we are going to have you indicate which limitation you're doing with a start date and end date and there's a series of narrative questions for federal requirements for documentation. I will just walk us through this part here. We do have to have the individual consent and that's the place we see here and the services Coordinator is the person that's going to be signing off on this. So really it's going to use the team process and we engage the individual and get their consent but as a services Coordinator they're going to be looking at all the elements there, do we meet the requirements before we go ahead and approve and have this go forward. So completing the form we do need to complete a limitations form for each limitation. That means a separate form. Now at the same time let's say somebody has a dietary restriction because maybe they have diabetes and maybe there's swallowing and aspiration stuff as well. It can be under the same limitations but we need to make sure all the information is there to make it relevant but you can group them by category. You don't need 30 limitations for all the different elements, just food texture and nutritional components and things like that. You will type that all in. They can come under the same category. But at the same time we shouldn't see a limitation form that indicates food access and visitors for example. Those would need to be on separate forms. We also want to make sure we're completing that form for limitations proposed

but not accepted. If we're at the point of proposing a limitation basically as a team we're saying the only absolute last resort way to keep this person safe would be these strategies here and we think they're necessary. This provides essential documentation; it's also our way of educating and edge gauging the individual in this process. So we're saying here is why we think the support is needed. What does it look like for the support? Ultimately the individual can reject the support. We can't override it but it creates great documentation. If we think about the category of controlled schedules and activities for example the need for behavioral supervision often falls in that category. So we have an individual who we do not think is safe in the community on their own. The individual does not want supervision in the community. As a team we say we really truly think this is a health and safety issue for the individual because of X, Y and Z. We can't do it anyway necessarily. But this documentation also helps support the provider so if something were to happen in the community maybe the individual engages in use of illicit drugs or activity we're concerned about or licensing or protective services says hey why are you not stopping this individual in the community. We have clear documentation that says the individual clearly rejected the support. So again it's an important piece to have because we can't force our supports on people but we also want to make sure individuals know we're willing and able to have these resource toss help them be safe and to have those optimal experiences. Now we have to have cop sent. In Oregon individuals are presumed to have capacity unless otherwise determined by a court. This is very critical. If an

individual is a guardian in most cases that guardian can consent to a limitation. We see great variation in the level of a guardianship order but in most guardianship orders there will be some indication that a guardian has decision making authority for health, safety and welfare. When we think about meeting the criteria for a limitation it has to be about health and safety. Most situations if that guardian has been appointed they can consent to the limitation but we always need to look at that. If you run into a situation where a guardian is consenting the individual is clear in objecting we might engage another resource like disability rights or some advocate to help us navigate that situation and look at is that in the scope of what the guardian can consent to or not? Is there another way to approach it that's a more proactive support rather than telling them they can't do something? Again I can't speak that it will always happen but in those cases if we have a guardian that guardian probably has the authority to consent and we have a lot of individuals that need a great level of support and just like now when we have individuals who are supported in services they have to sign and consent to their services plan for those services to be authorized. We can apply support decision making and limitations in much the same way and provide that significant level of support for individuals to sign and consent to those limitations if appropriate.

>> Rose can we pause for a couple more questions at this point?

>> We could. That would be fine.

>> I want to share a question. Is there only one person -- if there's only one person living in a 24 hour residential home does decorating the rest of

the house fit under this as well?

>> You know the federal rule talked about the individual he's unit or bedroom. So it's difficult because sometimes we have 24 hour homes where the home specifically is designed for one individual. Other times it might be one resident lives there but there's vacancy or other individuals. It would be difficult for me to answer. I think that it really would be between the individual and the provider to really talk about how can that individual's style be reflected in the household. But we do focus most of the rule around the bedroom and we want to really make sure it also doesn't turn into something where individuals will be expected to provide furnishing as well.

>> Another question. This is from Adam. Could you give an example of how all this applies to day supports and employment? Are there aspects of these services that may include Individually Based Limitations?

>> At this point when we think about these 6 specific areas we've identified for limitations as an individually based limitation they would not be for an employment or day setting because these 6 requirements are specific to that residential setting. If you think about it in your home you're the most liberated, you're the most free to make your choices and kind of self direct your activities. As we go into public environments like a job or some type of community setting often times there's going to be expectations of that environment that might have restrictions on whether or not we can bring food into that room or whether or not visitors can be brought in. So we kind of have to conform to the room of the setting when we leave our home versus when we're in the home. At the same time I would say

limitations can be valuable when we think about health and safety. So for example I have a restriction on my access to food because I have some swallowing and aspiration issues. That's going to be identified through a limitation from my residential setting. Now in my day setting that information and how I'm safe might be irrelevant. Because if I am accessing food at my day program it's important for people to know what are the strategies helpful to keep me safe. So I think there's some relevance but limitations are not required for employment and day settings for these 6 categories because they are not expected freedoms of that. We would expect in day and employment settings people have the same freedoms or restriction that is anyone else not disabled, non-Medicaid would have in that same environment.

>> Thank you Rose. And I'm going to hold a number of these other questions until we get more towards our Q & A portion. I just wanted to address one more key question. Since you're talking about the IBL form or individually based limitation form which you mentioned is available at ODDS web page we've placed a link in the chat so anybody here in the webinar can click on that link and of course you'll have access to these slides as well as the transcript of this webinar after the webinar completes. So we've had a number of questions related to that. We want you to know you'll be able to access all of those things and you're free to access these forms right now if you click on that link that's there in the webinar control panel. Finally to segway back to what you were talking about there have been several questions already. Can you clarify who has the responsibility of actually

completing the IBL form? There was a question around is -- can it be dell indicated to a provider to complete, responsibility of a provider, case management responsibility? Can you speak to that as you're moving back to your presentation, Rose?

>> The services coordinators are responsible that the form is completed because they're the ones signing off. At the same time that does not mean they're the ones necessarily writing them. I think in best practice we would see it as a collaborative effort. So it's really between the service Coordinator and the provider to make sure that all the elements are there. Ultimately the service Coordinator is the one that's signs off on in their role. Making sure all these pieces in the next slide we talk about that we don't have any conflicts or issues around the least restrictive, most appropriate and making sure the individual consents. So again we would see it as a team effort. In some situations there might be like hey I'm going to write it. Other times we will have providers that will jump on and do that. We did a pilot with limitations this last spring and we actually saw both. We saw some situations where the limitations were primarily written by the provider themselves then the service Coordinator really did an overview look and signed off and other situations we had a services Coordinator who completed them and reviewed it with the provider to make sure it kind of met everyone's needs then the services Coordinator signed off. So we're not being overly prescriptive of who is writing what, where but it's the responsibility of the service Coordinator to sign off and say all these elements exist and they're authorizing the use of that limitation. Okay.

Now I will go ahead and continue on again. I did want to mention there should be two versions of the form as well. We have a form where it can be electronic fill in so you can type that in and save it and update as you need but there's also one formatted if you will hand write that information.

Sometimes things come up on the fly and we do them in person so both forms and options should be available to you. So we can't do a limitation if an individual or their guardian does not consent. It's really important. We can't just override somebody. Now if we have a situation where an individual is not agreeing and we don't believe maybe they have the capacity to understand. An example I had in the training was they said this individual really totally objects to control over their food. But they're going to the emergency room multiple times a week because of what they're eating. That might be an indicator to us that this person is not understanding how they're impacting their health by the food choices they're making. If we come into those situations we need to look at is there some other means for decision making we need to explore, we need to look at maybe a public guardian and maybe they can help because of the safety for this person. Ultimately we have to have consent from the individual or guardian if we're going to impose a limitation. We can't do a limitation if not supported by health and safety needs and it needs to be specific. It can't be Danelle has poor safety skills so we will do these just in case. It needs to be direct about this is what's happening right now than is why we actively need to intervene. It can't be I might not like the choices Danelle makes in her friends so we'll restrict it. It has to be Danelle is in harm because of X, Y and

Z and we know we have to do that. We can't do a limitation as a convenience. So going back to the question we had about the lock. We can't do a limitation because someone doesn't want a lock but we can do a limitation if it's about health and safety risk or issue that's because of the presence of a lock would cause that or increase that. We can't do a limitation unless we've ruled out alternate less intrusive methods of addressing the risk. So again how do we think about this? Is there a way to turn that no into a yes that would be effective or a minimized risk? Then we also can't do a limitation if there's a barrier to other people in the home who don't require that limitation. So if we have an individual in a home maybe they have extreme food seeking behavior and we want all food on lock down and that includes that personal food. We need to consider how does that impact other people in the home. We need to have a plan for those other individuals that they don't require those restrictions on how they have unrestricted access to their food. So we can't take safety supports for one person and impose them on other people in the home. We have to be creative on how to support other people who don't require restrictions. Is there a work around? For example with the food access maybe those individuals are going to store that food in their room or have an alternate place they can easily access to get their foods. So again we need to make sure that we don't put restrictions on people that don't need them because of who they live with. This gets tricky because providers say what do I do if there's an emergency or something comes up? I have to keep people safe. We totally understand that. There's going to be emergencies. If

there's an emergency, providers please step in, address safety, intervene.

If there's something that you did not anticipate that affects health and safety use your professional judgment, address that safety issue, document, communicate and the team needs to look and say okay does this make us look as if this will happen more often or do we need permissions.

Emergencies happen. Maybe there's something related to food access or someone needs medical attention. We're obviously going to get that food away from that person and get them medical attention. We don't always anticipate who is going to come into the home or what event is going to happen so we need to respond with an urgent event if there's an active risk to safety and we need to move forward and say is there something we need to do moving forward. If we have an intervention that we reasonably anticipate that we are going to be applying we need to talk about it being a limitation. Then our last area before we get to more questions because I know there are plenty of them we talk about limitations versus variances.

When we looked at these HCBS rules and have the concepts of limitations we tried to look at all program rules to see can we minimize conflicts? Are there things we can adjust to take aware barriers or to be creative in those situations or maybe someone has something that requires a restriction. Is there wiggle room that allows less gentle ways to support people and minimize those barriers for others? A limitation is focused on the individual. It's about the individual's health and safety. That's where the individually based language is from. A variance is really about the provider in most cases. A variance of a provider getting permission from the department to

not follow a law. Typically it's going to be a physical requirement. Maybe it's going to be, you know, because of the support being in the house -- I'm making this up but windows that should be 38 inches wide are only 36 inches wide in this home. And we would like permission to have those more narrow windows. That would be something a variance would be. So in most situations we shouldn't see a limitation and variance because they're rather separate. We did come up with one situation where we will encounter that need for a limitation and variance and that's around a lock. If we have an individual where it's not safe for them to have a lock. Maybe we know that lock is going to trigger self injurious behavior or a barrier for response time because that person has such acute health care needs that lock is going to be a challenge. So we're going to say it's unsafe for the individual to have a lock. We're not putting a lock -- co-limitations. We also need a variance because that rule says, provider you will have a locking door knob on that door and we're not doing that. That's going to be a situation where you need both and when you're submitting that lock or variance for that no lock I should say we need to make a clear case of why that lock is a health and safety risk for that individual and really addressing there's no other benefit that person can derive. So we can't have a situation where this lock isn't meaningful to the person because they don't seem to understand it or they have limited body control. We would look at is there an element of privacy that lock can still give them that we're honoring on their behalf? Is there an element of protecting their privacy and their belongings from other house mates that's still a value to that individual? So

we just want to think about those things when we're considering taking away that freedom and all those potential benefits. Again --

>> Rose.

>> I'll follow up on the lock. You're talking about an example right now. There are questions in the cue related to locks. Some of the examples you were giving were -- we would fought want to consider a limitation if the person -- we're struggling to understand the person's communication or it may be vague or ambiguous. An example -- examples are coming in of a person explicitly requesting not to have a lock. It's their personal preference. Can you address that?

>> Yeah again and I thought I said it earlier but we can't not put a lock based on preference. That's going to be a standard requirement that need to be in place. So the default is a lock will be in place. An individual can choose not to use that lock and that's where the choice of the individual comes in. So we have the opportunity but they can choose not to use it. And that's really where that would weigh in. In extreme situations would be if that lock in some way triggered a health and safety issue for that individual then it comes into the health and safety category and we can look at a limitation but we can't manipulate that to make it a limitation.

>> Thanks Rose.

>> No problem. It's a tricky area and we've really tried hard to look at kind of where the balance is with that. Ultimately we want back to the federal language and the federal language only allowed the exception for the limitation which requires that health and safety risk. And this is really my

last slide of presentation but just again there's this link for our ODDS page. This is actually a little bit different pathway than most of our ODDS stuff because you will go through -- blah -- tongue tied. I apologize. We're going to be going through the HCBS page to the Oregon resources then there's that ODDS page and that's where the material is at. We tried to put it there and on our web page. We're trying to focus highly on HCBS materials being on the ODDS page. We also have a mailbox and this box is shared with APD and mental health. I will tell you I'm the person at the state working with HCBS or ODDS so it comes to me and I can respond to issues or comments or questions. If people have suggestion Board of Supervisors how to do things different or better we're always happy for those as well. We really do appreciate your feedback. It really informs kind of next steps for us. At this point I am more than happy to open up for questions. I understand there's quite a few in the cue so... Danelle or Alan you're welcome to fire away.

>> I was hoping we could tackle questions related to how it incorporates into the Oregon ISP. Because we have -- you did mention that an upcoming version of the ISP is going to ask a couple questions about IBLs if there are any IBLs in place that the person has consented to or that the person -- that were considered but not acted upon. The assumption was made it looks like through a couple of folks that somehow the requirements of the IBL form would be embedded into the ISP form. So we just wanted to clarify that's not the plan. The IBL form Rose has presented is expected to be used as she said one IBL form for each limitation that is considered or

approved. Is that right Rose or any details to add on that?

>> That's correct. I will tell you a lot of thought went into consideration on whether or not we would add another form or not. Ultimately it came down to call out these as critical. If we have a limitation for somebody without all the documentation requirements from the feds met that person's situation is not considered HCBS which means we're not eligible for that funding and what the feds have further said if there's one person in a setting whose service recent not considered HCBS client that entire setting is not HCBS compliant. We have to weigh the analysis and we thought we're going to call this out. The other reason why we didn't embed it into the ISP necessarily but call it out more is we want to see it more as an exceptional thing. These freedoms that we're supporting for people they're fundamental and we really want to take it very, very seriously and be a last resort there's no other way to support people from whom we're taking away from somebody. When we think about these HCBS IBLs, they really only apply to a subset of a subset of a population we serve. These 6 categories for limitations only apply to residential settings. And even in residential settings hopefully it's only a smaller portion of individuals who necessarily require someone restricting them of enjoying the freedom.

>> Thank you Rose. Let's talk about time lines. So how soon do service coordinators and personal agents -- how soon do they have a responsibility to make sure that an IBL is completed for any limitation?

>> So you're going to be responsible as the ISPs come due. Anytime starting with March 1 ISP effective date moving forward as that year comes

up that's where you're applying the formal process for existing supports or supports that are newly identified in that planning process. So I'm going to use Danelle. If she had an ISP in August as a services Coordinator I'm not going to jump on anything today or next month but maybe this summer as we start planning for Danelle's August ISP I'm going to start incorporating this process and I do need it in place if she has a limitation or a proposed limitation for her August plan moving forward.

>> We spoke about the service Coordinator having the final responsibility to sign the document and appreciated how you mentioned that it's filled out in a collaborative process. Frankly much the way the entire planning process is designed to work. In partnership. That was great. But a follow up question came to clearly pinpoint who is responsible for initiating the IBL form. Is the services Coordinator responsible to initiate it? Is the provider responsible to initiate it? And also who has responsibility for monitoring it?

>> So I will say there's a shared responsibility in each of those things. If I'm a services Coordinator and helping to develop a plan for somebody or there's a strategy with a limitation I need to call you out. If I'm a provider and planning strategies and caring for somebody and that looks like a limitation I may be held responsible through licensing if I'm not following that expectation. So I think there's kind of a vested interest and checks and balances. It's really a shared responsibility. Again we see services coordinators have that more lead role in the development and making sure all the planning elements are there but at the same time that provider is applying that plan and implementing the support and how they do that is

also measured and monitored as well. So it's definitely a shared responsibility. Then as far as -- that was proposing that. Then what was the other part of your question? I want to make sure I got it all.

>> Then monitoring it.

>> Monitoring is something that's a shared responsibility as well. A service Coordinator does need to have a role in monitoring but part of that form if you look on one of the last questions is specific about the plan for monitoring. As a team you're developing what's most appropriate. How often are we looking at it? Who is distributing to the monitoring of this plan? Again I'm assuming we all want to keep people safe and support people optimally so we all have kind of a shared interest. Again service coordinators want to authorize plans that make sense for people, providers want to apply supports that keep people safe so how do we do it that makes sense? It really needs to tie in what makes sense. Service coordinate remember doing monitoring when people live in residential settings. Do we tie the monitoring into the times? It might make sense. For other situations it might not necessarily. We want teams to have that freedom of what makes the most sense. Work load as well as safety on how often things should be monitored.

>> Okay we have a number of questions so we will try to speed round through a few of these questions. We'll see how many we can get through by 11:00. How will limitations affect tier rates? For example if supports document 2 to 1 in the community if a support document calls for 2 to 1 support in the community that it's necessary but the person does not

approve the support so the tier is not approved how can we ensure the support will be there if they later agree?

>> My understanding is that the needs assessment is going to be determining the tier rate. So the needs assessment is going to be allocating the resources to meet that individual's needs. The limitations form should not necessarily impact the funding for that tier establishment. It's identifying a way to support people knowing what their needs are. So that shouldn't change or be affected. If we have a situation where there's a disparity between supports that someone has identified as needing and what they're accepting then we do have probably an exceptional process we can look at to identify if let's say 2 to 1 supports were identified if the person is not using at that we certainly want to be allocating them but at the same time if they're needed and being utilized that shouldn't be an issue.

>> Can you talk about what role a health care representative plays with consenting to an IBL?

>> At this point we have not established a health care rep could consent to an individually based limitation. The mechanisms that we have and based on what we felt like was the feedback from Medicaid when they talked about informed consent we really have the individual, a guardian or a support decision maker where we will support the individual to sign a consent to a limitation. There's been a lot of work around ways that we can approach decision making and authorization of limitations but at this point we have not taken on that role for a health care rep. I will say that APD is leading an effort and there's a legislative concept ace bill proposed for decision making

for adults in their system to look at kind of a hierarchical goal decision making plan that might include something like a health care rep and it kind of mirrors that decision making process they use but that's kind of in the works right now. And part of the reason why they're exploring that for their system is they don't have that established person centered planning and ISP team that we have well established. We look at the individual and that legally established guardianship or supported decision making is our core way of approaching. We're not considering health care rep at this time to authorize limitation.

>> Okay. There are a couple of questions where people are giving specific examples of situations where the person may be choosing to engage in a behaviors that otherwise see as dangerous and as risky to them. And yet -- and when -- and they're presenting a situation where if the person was presented with the opportunity for a limitation to help protect their safety and the person declines they're asking about the provider's liability and are we off the hook for following orders and things to that nature. I will give one example then ask you to respond. Here's one. This comes from Valerie. Valerie asks what will occur when a person who will not agree for a limitation for going into the community alone is hurt, kidnapped or killed because she got into someone's vehicle because she's so friendly and does not understand the consequences of stranger danger. Wouldn't this be an ethical issue for the provider? And she closes by saying just saying it was her right doesn't seem right. Can you comment, Rose?

>> Yeah I mean it's very difficult. Oregon law actually presumes that

people have capacity unless determined otherwise. And with people's autonomy and risk and making poor choices. It's hard because we are going to have situation where is we really don't feel like somebody has that ability to make that safe choice. So really we have to work as a team and say I'm not asking people to make capacity decisions. I'm really saying evaluate if there are indicators that somebody has a capacity issue. Are there other steps we can take to look at is this person going to benefit from a guardian? We can't hold people down and stop them from going into the community that want to go into the community but yeah there are people that engage in high risk situations. It's very hard for me to speak to a general example because there's so many nuances and details that are relevant to each situation on how a team provides. But we try to look at what are strategies that we can put in place to encourage this person to have supervision. So it's not a restrictive supervision it's more like maybe around creating social opportunities like hey would you like to go to a movie or hey let's go do this fun stuff there there's a lot of shared support in that versus well go and see what you're going to do kind of a thing. So I think we have to get creative as teams. We might have to engage behavior consultants to say can you strategize ways to make this person accept supports but an individual does have the right to reject supports. As a provider you have the right to make that decision. If they reject the supports that is taking away the tools and resources I need to keep them safe. Am the person to serve this person and that's another decision that needs to happen as well. But every situation will be different. The level of risk is going to be

different, the choices the individuals make are different so we have to make our best effort in identifying all the information we can and saying okay what is our next path to go. It's probably in a lot of cases not going to be overriding the individual but how to get creative or are there legal mechanisms we can employ.

>> Rose can you talk to -- can you explain how this might apply to personal agents who are supporting those in their own home in a family home, in their own home or in the in home setting?

>> I think in a lot of situations it's going to be primarily based on if the individual were to change settings. So somebody's going to transition into foster care or 24 hour, maybe a supported living setting that provider has that property interest or even assisted living. It's important to know these things to know what type of things might impact the individual's freedom or safety restrictions they might need when they make that transition. I also say although the rules are not specific to an individual's home when we think about these core concepts of what someone has a freedom in their own home we really wouldn't expect their support plans even for in home plans really support people to have as much self direction and independence in their family home as much as possible as well. So I think it's more of a concept philosophy kind of carry-over versus an enforcement with in home plans when we think about these areas but it's also important to know because people have a right to choose any setting and if people are going to change setting type we're aware of how they can be supported in these other environments.

>> There were a couple questions specific to diet texture modifications. And I think this one sums it up fairly succinctly. If there's doctor's orders for food to be cut of up or the texture to be modified does that require an IBL form?

>> In most cases I would probably go ahead and do that limitation. My guess is if this person were to access food not modified in texture we would be stopping them. Limitation is about stopping somebody from freely accessing or freely doing anything. So really what I'm hearing is it's likely it would be stopping that person. Then we definitely would want to have a limitation there.

>> Okay. And so I guess a follow up from Sherry's question then would be so if the person declines to sign off on that just confirming then that we would therefore not be following the doctor's order. The provider would not be following the doctor's order but would be providing the person their food in the method that they were preferring.

>> I mean again I think with swallowing and extreme aspiration that tells us a lot right there. We need to look at that situation. As part of that team how do we approach this conversation with the individual? Because how you approach the conversation can make all the difference in the world. If we say okay Danelle your doctor says you have to do this so sign it. She says no thank you. That's not going to work. But if we talk about our intent to keep her safe and why we're doing that that's going to help a lot but not always successful either. Again if someone is choosing to choke that's a dangerous thing to me. That's going to be probably a little bit more

indicative of somebody not understanding the impact of their choices so are we going to look at some other support such as the public guardian to help us be able to enforce that type of dietary restriction. That might be something that would be important as well. It also comes down to if I'm a provider and I'm providing meals and snacks and I happen to serve things that already have a modified texture anyway and I'm going to Danelle's name because she's in the room again here. Danelle doesn't use her personal money on other food. She doesn't access other food. If she says jump in a lake, if we prepare regular foods and modify the texture that's not restricting the freedom. If I have to intervene because she brought it home or stop her from buying foods that's a little different too. We need to look at how that support is applied for that person whether or not it's a restriction.

>> Okay we're nearing the end of the webinar. We've got time for just a couple more here. And here's a thoughtful question. Shane is reflecting after looking at the IBL form the IBL form asks about what sort of less restrictive strategies have been used. So he's asking what if the limitation has actually been in place for a long time and we don't currently have record of previous less restrictive strategies that refused. Do we need to start over with the person? Potentially -- I'm reading now into the question using my own words. Potentially even putting the person at risk by stopping supports to try less restrictive strategies. Can you comment on that?

>> I think as a team you have to look at that situation, what's the type of risk. What's the issue there? Is there some type of information that we can get? You know? So if this person has a choking issue and we look 20

years back and can't find anything maybe it's appropriate to speak to their physician about maybe a swallow study. Is there a behavioral issue? Can we maybe have a behavioral specialist check and help us identify. Is it still an active thing we're intervening and stopping the person from or is it more hey this is a risk we should be aware of? There are quite a bit of differences there. Sometimes we see situations in the trainings I've done I used an example of we talk about the decorating and furnishings the bedroom. Chances are we will see other supports if we control that bedroom and don't have small objects maybe we don't have any data. If we're not seeing any driving behavior in other environments we might question that.

[Indiscernible] is not a forever diagnosis. Sometimes it's influenced by medication or interactions. So what type of things can we go to see is this still an active issue? We will not go cold turkey on support but do we consult a medical professional? Is there something we can do just to maybe do just a tiny baby step to offer support to test the water? As a team we always want to talk about safety first of course and are there safe control ways we can [Indiscernible] again is there some professional we can bring in to do some type of assessment or somebody else to help us kind of calculate that risk. But to me I would say when we see some type of restriction in place and we can find no information supporting that in the background we really need to look at that carefully and see, you know, why are we doing this and is this really a fair or valid restriction to have in place. Every situation is different. The nature of risk is different as well and that's a collective professional decision that needs to be applied, the appropriate next steps.

We're in transition time as well so this gives us time so if we encounter limitations that we don't have all the essential elements for but we also our gut tells us this is an active issue, we have the time to go ahead and get that referral or get that resource or build that case while we're in the transition time.

>> Rose thank you so much for sharing your expertise with us today. And thank you so much to all the participants who have been here with us today. This has been a record breaking turnout for a webinar hosted by OTAC and we're very pleased for everybody who is here. Now a number of you have asked questions and we want you to know that we do have record of all of your questions. We have your contact information and we'll be working with Rose -- sharing those questions with Rose so that we can get answers to you after this webinar. We don't want to leave any question unanswered. And of course if you have further questions or want to discuss this further there were a number of resources that Rose presented earlier including an email box ODDS that is monitored and there are ways for you to get further support with your specific questions about IBLs. Just before we wrap up I want to as we're saying thank you very much for your time here today we have been talking about new ISPs coming out. There is a new ISP scheduled to come out later this spring. We'll be sending a pipeline email with further information about the time lines for that but just know that completing IBLs is not contingent upon a new ISP. So the IBL form is available now and to those of you who are working on plans that are due to start March 1 you do want to include IBLs if that's necessary in that case.

So thank you all so much and also a special thank you to A La CARTE captioning for their captioning real-time captioning services today in the webinar and Danelle thank you so much Danelle. Any final comments from you?

>> Oh I just want to thank everybody again I'll just reiterate what you said. What a great turn out. I know everybody took time out of their day to be here and we really appreciate your time. Thanks so much.

>> And Rose thank you so much. It's great to have an expert here with us who can tackle the tough questions and get them all. Thank you.

>> I want to say really quickly as folks have questions especially if you're planning feel free to ask the questions I'm here to provide that technical assistance. I ask you include your team when you do that so I don't get 6 versions of the same question but I do want to be here to support you all because I know there was challenging new territory for us all.

>> Great. Thank you so much. As the webinar is coming to a close we're just popping a couple poll questions up on the screen. If you can take a moment to respond to the poll questions you will also receive a very short survey link in the follow up email and we'll be posting a recording of this webinar as well as the transcript and a copy of the slides at OregonISP.org after this webinar. Thank you so much and we're going to end the webinar now.