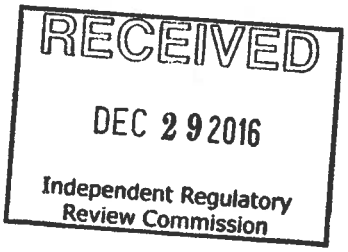
3160

14-540- 321

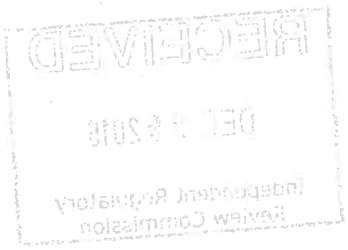
Kroh, Karen

From:	Mochon, Julie
Sent:	Wednesday, December 21, 2016 8:58 AM
To:	Kroh, Karen
Subject:	FW: Regulation No. 14-540
Attachments:	6100 Comments.docx; 6400 comments.docx



From: adharter@aol.com [mailto:adharter@aol.com]
Sent: Tuesday, December 20, 2016 11:52 PM
To: Mochon, Julie
Subject: Regulation No. 14-540

Thanks for receiving input!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Review Commission

ADH-Comments Template
Chapter 6100 – General Provisions

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

Discussion: Clarification

Recommendation: Subsection (a) omits mention of an essential purpose of chapter 6100 – the adoption of HCBS payment policies. As redrafted, (a) succinctly reflects the broad purpose of Chapter 6100. Language must be consistent with the CMS Community Rule for Home and Community Based Services (HCBS). CMS uses the term "services." The proposed regulations use the term "supports." Services indicates a contractual agreement for payment, while supports could be and often are unpaid

Citation: **6100.2. Applicability**

Discussion: Overall concern re: adding individuals with autism into the system providing services to individuals with intellectual disabilities. Our current system does not meet the needs of all people with ID, and it is unclear how adding another population will make things better for anyone. The people with autism only may well fall through the cracks because they might not even access services because they don't have a dual diagnosis. This plan of incorporation will also necessitate the revamping of the PUNS AND SIS processes because the criteria for services are not the same. Those with autism might actually be penalized by receiving less services under the system designed for people with intellectual disabilities.

Recommendation: I recommend that the Autism Waiver be reconfigured to actually meet the needs of the individuals it was designed to serve.

Citation: **6100.3. Definitions**

Discussion: Consistency of definitions throughout regulations

Recommendation: All definitions for these regulations should be included in Chapter 2390.5, and the definitions should be the same across Chapter 6100 and all licensing regulations. Definitions should be consistent and clear with the intent to facilitate communication and understanding. Deleting definitions from the program regulations and including them within Chapter 6100 and the licensing regulations promotes clarity, consistency, and reduces administrative burden across applicable services and programs.

Citation: **6100.41. Appeals**

Discussion: Wording choice of may vs. will – may implies choice will implies requirement

Recommendation: When an agency is required to do something will should be used otherwise it implies there is a choice for compliance.

Citation: 6100.42. Monitoring compliance

Discussion: Having multiple AEs complete monitoring is time consuming and costly and frankly 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. These waivers should be granted to allow for individual choice to allow for a quality of life which is directed and meaningful to the individual allowing them the opportunity to remain connected and have relationships with whom and where they chose

Recommendation: Allow waivers to renew automatically UNLESS there is a life changing event that warrants it's revocation.
The word waiver should be replaced with " exception" to avoid confusion with the specific Medicaid waivers and they should not be limited on the specific items,
Time line for dept should be determined recommend 30 days for response
4) "additional items deemed appropriate" needs defined to limit subjective decisions
d) department should specify start date but should renew with annual PSP as to not cause a delay in services for individuals
The individual and individual's team have fully reviewed and documented the benefits and risks associated with the proposed exception. Benefits that may result from granting the exception may include increased person-centeredness, integration, independence, safety, choice or community opportunities for an individual or a group of individuals.

Citation: 6100.44. Innovation project

Discussion:

Recommendation:

Citation: **6100.45. Quality management**

Discussion: While quality management is important, the new chapter poses several nearly impossible 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." (VERY general and VERY vague and VERY cumbersome). Providers have only had 3 years of experience under the newly required QM under Chapter 51. The extent of changes is not necessary. Quality management should be developed by individual providers of service unless the department or AE sees evidence repeat and prolonged issues regarding compliance or monitoring

Recommendation: 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. Absent criteria established by the U.S. Health and Human Services Secretary, 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: a) criminal history should be required and should use will or required
B) suggest the word "paid" be added
1) household member who are being paid but not all household members Dept does not have authority on who lives with another individual
3) consultants who do not have direct unsupervised time with individuals should not be subject to these requirements
5)volunteers should be number of hours assigned to this group and if not left unsupervised should not be required
If we are requiring individuals to be in the community, we cannot mandate everyone they have contact with have clearances and training and agency cannot be expected to monitor non employed persons
d) this conflicts with item 1

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

Discussion: The quality of staff is the most important element of any program, it has long been proven that staff turnover is both costly and detrimental to the individuals, if we value relationships, quality stability and health and safety this needs to be addressed.

Recommendation: Develop a method of payment incentives for direct care staff to both enter and remain in the field, loan forgiveness, health care or education stipend, encourage states to develop education programs and possibly certifications that will support retention in this field.

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: 1. If a provider is required to do something it should not use "shall"
2. An employer, cannot and will not tolerate retaliation. However, and employer cannot "assure" that another employee or co-worker or family member or individual will not act in a retaliatory way. The types of grievances should be spelled out (addressed here and in the waiver).

1. Replace shall with "will" or "is required to"
2. Recommendation: Recommendation: Consider rewording to "will not tolerate...."
Re: 6100.51 (i) add "if known" (because the initiator might not be known)

Re: 6100.51 (i) – add wording to prohibit the contents of written notice from violating anyone's confidentiality. (those who file complaints sometimes demand or expect more information than they are entitled to)

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: Confusion as to agency rights team vs individuals rights team
Providers work very hard to honor and protect individuals' rights. 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. There is no need to add a separate "Rights Team." In associated licensing regulations, a long-standing and well-stablished 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: If providers a current provider of hcbs services there is no need for them to resubmit documentation already on file. 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: In section d contact is vague and may not be made aware of persons is on excludable list until hire

Recommendation: d) change to providers may not employee contract or be governed by a person on the federal or state list of people to be excluded from Medicare and Medicaid programs

Citation: **6100.86. Delivery of HCBS**

Discussion: Dept should do provider qualification to provide consistency. It should not decide who can provide service, just who or what they will be paid for providing a service.

Recommendation: a) delete designated managing entity
C&d) provider will only be reinversed for and deliver services authorized is psp

Citation: **6100.141. Annual training plan**

Discussion: The purpose for a training plan is defeated by the idea that specific subjects or specific number of hours will address the needs of the clients or the organization. The training plan must be created based on an assessment that is by definition unique. As agencies analyze the needs of the people they support, the knowledge created in the field and their assessment of performance, a flexible, customized, quality focused plan will emerge. This new section collapses the critical elements of section 141 and 143 into one streamlined and accountable set of standards to not only maintain the basics, but to advance our work to the next level.

Recommendation: The plan will explain how the provider will assure that staff understand their responsibilities around the promotion of individual rights and the reporting of suspected rights violations, abuse or neglect in accordance with the regulations that define those rights and responsibilities.
The plan will explain how the provider will assure that staff understand the safe and appropriate use of positive interventions, including the training in the plans which are unique for any one person served.
(The plan will include the following positions
(1) paid staff with client contract;
(2) paid and unpaid interns who provide reimbursed supports to an individual and work alone with individuals;
(3) volunteers who provide reimbursed supports to an individual and who work alone with individuals.
(The annual training plan shall include the following
(1) the title of the position to be trained
(2) the required training courses including the training course hours for each position
(i) Records of orientation and training including the training source, content, dates, length of training, copies of certificate receive and persons attending shall be kept.
(j) The provider shall keep a training record for each person trained

annual training plans should be determined on needs of the individuals they serve and include items identified by the quality management plan or monitoring or licensing non compliance

Citation: **6100.142. Orientation program**

Discussion: This should be required only of licensed providers
When a provider hires a consultant, it is usually because the consultant possesses some professional expertise that the provider does not have. Adding a training / orientation requirement for consultants will add hours and cost to consulting agreement. Additionally, the topics identified (abuse, rights, incident reporting and job related skills) are often (though not always) way outside of a consultant's responsibility. The provider is still ultimately left with the responsibility of reporting, addressing and following up on all such matters.

Recommendation: Remove AWC and transportation providers as an agency's orientation is not applicable
Consultants should not be required to receive such detailed orientation because 1. They are competent professionals 2) there is too much time and cost involved – and sometimes individuals and agencies need help quickly and 3) Consultants who are used by more than one agency – by this definition would need to be "orientated" by every agency they work for.
Recommend *the Department* develop and administer a training for consultants so that providers are not re-inventing the wheel – all mandated topics are statewide. This would mean NO COST to the providers.
Recommend that for all non-DSP / 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. It is "splitting hairs" to make these separate – since there is so 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.

Additionally, while the topics listed in the waiver are important and necessary – and presumably the rates will be built to meet the 12 & 24 hour requirement, providers are still required to cover many training topics that are not listed such as: medication administration (16 -24 hours alone!), fraud waste and abuse prevention, compliance issues, handling grievances and complaints, proper documentation of service delivery, safe vehicle use, safeguarding client resources, quality management, professionalism, interacting with family members, ODP monitoring requirements, emergency medical treatment, fire safety, first aid, CPR and more.

The Department must understand that providers are required – whether mandated by regulation – or by best practice – or by agency requirement, to provider 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. See comment under 6100.141.

Citation: **6100.144. Natural supports**

Discussion: The use of the term " natural support" should not be used to replace a person need for paid supports especially in regards to health and safety of individual, true relationships should be encouraged and supported without the assumption that a person is expected to give or receive "support"

Recommendation:

Citation: **6100.181. Exercise of rights**

Discussion: 1. An individual cannot be continually supported to exercise individuals right 2. The language in 6100.181 (b) – is very vague: "shall be continually supported to exercise" his or her rights.

Recommendation: 1. b)should be amended to read an individuals will be informed and supported on exercising their individual rights as they desire The services, supports, and accommodation necessary for the individual to understand and activity exercise rights as they choose will be funded by the Department as part of the PSP.

C) add as desired by the individual

G) if the individual was determined to be incapacitated and requires a legal guardian the individual rights as well as decision making ability shall be directed by said order
H) on behalf of individual should be deleted and add to provide support to the individual
2. 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: 1. 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.
2. Consideration of court ordered legal guardians should be reflected, a person's right to choose where they live and work and form ongoing relationships should not be dictated by where the department or ae dictate or define success and meaningful

Recommendation: 1. 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 indivdual.

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

2. b) add except when otherwise directed by court order

c) the ability to make decisions and accept risks should be determined by legal guardian when individual has been declared incapacitated and should be indicated in sections f-l

(d) ~~-~~An individual has the right to make informed choices and accept personal risks that do not pose a threat to the individual's and/or another person's health, safety, or well-being.

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) In an everyday life – we all have the right to vote – but many choose not to. 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 can not 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 can not 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 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 section

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 un called for. Additionally it will required tremendous time and cost statewide at all levels.

Recommendation: a) agree that person should only have one approved plan but should not be mandated which form is used OLTL has plan but we are required to recreate a separate plan

a) The psp should reflect individuals choice and value their input as well as the people who they individual identifies as a member of the support team they should be valued and involved to the to the extent they direct. A persons communication mode and needs and meeting location and times should be valued and supported. The health and safety and quality of life and individuals values must always be primary focus.
b) Services should be written in a flexible manner to allow for an individual's everyday life and not prescriptive in nature
c) The sc should be responsible for facilitating plan development and revisions with the individual and their team and notifying team regarding changes and sending documentation to all team members outlining exact changes and effective date
d) I would suggest the initial psp have an avenue to develop an abbreviated plan until such time an assessment be completed and 60 days of admission date have some flexibility based in number of days in services to get a accurate and true assessment.
e) At least annually should be added as well as at the request of guardian or any other team member

"

Citation: **6100.222. The PSP process**

Discussion: Process needs to be updated to reflect current values.

Recommendation: Additions to form to document that address the and encourage at the very least discussion around the everyday lives principals

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

Discussion: PSP must be flexible enough to meet individual's needs as well as reflect personal choice allowing for success

Recommendation: 3) choice of healthcare should be amended to choice of healthcare providers
7) natural supports should be changed to reflect personal relationships and not focus on support
8) suggest amount frequency and duration of services be documented in a way to allow for greatest flexibility, suggest using phrases like not to exceed annual authorized units
10) community participation should be directed by individual
11) competitive integrated employment should be first but allow for an individual right to chose employment which is meaningful to the individual allowing for health and safety and success not be measured on person's definition not imposed by others Need to be mindful that people needs and values are different and should be reflected in services and location of supports
12 modification of rights should be required to be documented and reviews by restrictive procedure committee
17) any support or need identified by individual should never be considered unnecessary could not be funded but should be documented
18 financial information should include source of income for financial planning and benefits counseling i.e. SSI vs SSDI
19 behavioral supports, needs and services should be documented in PSP

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

Discussion: Not all things are in providers control and should be made an allowance for such as individual not attending as scheduled, community based services employment or others can change without notification to service provider.

Recommendation: Addition to be made to document if unable to provide service due to factors outside the providers control especially as it is reflective of an individual's choice.

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

Discussion:

Recommendation: a) would add during monitoring visits
5) add or disagreement as we should not assume everyone will be in agreement
9) addition of notification requirement and include and document specific changes just not a notification that there was a change

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:

Recommendation: Somewhere in this regulation – the department needs to make it clear that – as in all everyday lives – individuals have to plan community outings "according to their means" (ie: they may want / desire / chose to have season tickets to the Pirates, but they can only afford to go to 3 games per year. Additionally, ODP must be willing to pay for the staff portion of "access to the community" because of the required role in facilitating it....and keeping people safe.

Citation: **6100.262. Employment**

Discussion: 1. 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.
2. Dept should not have ability to dictate that the only employment that us valued and meaningful should not be based on preconceived and pre imposed values such as location, value, meaningfulness, success or quality but these should be an individuals right and choice

Recommendation: 1. Add a provision for retirement – which is a valid component of an " Everyday life"

2. The Department will ensure the funding necessary for individuals to access the community in accordance with the individual's PSP.

A)the psp team and sc should educate and provide information regarding competitive employment supports and services at psp or when requested by individual or designee
B) requiring referral or closure of ovr for people under 25 will eliminate the opportunity for young adult to acquire skills to gain successful employment and dept funded waivers have always been payee of last resort
C) individual will be offered and provided with information on services and supports regarding appropriate opportunities for competitive employment at least annually or at the request of an individual or their designee.

Citation: **6100.263. Education**

Discussion: Ongoing education is vital to all peoples growth and development

Recommendation: Addition of resources to support retention and development of ongoing functional skills as an addition to those listed

Citation: **6100.301. Individual choice**

Discussion:

Recommendation:

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

Discussion: Transition to a new provider should be responsibility of sc as well as all psp team members, communication, planning should be focus to assure health and safety needs are met as well as stability and success

Recommendation: b) transportation to visit new provider should not be responsibility of current provider but should be coordinated by sc or family as appropriate
Upon signature of permission to release of information should be provided to the new provider prior to start of services to assist in continuation of supports and services as needed, sc should be responsible for monitoring of this process during transition.
Upon request individual should be provided with any documentation regarding medical information developed by provider but not responsible for release of any third party developed information

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

Discussion: 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, Megan's Law, eminent domain, court or other legal actions, eviction by a landlord of the provider, natural disasters, 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. The Department and the AE will find out about the change when a critical revision or update is made. Since they have NO role in the decision about he change – they do not need notice of it.

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. The workforce is simply 1) not large enough (too many vacancies) or 2) qualified enough. When individuals have complicated medical or behavioral healthcare needs - a provider cannot simply pull staff out of thin air. 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: Provider cannot assume personal or fiscal liability during transition period at the cost of others or the program or agency

Recommendation: Provider shall continue to provide services during transition period but an immediate mechanism for supplemental funding must be developed dept or designee should be responsible for securing and funding interim placement to meet an individual's health and safety needs on a temporary basis not to exceed 30 days unless and extension is requested and agreed upon by psp team and dept

Citation: **6100.307. Transfer of records**

Discussion:

Recommendation:

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

Discussion: Support. Good change of title from "Safe Behavior Management"

Recommendation: a) positive interventions will be used when a challenging behavior is occurring or to prevent escalation of a behavior to decrease frequency, intensity and duration of behaviors in an attempt to identify teach replacement and coping skills to individuals which are problematic to the health and safety of the individuals or to others.

Citation: **6100.342. PSP**

Discussion: Documentation of behavioral needs services and supports are necessary and important any part of PSP.

Recommendation: The least intrusive intervention shall be used to deescalate the dangerous behaviors when the behavior is occurring.

A physical restraint may be used in the case of a dangerous behavior to prevent an individual from injuring the individual's self or others.

If the individual has a known dangerous behavior, it must be identified and addressed in the PSP, or if a new dangerous behavior is identified it should be added to the PSP through a revision.

1) delete word "dangerous"
2) add proposed or perceived in front of reason for behavior
5) benchmarks should be developed to achieve desired outcomes
Addition of restrictive review committee as appropriate and necessary to assure health and safety and provide for quality of life and individually defined success

Citation: **6100.343. Prohibition of restraints**

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

Recommendation: Change title to "Prohibition of certain types of restraints" and include provision for protection of imamate health and safety of individual and others

1) Delete verbally directed
3) Dept approved de-escalation and intervention designed to induce a release or bite should be defined and permitted in this section

4) Clarification on exclusion of medication used to control episodic aggressive behavior ordered by healthcare professional as all medication administered by provider must be ordered my medical professional

ii) medically ordered seizure protective device "easily removed by individual" needs to be considered on an individual basis

Citation: **6100.344. Permitted interventions**

Discussion:

a) **Recommendation:** Allowance for a verbal prompt should be permitted as a suggestion that a person can voluntarily choose to exclude themselves
b) Delete only in accordance and replace with " when an individual engages in dangerous behavior as identified and approved in psp or in an unanticipated emergency basis"
f. Not to exceed 30 second intervals needs to be added

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

Discussion: individuals need to take responsibility for choice, competency must be implied unless otherwise documented by legal or medical professionals

b) **Recommendation:** Addition of court ordered restitution
1) avenue should be part of psp for restitution to be required as a result of a act deliberately intended to destroy another property

Citation: 6100.401. Types of incidents and timelines for reporting

Discussion:

a) **Recommendation:** replace discovery with having knowledge of an incident or alleged incident. Also provider should only be required to report incidents which occur in their program or in their care, all others incidents should be reported to sc and reported by the sc
5) urgent care fa cities should be added to emergency room visits
8) "missing" person should be individually defined as time permitted as unsupervised in psp
12) emergency closure for weather should not be required to be reported unless it happens while individual is on site (closure due to weather prior to program start should not be required)
16) medication errors should be moved to the 72 hour requirement unless immediate medical attention is required
b) immediately should be defined as within 2 hours
d) incident report will be provided to individual, designee or legal guardian immediately upon finalization

Citation: 6100.402. Incident investigation

Discussion: The Department already has a mandated training for certified investigators – and they are trained on who to ask and what to consider. The entire process is comprehensive and thorough. There is no need for an additional "type" of investigation – ie: with a small "i". 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: provider shall review all reportable incidents to identify patterns and identify possible reductions quarterly as part of the providers quality management review process, including possible preventative measures to decrease numbers and severity of reoccurring incidents

Citation: **6100.404. Final incident report**

Discussion: Is directed and governed by dept incident reporting polcies

a) **Recommendation:** within 30 days should be added unless an extension is filed

Citation: **6100.405. Incident analysis**

Discussion: this is required under quarterly quality managent requirements and is a duplication

Recommendation: A provider will review and analyze all reportable incidents at least every three months.
As part of the review, a provider will identify and implement preventive measures when appropriate to attempt to reduce:
1) The number of incidents.
(2) The severity of the risks associated with incidents.
(3) The likelihood of incidents recurring.
(4) The occurrence of more serious consequences if the incident recurs.
(f) A provider will provide training/retraining to staff persons and the individual, based on the outcome of the incident analyses as necessary.
(g) A provider shall monitor incident data and take actions to mitigate and manage risk factors as necessary.

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: Develop format and process for requests emergency situations to accommodate an individuals need.

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, while presumably aimed at ensuring privacy, does NOT align in any way with an everyday life. Most citizens do not live in a house where they need a key to access their own bedroom. Additionally – in meeting individuals every day needs, staff may need to enter bedrooms many times per shift for many 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 serious lack of understanding of the amount of personal assistance our staff are providing on a daily – hourly 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. Staff who enter bedrooms on a regular basis are not strangers to the individuals. They are kind, caring and dedicated Direct Support Professionals who spend their hours, days, weeks and years building relationships with the individuals they support in a dignified manner.

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

Re: (e) Please specify who decides who is "authorized" – by name? by title? By position? Recommend language: The rights of the individual to privacy in his/her bedroom should be respected in accordance with sections 6100.181-183, with consideration for the needs of the health, safety, and welfare of the individual as determined in the PSP, or as needed in an unforeseen or emergency circumstance.

Recommend – addressing individual complaints or accusations of violation of privacy – as needed.

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.

Additionally – it has already been made clear in regulation 6100.303 regarding the conditions that are grounds for transferring (ie: discharging) an individual.

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: It is not clear whether or not this new regulation is legal or not. The use of a maximum number seems – by the Department's own admission – completely 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 no place an arbitrary maximum number of participants into the regs

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 tix 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/)

The regs should be careful not to single out people with IDD as SO DIFFERENT than everyone else – that this set of regs could never apply to another population.....especially while purporting to reflect the values of Everyday Lives.

Recommendation: Consider how discriminatory and limiting this regulation is.

Citation: 6100.461. Self-administration

Discussion:

Recommendation:

Citation: 6100.462. Medication administration

Discussion:

Recommendation:

Citation: 6100.463. Storage and disposal of medications

Discussion:

Recommendation:

Citation: 6100.464. Labeling of medications

Discussion:

Recommendation:

Citation: 6100.465. Prescription medications

Discussion:

Recommendation:

Citation: 6100.466. Medication records

Discussion:

Recommendation:

Citation: **6100.467. Medical errors**

Discussion:

Recommendation:

Citation: **6100.468. Adverse reaction**

Discussion:

Recommendation:

Citation: **6100.469. Medication administration training**

Discussion:

Recommendation:

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

Discussion:

Recommendation:

Citation: **6100.481. Department rates and classifications**

Discussion:

Recommendation:

Citation: **6100.482. Payment**

Discussion:

Recommendation:

Citation: **6100.483. Title of a residential building**

Discussion:

Recommendation:

Citation: **6100.484. Provider billing**

Discussion:

Recommendation:

Citation: **6100.485. Audits**

Discussion:

Recommendation:

Citation: **6100.486. Bidding**

Discussion:

Recommendation:

Citation: **6100.487. Loss or damage to property**

Discussion:

Recommendation:

Citation: **6100.571. Fee schedule rates**

Discussion:

Recommendation:

Citation: **6100.641. Cost-based rate**

Discussion:

Recommendation:

Citation: **6100.642. Assignment of rate**

Discussion:

Recommendation:

Citation: **6100.643. Submission of cost report**

Discussion:

Recommendation:

Citation: **6100.644. Cost report**

Discussion:

Recommendation:

Citation: **6100.645. Rate setting**

Discussion:

Recommendation:

Citation: **6100.646. Cost-based rates for residential habilitation**

Discussion:

Recommendation:

Citation: **6100.647. Allowable costs**

Discussion:

Recommendation:

Citation: **6100.648. Donations**

Discussion:

Recommendation:

Citation: **6100.649. Management fees**

Discussion:

Recommendation:

Citation: **6100.650. Consultants**

Discussion:

Recommendation:

Citation: **6100.651. Governing board**

Discussion:

Recommendation:

Citation: **6100.652. Compensation**

Discussion:

Recommendation:

Citation: **6100.653. Training**

Discussion:

Recommendation:

Citation: **6100.654. Staff recruitment**

Discussion:

Recommendation:

Citation: **6100.655. Travel**

Discussion:

Recommendation:

Citation: **6100.656. Supplies**

Discussion:

Recommendation:

Citation: **6100.657. Rental equipment and furnishing**

Discussion:

Recommendation:

Citation: **6100.658. Communication**

Discussion:

Recommendation:

Citation: **6100.659. Rental of administrative space**

Discussion:

Recommendation:

Citation: **6100.660. Occupancy expenses for administrative buildings**

Discussion:

Recommendation:

Citation: **6100.661. Fixed assets**

Discussion:

Recommendation:

Citation: **6100.662. Motor vehicles**

Discussion:

Recommendation:

Citation: **6100.663. Fixed assets of administrative buildings**

Discussion:

Recommendation:

Citation: **6100.664. Residential habilitation vacancy**

Discussion:

Recommendation:

Citation: **6100.665. Indirect costs**

Discussion:

Recommendation:

Citation: **6100.666. Moving expenses**

Discussion:

Recommendation:

Citation: **6100.667. Interest expense**

Discussion:

Recommendation:

Citation: **6100.668. Insurance**

Discussion:

Recommendation:

Citation: **6100.669. Other allowable costs**

Discussion:

Recommendation:

Citation: **6100.670. Start-up cost**

Discussion:

Recommendation:

Citation: **6100.671. Reporting of start-up cost**

Discussion:

Recommendation:

Citation: **6100.672. Cap on start-up cost**

Discussion:

Recommendation:

Citation: **6100.681. Room and board applicability**

Discussion:

Recommendation:

Citation: **6100.682. Support to the individual**

Discussion:

Recommendation:

Citation: **6100.683. No delegation permitted**

Discussion:

Recommendation:

Citation: **6100.684. Actual provider room and board cost**

Discussion:

Recommendation:

Citation: **6100.685. Benefits**

Discussion:

Recommendation:

Citation: **6100.686. Room and board rate**

Discussion:

Recommendation:

Citation: **6100.687. Documentation**

Discussion:

Recommendation:

Citation: **6100.688. Completing and signing the room and board residency agreement**

Discussion:

Recommendation:

Citation: **6100.689. Modifications to the room and board residency agreement**

Discussion:

Recommendation:

Citation: **6100.690. Copy of room and board residency agreement**

Discussion:

Recommendation:

Citation: **6100.691. Respite care**

Discussion:

Recommendation:

Citation: **6100.692. Hospitalization**

Discussion:

Recommendation:

Citation: **6100.693. Exception**

Discussion:

Recommendation:

Citation: **6100.694. Delay in an individual's income**

Discussion:

Recommendation:

Citation: **6100.711. Fee for the ineligible portion of residential habilitation**

Discussion:

Recommendation:

Citation: **6100.741. Sanctions**

Discussion:

Recommendation:

Citation: **6100.742. Array of sanctions**

Discussion: **If these are not licensing regulations, the language should not be so focused on corrective action.**

Recommendation: Change title to "Remediation."

Citation: **6100.743. Consideration as to type of sanction utilized**

Discussion:

Recommendation:

Citation: **6100.744. Additional conditions and sanctions**

Discussion:

Recommendation:

Citation: **6100.801. Adult autism waiver**

Discussion:

Recommendation:

Citation: **6100.802. Agency with choice**

Discussion:

Recommendation:

Citation: **6100.803. Support coordination, targeted support management and base-funded support coordination**

Discussion:

Recommendation:

Citation: **6100.804. Organized health care delivery system**

Discussion:

Recommendation:

Citation: **6100.805. Base-funded support**

Discussion:

Recommendation:

Citation: **6100.806. Vendor goods and services**

Discussion:

Recommendation:

cc: Nancy Thaler, Deputy Secretary, Department of Human Services, ODP

ADH-Comments
Chapter 6400 - Residential
Community Homes for Individuals with an Intellectual Disability or Autism

Citation: **6400.1. Introduction**

Discussion: 1. Word choice re: design of service should convey obligation in sentence 2
2. Overall concern re: adding individuals with autism into the system providing services to individuals with intellectual disabilities. Our current system does not meet the needs of all people with ID, and it is unclear how adding another population will make things better for anyone. The people with autism only may well fall through the cracks because they might not even access services because they don't have a dual diagnosis. This plan of incorporation will also necessitate the revamping of the PUNS AND SIS processes because the criteria for services are not the same. Those with autism might actually be penalized by receiving less services under the system designed for people with intellectual disabilities.

Recommendation: 1. Replace *shall be* with **must be** and change *will* to **can**
2. I recommend that the Autism Waiver be reconfigured to actually meet the needs of the individuals it was designed to serve.

Citation: **6400.2. Purpose**

Discussion: Adhere to document structure used in other chapters and streamline purpose

Recommendation: This chapter sets forth the minimum requirements that govern the operation of community homes for individuals with an intellectual disability or autism.

Citation: **6400.3. Applicability**

Discussion: 1. Word choice re: shall vs. must in sections b and d - must conveys obligation more strongly than shall
2. Suggestions for changes in wording in sections d, e and f
3. Suggestion for change in f2

Recommendation: 1. Replace shall with must in section b and d
2. (d) The Department will inspect each home serving nine or more individuals every year. Every home must have an individual certificate of compliance specific to the home.
(e)When an agency operates one or more homes serving eight or fewer individuals, the Department will conduct a sample of agency's homes each year. The certificate of compliance issued to an agency will specify the location and maximum capacity of each home the agency is permitted to operate.
(f) Add entities after following
3. Remove Resident facilities operated by Department from this list and require that they follow the same regulations as all other providers.

Citation: 6400.4. Definitions

Discussion: All definitions for these regulations should be included in Chapter 6400., and the definitions should be the same across Chapter 6100 and all licensing regulations. Definitions should be consistent and clear with the intent to facilitate communication and understanding. Deleting definitions from the program regulations and including them within Chapter 6100 and the licensing regulations promotes clarity, consistency, and reduces administrative burden across applicable services and programs.

Recommendation: *Adult Autism Waiver* - An HCBS Federal waiver program approved under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) and designed to provide community-based supports to meet the specific needs of adults with autism spectrum disorders.

Aversive Conditioning - The application of startling, painful or noxious stimuli in response to the exhibition of behavior in an effort to modify the behavior.

Autism spectrum disorder (ASD) - A developmental disorder defined and diagnosed in accordance with criteria established in the Diagnostic and Statistical Manual latest edition in effect at time of diagnosis.

Based-funded support coordination - A program designed to provide community-based support to locate, coordinate and monitor needed support for individuals who receive support through base-funding.

Chemical restraint - Use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug prescribed by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as treatment prior to or following a medical or dental examination or treatment.

Corrective action plan - a document prepared by a provider following a written determination by the Department of non-compliance with a provision(s) of this Chapter. The plan establishes timelines, person(s) responsible for the implementation and monitoring of corrective action steps.

Dangerous behavior – A decision, behavior or action by an individual that creates or is highly likely to result in harm or to place the individual and/or other persons at risk of harm.

Dignity of risk - Respecting an individual's expression of self-determination, even when it may adversely impact his/her health, safety, or well-being.

Direct support worker—A person whose principal job function is to provide services to an individual who attends the provider's facility.

Exclusion – when an individual voluntarily or willingly removes himself/herself from his/her immediate environment and places himself/herself alone in a room or an area.

Family—the person or people who are related to or determined by the individual as family

HCBS—Home and community-based support—An activity, service, assistance or product provided to an individual that is funded through a Federally-approved waiver program or the Medical Assistance State Plan.

Incident - A situation or occurrence that has a high likelihood of a negative impact on an individual.

Individual—An adult or child who receives a home and community-based intellectual disability or autism support or base-funded services.

Mechanical restraint - A device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints. A mechanical restraint does not include:

(i) A device prescribed by a health care practitioner that is used to provide pre/post-surgical/medical care, proper balance or support for the achievement of functional body position.

(ii) (ii) A device prescribed by a health care practitioner to protect the individual in the event of a seizure.

Natural support—An activity or assistance that is provided by family, friends, or other community members without expectation of payment

Non-conformity - Failure to conform to or meet the expectations outlined within this chapter.

Person-Centered Support Plan (PSP): The comprehensive plan for each individual that is developed using a person-centered process and includes HCBS, risks and mitigation of risks, and individual outcomes for a participant.

Physical restraint - A physical (manual) hands-on technique that lasts longer than 30 consecutive seconds and restricts, immobilizes, or reduces an individual's ability to move his/her arms, legs, head, or other body parts freely.

Positive interventions - actions or activities intended to prevent, modify, decrease or eliminate challenging behaviors. These interventions or positive behavior supports include, but are not limited to: environmental adaptations or modifications, identifying and addressing physical and behavioral health symptoms, voluntary physical exercise, health and wellness practices, redirection, praise, modeling, conflict resolution, trauma informed care, de-escalation, and reinforcing desired behavior (contingent and non-contingent rewards).

Pressure point techniques - The application of pain for the purpose of achieving compliance. This technique does not include utilization as a method of intervention from approved physical management techniques in response to aggressive behavior, such as bite release.

Provider - The person, entity or organization that is authorized to deliver services under the Medical Assistance Program.

Seclusion - Involuntary confinement of an individual in a room or area from which the individual is physically prevented from leaving.

Services - An activity, assistance or product provided to an individual that is funded through a federally approved waiver program, the State plan, or base funding. A service includes HCBS, supports coordination, targeted support management, agency with choice, an organized health care delivery system, vendor goods and services, base-funding service, uncles specifically exempted otherwise within this chapter.

State plan—The Commonwealth's approved Title XIX State Plan

Support coordination - an HCBS Federal waiver program under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) designed to provide community-based support to locate, coordinate and monitor needed HCBS and other support for individuals.

Vendor - A directly-enrolled provider that sells goods or services to the general public, as well as to an HCBS program.

Volunteer - A person who works without compensation and under the supervision of an authorized provider or family member alone with an individual in the performance of a service

Citation: 6400.15. Self-assessment of homes

Discussion:

Recommendation:

Citation: **6400.18. [Reporting of unusual incidents.] Incident report and investigation**

Discussion: Procedures for Incident Management already established, regulations should simply support that process

Recommendation: a) A provider will report the following incidents and alleged incidents through the Department's information management system within 24 hours of having knowledge of the incident:
(8) An individual if missing for more than 24 hours or if the individual is in immediate jeopardy if missing for any period of time.

(13) Use of an inappropriate or unnecessary restraint.

15(b) A home will report the following incidents in the Department's information management system within 72 hours of the occurrence or discovery of the incident:

(1) A medication administration error.

(c) The individual-and person(s) designated by the individual-shall be notified upon discovery of an incident related to the individual.

(d) The incident report, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual, and persons designated by the individual, upon request.

(e) The home shall take immediate action to protect the health, safety and well-being of the individual following the initial knowledge or identification of an incident, alleged incident and/or suspected incident.

(f) The home will initiate an investigation of certain incidents within 24 hours of the occurrence or discovery by a staff person of the incident of the following:

(1) Death
(2) Abuse
(3) Neglect
(4) Exploitation
(5) Missing person as defined in PSP
(6) Theft or misuse of individual funds
(7) Violations of individuals rights
(8) Unauthorized or inappropriate use of a restraint
(9) Rights violation
(10) Individual to individual physical and/or sexual abuse

(g) The incident investigation will be thorough and conducted by a Department-certified incident instructor.

(h) The home will finalize the incident report in the Department's information management by including additional information about the incident, results of a required investigation and

corrective actions taken within 30 days of the occurrence or discovery of the incident unless an extension is filed.

(i) A home will provide the following information to the Department as part of the final incident report:

(1) Any known additional detail about the incident.

(3) A description of the corrective action(s) taken or planned in response to the incident as necessary.

(4) Additional action(s) taken to protect the health, safety and well-being of the individual

Citation: 6400.24. Applicable laws and regulations

Discussion:

Recommendation:

Citation: 6400.44. Program specialist

Discussion: Program Specialist requirements vary between regulations. A degree in a Human Service field in no way ensures more qualified candidate for 2390 programs. Many experienced personnel come into the field through residential positions, garner experience and move into day programs.

Recommendation: Have all Program Specialist requirements be consistent with those required in 6400/2380 regulations.

Citation: 6400.45. Staffing

Discussion:

Recommendation:

Citation: 6400.50. Annual training plan

Discussion: Training plan should be comprehensive, but needs flexibility

The purpose for a training plan is defeated by the idea that specific subjects or specific number of hours will address the needs of the clients or the organization. The training plan must be created based on an assessment that is by definition unique. As agencies analyze the needs of the people they support, the knowledge created in the field and their assessment of performance, a flexible, customized, quality focused plan will emerge. This new section collapses the critical elements of section 141 and 143 into one streamlined and accountable set of standards to not only maintain the basics, but to advance our work to the next level.
Collapse 6400.50 and 6400.52 into one section.

Recommendation: (a) The home will design an annual training plan based on the needs specified in the individual's PSP and the provider's quality improvement strategy.

(b) The annual training plan will include the orientation program as specified in § 6400.51 (relating to orientation program).

(c) The annual training plan will include training intended to improve the knowledge, skills and core competencies of the staff persons to be trained.

(d) The plan shall address the need for training in basics such as rights, facilitating community integration, honoring choice and supporting individuals to maintain relationships.

(e) The plan will explain how the provider will assure that staff understand their responsibilities around the promotion of individual rights and the reporting of suspected rights violations, abuse or neglect in accordance with the regulations that define those rights and responsibilities.
(f) The plan will explain how the provider will assure that staff understand the safe and appropriate use of positive interventions, including the training in the plans which are unique for any one person served.
(g) The plan will include the following positions
(1) paid staff with client contract;
(2) paid and unpaid interns who provide reimbursed supports to an individual and work alone with individuals;
(3) volunteers who provide reimbursed supports to an individual and who work alone with individuals.
(h) The annual training plan shall include the following
(1) the title of the position to be trained
(2) the required training courses including the training course hours for each position
(i) Records of orientation and training including the training source, content, dates, length of training, copies of certificate receive and persons attending shall be kept.
(j) The provider shall keep a training record for each person trained

Citation: **6400.51. Orientation program**

Discussion:

Recommendation:

Citation: **6400.52. Annual training**

Discussion: Focus on reducing the need for certain training in different levels. Focus on protecting the individuals and limiting the extensive training requirements for certain positions. It seems contradictory for the regulations to demand extensive training for all staff/people remotely connected to a licensed provider when the emphasis is to have all individuals with intellectual disabilities completely integrated in their local communities where no one has any training. The far reaching scope of the training proposed is a wonderful ideal, but should not be a mandate.

Recommendation: 12/24 hour training requirements should be reserved for staff who work directly with individuals receiving services through a provider. Other staff indicated could receive an annual review of critical topics.

Citation: **6400.181. Assessment**

Discussion:

Recommendation:

Citation: **6400.197 — 6400.206. (Reserved)**

Discussion:

Recommendation:

Citation: **6400.213. Content of records**

Discussion:

Recommendation:

cc: Nancy Thaler, Deputy Secretary, Department of Human Services, ODP