

**COMMUNITY HOUSING AND SERVICES FOR PERSONS WITH DISABILITIES FOR  
REVOLVING LOAN PROGRAM FUND  
SERVICE PROVIDER QUALIFICATIONS**

**INTRODUCTION AND GENERAL EXPECTATIONS**

1. This program is to serve a target population of Medicaid members enrolled in or eligible for the Home and Community Based (HCBS) Intellectual Disability (ID) and/or Brain Injury (BI) Waivers, and/or Habilitation services who:
  - ❑ exhibit a continued pattern of physically aggressive or destructive behavior,  
OR
  - ❑ are currently placed out of state OR living in a licensed health care facility  
OR
  - ❑ are at risk of being placed out of state OR in a licensed health care facility.
2. This program is NOT intended to serve persons who are *sexually violent predators* per the definition found in Iowa Code 229.A2, nor is it intended to serve persons who are *medically unstable* per the definition found in Iowa Administrative Code (IAC) 481—69.1 (231C).
3. The tenants of the housing shall have a Service Plan in place that addresses how all of their needs will be met.
4. The housing shall be restricted to four people maximum per home, and shall not result in an overconcentration of supported community living units in a geographic area.
5. The service and setting shall be integrated into the community in the manner described by IAC 441—22.2(225C).
6. Applicants shall meet all the applicable federal Housing and Urban Development (HUD) and Iowa Finance Authority (IFA) laws, rules, requirements, policies and procedures including fire safety code and physical standards including 265—43.5(16) and shall complete the application process as required by IFA. HF 649 Sec.50 establishes an exemption from complying with boarding home rules.
7. Policies and procedures shall be in place which prohibit discharge of the individual unless an alternative placement is identified that is acceptable to the client or the client's guardian.

## **DEFINITIONS**

**Applicant** means the entity applying for funding through IFA to develop housing under this program.

**Crisis intervention plan** means a personalized, individualized plan developed with the individual using the service that identifies potential personal psychiatric, environmental, and medical emergencies. This plan shall also include those life situations identified as problematic and the identified strategies and natural supports developed with the individual using the service to enable the individual to self-manage, alleviate, or end the crisis. This plan shall also include how the individual can access emergency services that may be needed.

**Department** means the Department of Human Services.

**Discharge Planning** means a process used to decide what a member's needs for a smooth move from one level of care to another. This is done by a social worker or case manager. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the member's home care.

**Member** means a person who has been determined to be eligible for Medicaid under 441—Chapter 75 and who is in the target population for this program.

**Service provider** means the entity who holds a Memorandum of Agreement with the Applicant to serve the members living in the housing created under this program.

## SERVICE PROVIDER REQUIREMENTS

1. Service providers shall meet all the applicable IFA, Department of Human Services (DHS), Department of Inspections and Appeals (DIA) laws, rules, requirements, policies and procedures or other applicable State agencies or oversight entities.
2. Service providers serving persons with intellectual disability shall be an enrolled HCBS provider and shall meet all the requirements of Iowa Administrative Code (IAC) 441—77.37 and IAC 441—78.37 including abuse reporting, and incident management, and medication storage and provision requirements.
3. Service providers serving persons with brain injury shall be an enrolled HCBS provider and shall meet all the requirements of IAC 441—77.39 and IAC 441—78.43(249A) including abuse reporting, and incident management, and medication storage and provision requirements.
4. **Organization and staff.**
  - a. The service provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.
  - b. The service provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.
5. **Safety plans.** The service provider shall have policies for ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
6. **Life safety—emergency policies and procedures and structural safety requirements.**
  - (1) Service providers shall follow written emergency policies and procedures, which shall include the following:
    - a. An emergency plan, which shall include procedures for natural disasters (identify where the plan is located for easy reference);
    - b. Fire safety procedures including fire drills;
    - c. Other general or personal emergency procedures;
    - d. Provisions for amending or revising the emergency plan;
    - e. Provisions for periodic training of all employees on safety policies;
    - f. Regulations regarding smoking;
    - g. Monitoring and testing of smoke-control systems;
    - h. Tenant evacuation procedures; and
    - i. Procedures for reporting and documentation of safety concerns or violations.
  - (2) The provider shall have the means to control the maximum temperature of water at sources accessible by a member to prevent scalding and shall control the maximum water temperature for members.

- (3) An operating alarm system shall be connected to each exit door under this program. The provider shall have:
    - a. Written procedures regarding alarm systems and appropriate staff response when a member's service plan indicates a risk of elopement or a member exhibits wandering behavior.
    - b. Written procedures regarding appropriate staff response for members who are at risk of elopement or a member exhibits wandering behavior.
7. **Crisis intervention and stabilization.** A crisis intervention plan shall be developed for each member and updated no less than annually. The plan shall identify potential personal psychiatric, environmental, and medical emergencies. This plan shall also include those life situations identified as problematic and the identified strategies and natural supports developed with the individual using the service to enable the individual to self-manage, alleviate, or end the crisis. This plan shall also include how the individual can access emergency services that may be needed.
8. **Restraint, restriction, and behavioral intervention policy.** The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members shall be afforded the protections imposed by home- and community-based waiver services rules when any restraint, restriction, or behavioral intervention is implemented. Behavioral intervention plans shall be developed whenever restraint, restriction, or other strategies are used to manage or reduce maladaptive behaviors. Use of medications to manage or reduce maladaptive behaviors shall require a behavioral intervention plan.
  - a. The system shall include procedures to inform the member and the member's next of kin and/or legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.
  - b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention plan and are approved by the interdisciplinary team.
  - c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.
  - d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.
  - e. Restraint, restriction, and behavioral intervention plans shall identify the person(s) responsible for implementation of the plan.
  - f. Corporal punishment and verbal or physical abuse are prohibited.

- g. Documented initial approval and quarterly re-evaluation of the progress and effectiveness of the intervention steps by the interdisciplinary team (IDT).
  - h. Documentation of previous attempts or strategies to manage the targeted behavior prior to the development of a restraint, restriction, and behavioral intervention plan will be obtained.
  - i. Provider shall maintain documentation in the member record of the implementation of the restraints, restrictions, and behavioral intervention plans.
  - j. The behavioral intervention plan, at a minimum, shall identify the following:
    - 1. The targeted behavior to be reduced or eliminated.
    - 2. The baseline measurement of the targeted behavior taken before development of the behavioral plan.
    - 3. Intervention steps in response to the targeted behavior.
    - 4. Reinforcements for positive behaviors.
  - k. The restriction plan, at a minimum, shall identify the following:
    - 1. The plan to restore rights or documentation why a plan is not necessary.
    - 2. The training developed to reduce or eliminate the restrictions.
  - l. The restraints plan, at a minimum, shall identify the following:
    - 1. The criteria for emergency restraints (not previously authorized in a behavioral plan).
    - 2. The training requirements for staff prior to participation in any restraint.
9. **Discharge policies.** If a service provider initiates the involuntary discharge of a member and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the member or member's legal representative contests the transfer, the following procedures shall apply:
- a. The service provider shall notify the member or member's legal representative, in accordance with the occupancy agreement, of the need to transfer the member and of the reason for the transfer.
  - b. The service provider shall immediately provide to the member or member's legal representative, by certified mail, a copy of the notification and notify the member's treating physician, if any.
  - c. If, following the internal appeal process, the service provider upholds the transfer decision, the member or member's legal representative may utilize other remedies authorized by law to contest the transfer.
  - d. In no instance should a person be discharged from a home with directions to seek housing or shelter in an emergency shelter. Every effort must be made through careful discharge planning to work with the member and area resources to seek adequate, permanent housing.

- e. If "temporary" shelter placement is unavoidable, the reasons for this should be well-documented. Active case management should focus on locating a suitable housing alternative as well as ensuring that the member continues to receive appropriate mental health services. In all instances, a case manager should be identified.
- f. If a member exercises the right to refuse treatment and/or aid with placement, this should be documented. Documentation should include case management efforts. Whenever possible, outreach efforts should continue.
- g. If a member receiving out-patient services becomes homeless, the case manager should work actively with the member and community resources to locate suitable housing.
- h. The service provider shall involve the member and their legal representative in the discharge planning process.

### **EXPECTATION OF BEST PRACTICES FROM SERVICE PROVIDERS**

1. Service providers shall discuss their experience with and demonstrate adherence to:
  - \* Person-centered services planning that meets the Medicaid members' needs and goals
  - \* Medical-home-style enhanced collaboration with community (ie, physicians, community organizations, school where applicable, employment, etc.)
  - \* Staff-to-member ratio adequate to meet the Medicaid members' needs
  - \* Initial and Quarterly Assessments
  - \* Family involvement as much as possible
  - \* Be an agency that is, or partner with agencies that are, trained in multi-occurring disorders
2. Service providers shall discuss how they coordinate review of their individual service plans with Case Management.
3. Service providers shall discuss their prior experience with the target population.
4. Service providers' accreditation shall be in good standing with no outstanding quality issues to be addressed.
5. Service providers shall discuss what considerations they have given to the physical needs of the tenants/members.
6. Discharge Planning Best Practices
  - a. Exemplary discharge plans are conscious of factors such as the relationship between genetics and medication; the role of eye contact, language, social space, and body language in a culture and the relationship of these elements to diagnosis; and the culture's view of mental illness and stigma.
  - b. Exemplary discharge planning recognizes that, for a variety of reasons, difficult cases happen. Some members will choose to become disconnected from the

system and some agencies will occasionally refuse to offer services to certain members.

- c. Exemplary discharge planning anticipates these difficulties and attempts to develop alternative resources to meet potential and likely needs. These resources might include outreach programs, Safe Havens, jail diversion programs, alternative programs developed in unused areas of state hospitals, and other innovative programs.
- d. Exemplary discharge planning ensures that if members leave a program or facility against medical advice, they will be able to return to the system, and resources will be available.
- e. Effective discharge planning procedures and policies are supported by all relevant community planning documents, including the consolidated plan, continuum of care, and mental health and public housing authorities' strategic plans.
- f. Effective discharge planning systems make use of all available resources including Community Development Block Grant (CDBG), Projects Assisting in Transition from Homelessness (PATH), Supportive Housing Program (SHP), and Section 8 funds.