Kroh, Karen #3160

#14-540—(80)

From: Mochon, Julie
Sent: Monday, December 19, 2016 8:31 AM
To: Kroh, Karen
Subject: Fw: reply to 6100's
Attachments: My Preable.docx

From: Solomon Joe <JSolomon@pittsburghmercy.org>
Sent: Friday, December 16, 2016 1:01 PM
To: Mochon, Julie
Subject: reply to 6100's

Hi,
I hope you find something of value here

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PLEASE NOTE: Effective January 7, 2016, my new email address is jsolomon@pittsburghmercy.org.
To help us stay connected, please update your address book

Solomon-My Preable

I thought it might be wise to tell a little about myself so you can gain perspective of my perceptions. I will try to keep it short, really.

Graduated with a major in Elementary Education, concentration in Special Education. (yes that long ago). Worked in direct care at an icf/mr (now icf/ID)--- worked in direct care a Dixmont State Psychiartric Hospital in Pittsburgh, Pa are---worked in an icf/mr-an annex of Western Center near Pittsburgh called Southwest Habilitation Center on the grounds of Mayview State Hospital---employed by Southwinds, Inc as a Program Specialist (community residential facility)---became a casemanager for Northern Communities MH/MR unit which I lead a team of staff bringing folks out of state centers and at that time, also, directed a "Host Home" program that I later converted to family living. I was hired by Northern Communities and have stayed employed by that company through great amounts of change and growth (today known as Pittsburgh Mercy Health System-delivering MH/ID/D and A supports/and various other community supports, residentially as well as day supports). I have overseen, since 1993, residential and day support, a nurse consultant, unlicensed home and community program, mileage reimbursed folks, and we manage bus passes for those ID folks needing them. Current title "Quality Director". Sorry to bore you but I do not see myself as a "fly by night". I, also, have a 69 year old severely intellectually brother whom my parents have raised at home giving me a different perspective of the ID system. Done.

This was a difficult task. I did my best in the limited time I have. I did not review certain sections hoping that other team members and providers would provide feedback (medications, psp, 6500, restraints. It may have some replies skewed). That is not to say I did not care but time is limited. I hope I am clear in my responses. If I have any concerns, generally, I would like to see unlicensed home and community (habilitation, companion, etc) viewed as a very different support and support structure. Later I explain how we manage our program and it has much value in how it is provided.

2380.37(a)/ 2390.40(a)
When we get into training to specific individual needs, which makes sense, we have the problem of training all staff whom will support them in residential/day support sites. It seems large providers see things differently and are effected differently. We can interchange staff easily but if we train them on the spot is that really a training. Is that the best way to provide the service? Should we be promoting short cuts so we may staff a facility? Due to our size we have a contingency of "casual staff" who are called to come in to work at a large number of different sites. Preparing them adequately is difficult from a quality perspective. Do not believe there is a solution to this except to do our best.

2380.39(b)1,2/2390.49(b)1,2/6100 143.(b) 1
Training for staff that do not make direct contact with persons with ID should be limited to folks who do ***make direct contact and are having their salary paid via State ID waiver dollars.*** *PMHS is large. Our mail person would have to take trainings specific to hundreds of folks since they enter facilities to deliver mail. Maybe that is a question.*
Better define conditions for ancillary staff to receive trainings-see above. Trainings cost, directly and indirectly. This can be a major cost to providers. If providers are to maintain overtime costs/staff costs it

would seem what this ends up doing is not calculating the human factor. Burn out and stress. Can this reduce the quality of services? I noticed the numbers one and two of the 2380 and 2390 were separated not so in the 6100. Any reason for that?

2380.39(c)/2390.49(c)
Good core trainings.

I believe there to be differences in support models. Not an astute point but none the less I said it. Residential/Day Support programs are models I believe 24 hours of training are important. Not the 24, that could be changed, but the fact that having a large contingency of folks playing a very important role in the lives of folks we support we need to have common understandings. ***For unlicensed home and community,*** *providing day respite (in home and out of home), hourly respite, hourly habilitation and companionship I would hope gets viewed differently regarding training. Many family members are involved in the care given to family members who have an ID. Here at PMHS we formally hire "staff" who are often family members and close family friends (because they are trusted by the family and individual- we don't trust unfortunately) being employed to care for a sibling, son, daughter, uncle, niece, neighbor, etc. What I think is odd is when we request a brother or sister of an individual having diabetes living with their parents to take diabetes training because that is what we would expect to be training issues when they know so much about it already. We really train them in the ways of the system (EIM reporting, abuse, etc). The provider cost to train staff, the difficulty to carry out trainings and the staff time managing training aspects are out of line with making a simpler world in attempting to keep folks with family at home. These staff have spent hours alone with the individual, but now need an overload of training?*

2380.156 (b) 2,iii/2390.176(b) 2 iii/6100.52 (b)2 iii/6400.196 (2) iii
Rights team-necessary component to provide quality services and protect folks. But this would hold providers to an elusive demand. Maybe rewrite to….. "document events, analyze, and procure professional assistance (if necessary) to work with individual's specific team for resolution". Defining necessary would be necessary

2380.39 (c)/2390.176(c) Note-not in 6100.52 (c)/6400.196(c)
Funding agency? Explain who they are and why they would. If a person is named they may need to move their office to provider's offices. Not sure what function they provide. Is there a monetary function to care? If funding is necessary the SC would utilize current practices to get those funds authorized. Don't believe they need listed
Remove funding agency

2380.39 (e)/6400.196 (e)
For what purpose? How does this work? A phone call to alert of the restraint used and asking them to document? To schedule an appointment to do a body check? To respond in a timely manner we would be using med firsts, emergency room etc because I am sure a health care practitioner will not drop everything to do the check. Even if they did it once I think at some point they would tell us, in a kind way, in is not necessary based on the past experiences. They will tell us to take to the er if we feel the person would need to go and more than likely we would do that as an automated response. This will not build community friendly relationships. Just adds levels of work in the system. If we take medical action due to a restraint, a call to the practitioner may be a responsible act.
Reword

2380.17(c)/2390.18(c)
In attempts to keep less on paper vs electronically would not the EIM report support this requirement? Remove

2380 .17 (d)/2390.18 (d)/6100.401(d)
What about staff names in the report? Could an angered person present as a problem to staff named in the report? If it becomes an investigation could that investigation be effected if someone would become intrusive and "meddle" in the investigation? Maybe, we remove staff names, too

2390 Definitions
Chief Executive Officer-do the 2380's define this? 2390.32-could not find

6100's
6100.43f
Maybe I am having tunnel vision at this point, but immediate protection mean now to me. No further waiting. A provider should be able to take action as a reasonable step to secure someone's safety. There have been life and death situations, such as deadly seizure activity which the person must be monitored constantly (as much as they allow). A provider may need to view this person in their private bed room, having clearance from all person's involved.
Restate to allow providers to take specific action and clarify such action is approved by the team and feels it is necessary. Then file the paperwork. We cannot take away the providers ability to act in an appropriate manner. Trust not micro manage a provider and the person's team.

6100.44
Don't make it so hard to get through that providers will just not do

6100.45 (a)(b)
Change word provider to individual's team
(b) seems out of place in this section. How does a provider schedule and do this when there may be 500 plus to do? Better doing this in an already created process. The isp process.
Find another place for this to be stated. The rest is to be accomplished via a Unit Quality team.

6100.45(b) 6
We can give you pass/fail results for training in core competencies. We can only document lack of events, etc due to trainings but that seems foolhardy. IE: no one fell this month so our trainings on how to properly dress folks in appropriate footwear for the winter worked or no one died from a heart attack this quarter because we did not have to utilize cpr. Maybe I exaggerate some. This seems difficult to really accomplish. We can look at incidents and train to those areas. That would be more sensible as we would note improvements in the form of data.
Rewrite

6400.47(b) 1
Are we talking about unlicensed homes as in unlicensed home and community?
Clarify/rewrite to state those paid family members not natural family members in the household. Life sharing family members can remain receiving clearances. We need to be cautious of how much strain we put families through.

6100.48(a) 1

Clarify/rewrite to exclude unlicensed home and community family members. See above statement.

6100.48 (b)
I am assuming this could clarify the two above statements but it still should be clarified that natural household members do not need clearances vs an uncle that is visiting for an extended time.

6100.141(a)
Clarify. Separate individualized annual plans? Should a PSP contain this information? An annual training plan should be generic making some statement about including specific needs.

6100.142 (a)4
Seems a little late that these folks need 30 hours of preservice training before service is rendered. Training in Unlicensed home and community should coincide with service under the supervision of the family as the family sees fit. Most of the folks working with family members are, at least in how PMHS provides the service, close to the individual already. We built in family's desires, to trust the person coming into their home and care for their relative. Staff are known to them. They refer them to us for hire. It is a great comfort to many folks and quality is apparent in the care this person can offer the individual. The trusting relationship is there from the start. They only need trained in abuse and neglect aspects. They inherently live person centered, rights, integration into the neighborhood, honor choice and help build and maintain relationships. They do it naturally.

6100.142 (a)1,2/6400.51 1,2
Again, concerns about who needs this orientation. (when they are in direct contact and are paid via waiver dollars?)

6400.52(b) 1,2
Again, need to clarify, direct contact and paid via waiver dollars. Our fiscal folks are housed far away from consumers. Our agency, all staff, should receive training in reporting abuse, neglect, etc.

6100.182 j
Rewrite- an individual has the right to and can deny receiving supports from a provider. (an individual can wait for a provider to have the capacity to serve but no one can force a provider to serve)

6100.183/6400.32
Somewhere it should be clear that rights are taken in consideration of the health, welfare and safety of an individual. When choices are made that are seriously detrimental to themselves (and others) and the provider has no control it forces a discussion of discharge. We ARE working with a special population and the right to risk goes only as far a terrible event that the provider could not stop from happening. And I believe in the right to risk with limitations. On a personal note, you can ask my brother if he wants chocolate or vanilla cake but I will not have him make a decision of whether or not he wants to take lifesaving or health saving medication. And I love my brother. An assessment is needed that qualifies what choices a specific individual can make. We are our brothers' keepers and we need to give freedom and rights to risk in check.

6100.183 (g)/6100.443 (f)
Rewrite- an individual has the right to lock the individual's bedroom door unless it presents a personal safety issue or one that affects the safety of others. A key must be maintained by provider staff for emergency events

6100.401(a) 16
This had been 72 hours since we had learned long ago that we could resolve the event with one report. If going back to 24 it will require two reports. More staff time taken away from more important duties. Don't change current timeframes.

6100.401 a (17)
What types of these events will not be caught in 6100.401 1 through16?

6100.402. (c)/2380.17(a) 6400.15 (g)
Drop 6100.401. 16 (only in 6100's) for being investigated. At this time drop (12), (17-only in 6100's), (3,) (4), (9), (10), (11). A formal investigation is costly and not necessary for medication errors and the others listed above. There are other controls for reviewing medication errors via the quality team and a provide, just following the EIM process will have reviewed the event and made suggestions or plans of corrections. Our quality process should will, also, address these events for resolution. This is overkill. Providers would only be able to do investigation and nothing else if we investigate every event. We have, being large, 16 (average) med errors a month, 26 (average) other reportable incidents a month. We would need to have a Certified Investigators Unit to complete this task. This is costly.

6100.404. (2)
Remember to take out 6100.401 (16)

6100.443(a)(f)
We have crossed the bedroom lock already in 6100.183 (g). but there is no clarification as such with (f) in 6100.183
Need to add a statement as (f) in 6100.183.

General comment/discussion
I cannot and will not argue quality of life issues. I cannot and will not argue philosophy nor the direction we should be, and believe, we are going. The best care the majority of folks get will be by family and close friends, period. Barriers need removed to allow this direction to blossom. We need to keep it simple for families and for providers who, in attempting to shield families from the "system", take on an immense burden. Providers basically suck it up and protect the families from the raw aspects and, we do, but at a cost.
At PMHS we provide mileage reimbursement to drivers who drive folks to ISP documented places (day program). We ask for clearances of the drivers. Our drivers are 99.9 percent of the time parents. If a bad clearance comes back on one of the parents they may not be able to drive the person to day program. They do not get reimbursement. But they do continue to drive the person anyways. The clearance does no good. We did not protect the person or change the concern. Yes, this is not the majority of cases by any means. In fact, almost all drivers come back with a clean record. You would think after running hundreds of these clearances on drivers we would just stop asking for them. It is the fear of just one time something getting past us which becomes an issue. Litigation, such a scary word.
Agencies, just as individuals, should have the right to risk. To be trusted to do what is right and, if not done right, be separately held accountable. There are too many constraints placed on providers that detract them from doing what really need done-flowing funding to the care of individual not processes.

There is a cost to 6100 changes. There are costs to the PFD/Consolidated changes. The ACA, the potential labor laws (exempt/non exempt changes).....can providers survive this? The only way to survive

is to cut where you can...staff salaries. So no raises for folk already working two jobs to make ends meet. Positions get cut and we reduce staff hours which will have an effect on the quality of services offered. It will probably increase the number of EIM reports and investigations being done...both drawing dollars out of a budget. The devil really is in the detail. The changes made in 6100's are not cost neutral. We need to stop living in a bubble and remember there is a real world that will not succumb to a state department. We beg now for things to get done by external folks and they do it while they shake their head quizzically. The community may need to change some but, man, good luck.