

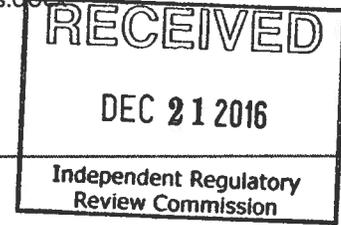
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**Kroh, Karen**

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**From:** Mochon, Julie  
**Sent:** Tuesday, December 20, 2016 8:40 AM  
**To:** Kroh, Karen  
**Subject:** FW: 6100s REFERENCE REG. NO. 14-540  
**Attachments:** 6100s Cover Letter.docx; Emmaus Comments on 6100s.docx



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**From:** David Treece [<mailto:dtreece@emmauspgh.org>]  
**Sent:** Monday, December 19, 2016 3:01 PM  
**To:** Mochon, Julie  
**Subject:** 6100s REFERENCE REG. NO. 14-540

Attached is a cover letter and also comments re: the proposed 6100 regulations. Thank you.

REFERENCE REG. NO. 14-540

David Treece  
Compliance Officer  
Emmaus Community of Pittsburgh  
*A Community that Serves Persons with Intellectual Disabilities and Autism and Promotes Public Awareness of Their Needs*

(Phone) 412-381-0277 ext. 206  
(Fax) 412-431-8653  
[www.emmauspgh.org](http://www.emmauspgh.org)

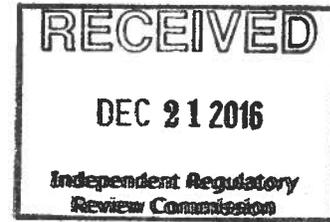
"The spirit of a community is more than a way of life. It is a hope, an incarnation of love." --Jean Vanier

United Way of Allegheny County Contributor Choice Agency #9123  
3 Rivers Combined Federal Campaign Code #34738

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December 19, 2016



Ms. Julie Mochon

Human Service Program Specialist Supervisor  
Office of Developmental Programs  
Room 502, health and Welfare Building  
625 Forster Street  
Harrisburg PA 17120

Dear Ms. Mochon:

Attached are some comments on the proposed Chapter 6100 regulations, "Support For Individuals With an Intellectual Disability or Autism. Hopefully these comments will be of help in finalizing the new regulations. Thank you.

Sincerely,

David R. Treece  
Compliance Officer



# Treece-Comments Template

## Chapter 6100

**Citation:** 6100.1. Purpose (a)

**Discussion:** wording is confusing

**Recommendation:**

***This chapter governs the provision of and payment for Home and Community Based Services (HCBS) and base-funded services to individuals with an intellectual disability or autism.***

**Citation:** 6100.2. Applicability

**Discussion:** Licensing and the regulations put forth here sometimes conflict.

**Recommendation:** Add "In the event of a conflict between the regulations set out in this Chapter and related but separate licensing regulations, the licensing regulations apply and supersede this Chapter."

**Citation:** 6100.3. Definitions

**Discussion:**

**Recommendation:**

**Citation:** 6100.41. Appeals

**Discussion:**

**Recommendation:**

**Citation:** 6100.42. Monitoring compliance

**Discussion:** Having multiple AEs complete monitoring is time consuming and unnecessary. Re: corrective action plan: it does not seem reasonable to be required to have a CAP for an "alleged violation" if the allegation turns out to be FALSE.

**Recommendation: Specify that only ONE AE should be allowed / required to complete provider monitoring**

**Do not require CAPs for false allegations.**

**Citation: 6100.43. Regulatory waiver**

**Discussion: When a waiver is requested it is very rarely due to a temporary condition. It is almost always due to a permanent need the individual has. An annual request is a costly and redundant exercise.**

**Recommendation: Allow waivers to renew automatically UNLESS there is a life changing event that warrants it's revocation.**

**Citation: 6100.44. Innovation project**

**Discussion:**

**Recommendation:**

**Citation: 6100.45. Quality management**

**Discussion: The new chapter poses several requirements such as “individual and family satisfaction surveys and informal comments by individuals, families and others” or “analyzing the successful learning and application of training in relation to established core competencies” that are general, vague and/or cumbersome). Providers have only had 3 years of experience under the newly required QM under Chapter 51. The extent of changes is not necessary.**

**Recommendation:** A provider will implement an evidenced based, quality improvement strategy that includes continuous improvement process, monitoring, remediation, measurement performance and experience of care.

(a) When developing a quality improvement strategy, a provider must take into account the following:

- (1) The provider’s performance data and available reports in Department’s information reporting system.
- (2) The results from provider monitoring and SCO monitoring.
- (3) The results of licensing and provider monitoring.
- (4) Incident management data, including data on incident target(s), repeated or serious incidents, root cause analyses, and quarterly review of incidents.
- (5) Results of satisfaction surveys and reviews of grievances.

(b) The provider will include the following tasks as part of its quality improvement strategy:

- (1) Goals that measure individual outcomes, experience, and quality of care associated with the receipt of HCBS and related to the implementation of PSP. Providers will establish goals based on identified need within their programs.
- (2) Target objectives that support each identified goal.
- (3) Performance measures the provider will use to evaluate progress.
- (4) The person responsible for the quality improvement strategy and structure supporting this implementation.
- (5) Actions to be taken to meet the target objectives.

(e) A provider must review progress on the quality improvement strategy and update at least every 2 years.

(f) A provider will maintain a written copy of the quality improvement strategy to be available for the Department to review as part of provider monitoring.

(g) This section does not apply to an SSW provider and to a provider of HCBS in the Adult Autism Waiver.”

**Citation:** 6100.46. Protective services

**Discussion:**

**Recommendation:**

**Citation:** 6100.47. Criminal history checks

**Discussion:**

**Recommendation:**

**Citation: 6100.48. Funding, hiring, retention and utilization**

**Discussion:**

**Recommendation:**

**Citation: 6100.49. Child abuse history certification**

**Discussion:**

**Recommendation:**

**Citation: 6100.50. Communication**

**Discussion: It is sometimes difficult, if not impossible, to truly ascertain whether or not, or how much an individual understands.**

**Recommendation: add language such as “Written, oral and other forms of communication with the individual, and persons designated by the individual, shall occur in a language and means of communication as *best and to the extent understood* by the individual or a person designated by the individual.**

**Citation: 6100.51. Grievances**

**Discussion: As an employer, I cannot “assure” that another employee or co-worker or family member or individual will not act in a retaliatory way. Language could reflect the statement that retaliation will not be tolerated.**

**Recommendation: Reword to “will not tolerate....”**

**Re: 6100.51 (i) add “if known” (because the initiator might not be known)**

**A written notice to initiator implies detailed findings. If the notice states only that the matter is resolved, the initiator will invariably want more information. In their a notice makes sense but in practice will cause issues.**

**The department must address / spell out the types of grievances that this waiver intends. It is not uncommon across the state, for family members to refuse to accept services from staff person if they do not like the color of their skin or because of their sexual orientation. Family members must understand that by accepting a Medicaid waiver for their loved one, they must also adhere to federal law prohibiting discrimination.**

**Citation: 6100.52. Rights team**

**Discussion: When someone’s rights are violated, an incident is reported and investigated. This new requirement cannot be implemented as written for the following reasons: The code states that each provider is “required to have a rights team” however all of the subsequent requirements make it clear that *each individual* has a rights team based on each incident. In fact the individual is ON the team. Thus a provider could potentially have dozens of rights teams – one for each individual who has a rights (or alleged rights or suspected rights) violation. To require the team to (iii) “discover and resolve the reason for an individual’s behavior” is antithetical to an understanding of human behavior (an individual’s behavior can be supported, understood, addressed, etc) but NOT RESOLVED. Additionally, with rights violations – a provider is most concerned with the *behavior* of the “target” – the person who violated someone else’s rights. No need to “blame the victim” – as if something in their behavior caused an incident or a rights violation. Meeting quarterly with the individual for something that happened in the past is not productive. Making the team a majority of persons who do not provide direct services is not helpful precisely *because* they are not involved in the day to day care of the individual and the dynamics between the individual and other staff or other individuals.**

**Recommendation:** Delete this section completely. There is no need to add a separate “Rights Team.” In associated licensing regulations, a long-standing and well-established process exists for the oversight and appropriate management for the use of any restrictive procedures, including restraint. The regulations have already established the “Restrictive Procedures Committee” and restrictive procedures process which is tasked with the same basic functions of the newly created team. By replacing a currently existing and appropriately operation expectation, unnecessary costs are added to the system. It is entirely unclear why the creation of a new “rights team” is necessary or adds any value to the actual protection of individuals’ rights, but rather only would add cost and administration burden. Individuals who are not satisfied with the follow up or corrective action plan have recourse to filing a complaint or grievance.

**Citation:** 6100.53. Conflict of interest

**Discussion:**

**Recommendation:**

**Citation:** 6100.54. Recordkeeping

**Discussion:**

**Recommendation:**

**Citation:** 6100.55. Reserved capacity

**Discussion:**

**Recommendation:**

**Citation:** 6100.81. HCBS provider requirements

**Discussion:** The regulation wording under provider requirements should more accurately match *the actual* requirement for provider enrollment (for example – a license from the Dept. of Health” is mentioned in 6100.81 (c) – but is NOT in fact required for most facilities. This is VERY important, because provider enrollment has historically been extremely slow and is often held up because providers miss one or two documents – that were NOT listed correctly / clearly in the published directions. This then caused LONG delays for providers and worse – for individuals waiting to receive services.

**Recommendation:** Include wording that matches the actual provider requirements:

*A provider enrollment application, on a form specified by the Department.*

*A medical assistance provider agreement, on a form specified by the Department.*

*A home and community-based waiver provider agreement, on a form specified by the Department.*

*Verification of compliance with § 6100.81(2) (relating to pre-enrollment provider qualifications).*

*Verification of compliance with § 6100.476 (related to criminal history background checks).*

*Documents required in accordance with the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).*

*Verification of successful completion of the Department’s pre-enrollment provider training as specified in § 6100.142 (related to pre-enrollment training).*

*Monitoring documentation*

*Copies of current licenses, if applicable, as specified in § 6100.81(2) (relating to provider qualifications).*

*Verification of compliance with § 6100.46 (related to criminal history background checks).*

*Prior to applying for participation in the HCBS program, the applicant shall complete the Department’s pre-enrollment provider training.*

**Additionally:** 6100.81 (c) 1 & 2 seem to contradictory or confusing. Please clarify.

**Citation:** 6100.82. HCBS documentation

**Discussion:**

**Recommendation:**

**Citation:** 6100.83. Submission of HCBS qualification documentation

**Discussion:**

**Recommendation:**

**Citation: 6100.84. Provision, update and verification of information**

**Discussion:**

**Recommendation:**

**Citation: 6100.85. Ongoing HCBS provider qualifications**

**Discussion:**

**Recommendation:**

**Citation: 6100.86. Delivery of HCBS**

**Discussion:**

**Recommendation:**

**Citation: 6100.141. Annual training plan**

**Discussion:**

**Not ALL DSPs will require the same courses (6100.141 d(2) – some could need training on aging issues, medical issues, or behavioral health issues and others not thus some flexibility is needed. This requirement seems to be asking that every staff member has an annual training plan – that must – at a minimum cover certain topics.**

**Recommendation: Re; 6100.141(c) A list of the core competencies would help clarify system wide expectations.**

**Citation: 6100.142. Orientation program**

**Discussion:** Adding a training / orientation requirement for consultants will add hours and cost to that consulting arrangement and the topics identified (ie. abuse, rights, incident reporting and job related skills) are often outside of a consultant's responsibility.

**Recommendation:** Consultants should not be required to receive such detailed orientation because of the time and cost involved and it involves issues outside their responsibilities. Also as is, Consultants who are used by more than one agency "orientated" by every agency for which they work.

**Recommend that for all non-program staff – orientation and training focus on "Everyday Lives" – a code of ethics, and the "big picture" rather than on specific policies and procedures which they most likely will never have to act on.**

**Citation: 6100.143. Annual training**

**Discussion:** As written, the regulations are confusing. It would make more sense to address orientation first, and then move on the annual training plan and annual training. There is much overlap.

Specifying that 8 of 12 hours must be on certain, listed topics is unnecessary, because the items that **MUST** be covered will take at **LEAST** 12 hours if done correctly.

The topics listed in the waiver are important but providers are still required to cover many training topics that are not listed such as: medication administration (16 -24 hours), fraud waste and abuse prevention, compliance issues, handling grievances and complaints, proper documentation of service delivery, safeguarding client resources, quality management, ODP monitoring requirements, emergency medical treatment, fire safety, first aid, CPR and more. Must be built into the rates to meet the 12 & 24 hour requirement,

The Department must understand that providers are required to provide extensive training that goes way beyond 24 hours of narrowly focused requirement and must set rates accordingly. Compliance with bare minimum standards will not ensure system wide quality.

**Recommendation:** AWC and OHCDs should be removed from the regulations and that Transportation Trip and Unlicensed home and community based providers be excluded from 6100.143 as written. This list of training is geared strictly towards licensed providers and impedes the promotion of family support models of service delivery. A prescribed number of hours for training will not support appropriate training specific for the individual and does not afford the opportunity for families/participants and the unlicensed providers and Transportation trip providers that support them with the type and frequency of training that is needed for the individual. When there are established mandates to hours versus individuality, the quality is a lost and the opportunity to supporting the values of ODP and everyday lives is lost. The current unit rates will not support the increase in training requirements. Optimally, AWC and OHCDs providers will be removed from 6100 regulations and unlicensed providers and transportation trip providers should have separate training requirements that do not include a specific number of hours.

**Citation:** 6100.144. Natural supports

**Discussion:**

**Recommendation:**

**Citation:** 6100.181. Exercise of rights

**Discussion:** The language in 6100.181 (b) – is very vague: “shall be continually supported to exercise” his or her rights.

**Recommendation:** Please specify exactly what is meant by “continually supported to exercise” rights. Explain how that is done, how it is documented, how it is proven or measured.

**Citation:** 6100.182. Rights of the individual

**Discussion:** Re: 6100.182 (b) If individuals have the right to speak freely, then they should also have the right to be free from allegations of and investigations of verbal abuse every time they say something that offensive to another individual.

**Recommendation:** If this right is left as written, recommend adding that the individual will be held accountable for “speaking freely” if another individual, a staff person, a behavior specialist, or a consultant, feels that the speech is abusive or allegedly abusive.

Same recommendation for (e) – If a person makes a choice and “accepts” risks, then they should be free from accusations based on another individual’s interpretation of that behavior. Currently - as related to incident management – providers are being required to enter incidents based on the values and perceptions of staff and other “outside” individuals and NOT on the individuals’ words and actions or on the perceptions / understanding of the individual.

Recommend adding individuals have a right to be educated about the consequences for violating another’s rights (perhaps addressed in 6100.183)

**Citation:** 6100.183. Additional rights of the individual in a residential facility

**Discussion:** It needs to be made clear that individuals have the right NOT to exercise all of their rights (ie: they have a right not to have a lock on their door if they so choose) Additionally – many individuals have limited financial management abilities. A “right’ to unrestricted access to telecommunications – could be interpreted as a right to a data / coverage plan that one cannot afford.

**Recommendation:** Make clear that individuals rights cannot conflict with regulation, with others’ rights, or with documented health and safety information in the ISP. (ie: access to food at any time is clearly contraindicated for a person with Prader Willi)

**Citation:** 6100.184. Negotiation of choices

**Discussion:** The title here is mis-leading. The regulation is NOT referring to individuals’ choices but rather to individuals’ rights. Ie: the rights of one cannot trump the rights of another.

In group home / living situations – negotiation of choice is not an isolated “event” or a single conversation but rather an ongoing dialogue and constant revision and compromise. Choice negotiation is extremely subjective – and based on many variables. No one procedure can be expected to resolve differences to everyone’s satisfaction.

**Recommendation:** Since “rights” should be non-negotiable – the wording should reflect more accurately that which is intended by this regulation:

**Suggest:** Responsible exercising of rights

**Citation:** 6100.185. Informing of rights

**Discussion:**

**Recommendation:**

**Citation:** 6100.186. Role of family and friends

**Discussion:** Family and friends are by definition “natural supports.” It is unreasonable to “regulate” that role. There is way too much variance in family roles / dynamics to mandate a provider role in “facilitating” and making “accommodations necessary.”

If all activity here is under the direction of the individual, then the provider has a very limited role to play – and again that role should NOT be regulated.

**Recommendation:** delete this section completely.

**Citation:** 6100.221. Development of the PSP

**Discussion:** An ISP is by definition a Person Centered Support Plan. The “plan” has undergone several title changes over the past 20 years, but the content remains virtually the same. Changing the language for the sake of a few updated / nuanced additions is not necessary and will require time and cost at all levels.

**Recommendation:** Continue to call the plan an ISP. Update content as desired.

Define what the “service implementation plan” is. (ie: is this a separate “plan” from the ISP?)

**Citation:** 6100.222. The PSP process

**Discussion:** Please define how the individual “directs” the PSP process. ie: What are they expected to do? How will they know what the PSP process is? What if they are not capable for directing the PSP process or they do not want to “direct” the process?

**Recommendation:** Rewording is needed:

6100.222 (b) (1) ....A PSP process does not invite and include individuals....An individual must identify and include individuals. Please describe exactly WHO is doing (b) 1-11.

**Citation:** 6100.223. Content of the PSP

**Discussion:** More information is needed:

**Recommendation:** include information on behavioral supports needed.

Re: (14) – consider adding this to 6100.184 – re: negotiation of rights / balanced w/ risk. Or refer to THIS reg under .184.

**Citation:** 6100.224. Implementation of the PSP

**Discussion:**

**Recommendation:**

**Citation:** 6100.225. Support coordination and TSM

**Discussion:**

**Recommendation:**

**Citation:** 6100.226. Documentation of support delivery

**Discussion:**

**Recommendation:** ODP should develop a statewide mandated form for use by all providers. This will greatly reduce “violations” due to variance among providers.

**Citation:** 6100.261. Access to the community

**Discussion:** As in all everyday lives – individuals have to plan community outings “according to their means” (ie: they may want /chose something beyond their affordability. Additionally, ODP must be willing to pay for the staff portion of “access to the community” because of the required role in facilitating it.

**Recommendation:**

**Citation:** 6100.262. Employment

**Discussion:** Many of our individuals are living good long lives. Providers have been saying for years that folks should have the right to retire. There is no mention of people at or near retirement age.

**Recommendation:** Add a provision for retirement – which is a valid component of an “ Everyday life”

**Citation:** 6100.263. Education

**Discussion:** Higher education is very expensive.

**Recommendation: Please describe where the funding comes from for (1-4)**

**Citation: 6100.301. Individual choice**

**Discussion:**

**Recommendation:**

**Citation: 6100.302. Transition to a new provider**

**Discussion:**

**Recommendation:**

**Citation: 6100.303. Reasons for a transfer or a change in a provider**

**Discussion: Discussion 6100.303:**

This section is defined too narrowly to be practicable to the point that it contradicts other portions of the chapter and are unable to execute the residency agreement. There are many circumstances such as program closure, safety of others, provider closure which may require transfer or change in spite of individuals' wishes. This list is not exhaustive – they regulation needs to allow for unforeseen occurrences.

What if exercising rights impinge on others, is that grounds for transfer? What if rights place the individual or others at risk? 6100.184(a) states, "An individual's rights shall be exercised so that another individual's rights are not violated."

**Recommendation: Change (a) to read: A change in provider, against the individual's wishes will be made only in for serious reasons including:.....**

**Citation: 6100.304. Written notice**

**Discussion: There are 3 main parties involved in notice of a provider no longer being "willing or able" to provide a service: The SC, the individual / family, and the provider." There are many PSP team members who do not need to be informed of a change in one provider of one service.**

**Recommendation:**

**Citation:** 6100.305. Continuation of support

**Discussion:** There is a fundamental lack of understanding on ODPs part as to why it is sometimes impossible for a provider to continue providing services. When individuals have complicated medical or behavioral healthcare needs - a provider cannot create staff or skills to handle such. Nor can a provider force staff to stay in a situation that they feel unsafe in or unqualified for. Even with additional funding – the enormous amount of pre-service training that is required makes replacing staff a very long process.

**Recommendation:**

**Citation:** 6100.306. Transition planning

**Discussion:**

**Recommendation:**

**Citation:** 6100.307. Transfer of records

**Discussion:**

**Recommendation:**

**Citation:** 6100.341. Use of a positive intervention

**Discussion:**

**Recommendation:**

**Citation:** 6100.342. PSP

**Discussion:** Title “PSP’ here will be confusing when also referenced in 6100.221 This section is only about a very narrow piece of the PSP namely “dangerous behavior”

**Recommendation:** move this section to the PSP section

**Strongly recommend finding a different term than “dangerous behavior” – which sounds predatory and has a tone that harkens back to the days of institutionalization ....and society’s fears of people with IDD as “dangerous”**

**Consider: Risky behavior or potentially harmful behavior.**

**Citation:** 6100.343. Prohibition of restraints

**Discussion:** Title can be misleading to appear that no restraints are ever allowed

**Recommendation:** Change title to “Prohibition of certain types of restraints.”

**Citation:** 6100.344. Permitted interventions

**Discussion:**

**Recommendation:**

**Citation:** 6100.345. Access to or the use of an individual’s personal property

**Discussion:**

**Recommendation:**

**Citation:** 6100.401. Types of incidents and timelines for reporting

**Discussion:** Med errors should not need to be reported w/in 24 hours, but rather 72 hours

**Recommendation: re: individual to individual incidents: Require incidents to reported not just on the victim but on the “target” – There are many individuals who are the initiators of incidents – yet their behavior and support and corrective action plans and ongoing need for therapy – is NEVER captured or recorded.**

**Citation: 6100.402. Incident investigation**

**Discussion: The Department already has a mandated thorough and comprehensive training for certified investigators. There is no need for any additional “type” of investigation. However – all incidents are indeed analyzed – both on an individual basis and quarterly – in relation to all other incidents.**

**Recommendation: Move 6100.405 to 6100.403 – do not use the word “investigating” in any other way than when intended as “Certified Investigation”....this is more practical and useful to providers.**

**Citation: 6100.403. Individual needs**

**Discussion:**

**Recommendation:**

**Citation: 6100.404. Final incident report**

**Discussion:**

**Recommendation:**

**Citation: 6100.405. Incident analysis**

**Discussion:**

**Recommendation:**

**Citation:** 6100.441. Request for and approval of changes

**Discussion:** There are many situations within which individuals would benefit from rapid placement. These situations include natural disasters, program closures, and removal from abuse. It is important that this chapter allow the department to develop an expedited capacity change process to accommodate individual's needs in their everyday lives.

**Recommendation:**

**Citation:** 6100.442. Physical accessibility

**Discussion:** This item can create remarkable costs. The department needs to develop capacity to compensate providers for these costs in their rate-setting process.

**Recommendation:**

**Citation:** 6100.443. Access to the bedroom and the home

**Discussion:** This proposed regulation does not align with an everyday life as people typically do not live in a house where they need a key to access their own bedroom. Additionally staff may need to enter bedrooms many times per shift for many non-emergency or non "life safety" reasons: helping to get dressed, assisting with bed making, collecting laundry or putting away clean clothes, helping to fix someone's hair, assisting with bed time routines or personal hygiene. Staff are always expected to treat the entering of individuals' rooms with respect – to ensure dignity and privacy – but to prohibit entry without "express permission" for each incidence of access – demonstrates a lack of understanding of the amount of personal assistance staff provide on a daily basis. Further, documenting or proving that "Required express permission of each incidence of access" was granted or denied will be impossible....and if not impossible – it makes a homelike environment seem very much like an institution.

**Recommendation:** If an individual makes the choice or requests that a lock be put on their bedroom door, then a provider will ensure that it happens.

**Recommend working to reflect language from the Community Rule:** Each individual has privacy in their individual sleeping or living unit: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

**Citation:** 6100.444. Lease or ownership

**Discussion:** It is necessary under the Community Rule that individuals have a legally enforceable document that offers the same responsibilities and protections from eviction as our prevailing law. To that point, 6100.444(a) is clear and direct. 6100.444(b) while describing reasonable limits, inadvertently refers to providers as “landlords” and to individuals as “tenants” and their units as “leased space”. The rights conferred under the rule and as cited in 6100.444(a) do not make providers landlords. Having the same protections as provided by law does not make individuals tenants nor their spaces “leased”. This language distinction is important in that we need to preserve the American Disability Act’s protection of community residences as homes rather than businesses which can be excluded from residentially zoned areas. This distinction will also be crucial if/when the state develops guiding language or uniform formatting for the residency or room and board agreements in the future.

**Recommendation:** Remove reference to the Landlord and Tenant Act of 1951. It is not nuanced enough for the actual purpose of an enforceable agreement between a provider and an individual with IDD.

**Citation:** 6100.445. Integration

**Discussion:**

**Recommendation:**

**Citation:** 6100.446. Facility characteristics relating to size of facility

**Discussion:** The use of a maximum number seems arbitrary, and should therefore be omitted. Capping a number of participants working or living near one another seems contrary to ADA and Everyday Lives. The Community Rule does not specify an absolute cap on program size and so neither should Pennsylvania.

**Recommendation: Do not place an arbitrary maximum number of participants into the regulations.**

**Citation: 6100.447. Facility characteristics relating to location of facility**

**Discussion: 6100.447 (a) 1 & 2 & 5 are redundant**

It seems that someone with compromised health, or aging needs, or a chronic behavioral or physical healthcare need –could benefit from living in “close proximity” to a hospital. No need to disallow it. Lots of people *without* disabilities live in close proximity to hospitals and nursing facilities – people with IDD should be “allowed” to too. Otherwise – expressly define “close proximity” as it is extremely vague – and could mean one thing in an urban area and another thing in a rural area.

The system has been moving away from institutionalization and segregated living for decades. As more and more programs and services open up IN the COMMUNITY – there will be closer proximity to one another. It seems that this regulation is trying to fix something that is NOT broken. Unless the Department can provide evidence that people are being served in super-congregate settings, or show some evidence based research / data that shows the trend is heading that way, then COMMUNITY providers should have more flexibility in where they develop COMMUNITY based services.

Additionally – regarding the waiver renewal and the addition of people with Autism, the Department should be aware of a movement TOWARDS congregate living – in an effort to foster acceptance and share resources (see <http://www.ahdcp.org/>)

**Recommendation: Consider how discriminatory and limiting this regulation is.**

**Citation: 6100.461. Self-administration**

**Discussion:**

**Recommendation:**

**Citation: 6100.462. Medication administration**

**Discussion: Discussion: Medication Administration**

**There are two extremely important issues concerning the proposed new regulations pertaining to medication administration. These need to be addressed to prevent unintended negative consequences.**

**1. Codifying content that requires modifications over time into regulations will lock a crucial component of service provision into temporal practices which will become obsolete as new information, prevailing practices and technology emerge. Duplicating content which is as detail-specific as the proposed five-and-a-half pages of regulation across 5 sets of regulations when the state already has an externally accepted training module invites discrepancy between the regulations and the training manual and prohibits the training module from staying current as new information, prevailing practices and technology emerge.**

**2. Requiring 6500 LifeSharing providers to complete and adhere to ODP's Medication Administration Module is a new and counterproductive requirement which is in direct contract to Everyday Lives principals and the Department's stated intent to develop more integrated and natural life opportunities for individuals.**

**As a ready example of the problem with codifying material which requires change over time, an area has been identified in which the proposed regulations are at odds with prevailing practices as detailed by Title 49 of the State Nursing Board. 49 PA. CODE CH. 21 explicitly provides for Licensed Practical Nurses to accept oral orders for administering medication. The proposed 6100.465 provision only allows this practice for Registered Nurses.**

**This discrepancy is instructive both to the specific issue regarding LPN's and to the process issue of codifying Nursing Practices content which changes from time to time according to authorities outside of the Department. It is noted that the provider system needs LPN's to be able to do all that state law provides for them to do. In the second case, we need regulations which do not lock providers to standards which may soon become obsolete due to new and emerging best practices and advances. A second example of the problem with trying to maintain this content in multiple places is that there are already discrepancies between the proposed 6100's and the Department's Approved Medication Administration Training. The training's required checklist for medication self-administration has discrepancies with the proposed regulation. There is also a notable practice discrepancy regarding pre-pouring of medications. We should avoid such confusion by maintaining this content in just one place, namely the Medication Administration Training module and not regulations.**

**Recommendation: Keep the current medication policies and procedures in place.**

**Do NOT cover 6500s in this regulation.**

**Discussion:** It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.

**Recommendation:** Keep the current medication policies and procedures in place.

**Citation:** 6100.464. Labeling of medications

**Discussion:** It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.

**Recommendation:** Keep the current medication policies and procedures in place.

**Citation:** 6100.465. Prescription medications

**Discussion:** It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.

**Recommendation:** Keep the current medication policies and procedures in place.

**Citation:** 6100.466. Medication records

**Discussion:** It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.

**Recommendation:** Keep the current medication policies and procedures in place.

**Citation:** 6100.467. Medical errors

**Discussion:** It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.

**Recommendation:** Keep the current medication policies and procedures in place.

**Citation:** 6100.468. Adverse reaction

**Discussion:** It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.

**Recommendation:** Keep the current medication policies and procedures in place.

**Citation:** 6100.469. Medication administration training

**Discussion:** It is unclear why there are so many changes recommended under the medication section. It is also unclear as to how these changes will, if at all, improve or enhance quality.

**Recommendation:** Keep the current medication policies and procedures in place.

**Citation:** 6100.470. Exception for family members

**Discussion:** Family members should however, be expected to administer medications in the proper way (correct dose, route, time/s, etc. ) failure to do so sometimes both compromises the individuals' health and also puts the provider – which knowledge of such mistakes (or intentional decision to not follow doctor's orders)...at risk. Elderly parents often forget...or sometimes have different ideas of what their child / relative actually needs. Or might believe in cutting the pills in half to make them last longer (like they do for themselves). Or they have been given "discretion" by the doctor to "up" or "down" the dose according to observations...etc. Discretion that our staff do not have. This is a difficult situation for providers. Some clarification would be helpful here.

**Recommendation:**

