3160

14-540 (293)

Kroh, Karen

From: Mochon, Julie
Sent: Wednesday, December 21, 2016 8:54 AM
To: Kroh, Karen
Subject: FW: Proposed 6100 regulations
Attachments: LVF 6100 Reg comments.docx

From: Mary Jane Fletcher [mailto:MaryJane.Fletcher@Lenapevf.org]
Sent: Tuesday, December 20, 2016 5:33 PM
To: Mochon, Julie
Subject: Proposed 6100 regulations

Please see attached comments - many are the same as the ones RCPA has sent in but I wanted to repeat them as they are important. I apologize as the formatting was giving me a lot of trouble.
Thank you for your consideration of these comments.

Lenape Valley Foundation

Mary Jane Fletcher
Associate Executive Director
Lenape Valley Foundation
500 N. West Street
Doylestown PA 18901
Phone: 267-893-5218
Fax: 267-893-5340
MaryJane.Fletcher@Lenapevf.org

Lenape Valley Foundation Supports Coordination Organization

Section	Comment / Recommendation
General comment	What was proposed by ODP November 5, 2016 are an improvement and a step in the right direction. There is a consistent focus on person-centered outcomes based on personal preferences.
General comment	Overall, these regulations will increase paperwork, documentation and analysis. While this information may be valuable, there is significant concerns that the rates DHS is paying do not provide the level of funding to support the increased documentation and analysis.
General Comment	Please use PSP throughout the regulations as ISP is used in some parts and PSP is used in other places.
General Comment	Please change "Support Coordinator/Support Coordination" to Supports Coordinator/Supports Coordination.
GENERAL PROVISIONS	
6100.1 6100.2	Purpose - (a) and Applicability (c) – There is a concern that base-funded programs are subject to these same regulations without the ability for exceptions, given that base funds are the safety net for circumstances that require some flexibility. For example, in section 6100.221, it is required that an individual have a PSP in order to receive services. If there is an emergency that comes up with an individual previously unknown to the Administrative Entity/SCO and as a result the person does not have a PSP, how could a provider offer emergency respite services? Please give counties/AEs the authority temporarily waive sections of the regulations when necessary to meet emergency, unexpected, or extraordinary situations.
6100.3	Definition of "Family" – If there is no reason to include "natural", please remove. Also, the definition overall is not clear. If the department wants a definition that is outside what is typical, then it needs to be clear and define who is considered family, especially when it comes to Life Sharing and who gets paid for providing services.
6100.3	Definition of "Natural Support" – Please consider changing this definition. The problem is with the word "reimbursed". Not all natural supports are voluntary/with no reimbursed support. For example, a babysitter is a natural support but is typically paid. Volunteers often work with a paid Volunteer Coordinator. Please change the definition to "...provided to the individual with no waiver, state plan, or base funding reimbursement."
GENERAL REQUIREMENTS	
6100.221	D – Supports Coordination in this instance is not a reimbursed service then since it would have to be provided prior to the PSP being developed and approved. F – what is the 'initial assessment" – please specify

6100.44	Innovative project - The introduction of Innovation projects is very positive, as it will allow for ideas that might not fit cleanly in the definitions. This is an excellent way to enable providers and families to pioneer new programming that could advance the development of best practice that better serve individuals with disabilities.
6100.45	Quality Management – The proposed definition of quality management is better than the existing one because the existing definition is too open ended. Also, providing examples of low-cost tracking tools or ones that are developed as a statewide initiative will be helpful. ODP has issued a QM Bulletin with requirements for the areas providers must address in their QM plans, and it was based on state priorities – please clarify whether that bulletin still be applicable.
6100.46	Protective Services – (b) – Please add the word "involved" after "the" and before the second reference to "staff".
6100.46	Protective Services - (b) – In the third line, please clarify whether the word "an" should instead be "the" or "any" when referring to "individual". As written, it is not clear which individual or individuals the provision is talking about. It is recommended that it say "any individual", which would make it clear. Also, if the abuse is confirmed, this regulation as written seems to usurp the providers' right and flexibility to determine staff disciplinary action. It is recommended that the sentence in (b) end after the word "concluded", and the rest of that sentence be changed to read "Once concluded, the provider would initiate internal disciplinary action as appropriate." Also, when it says "until...the investigating agency has confirmed that no abuse occurred", please clarify what happens if the investigation is inconclusive, which agency is meant, and what happens in the event that different "agencies" come to different conclusions (e.g., agency doing a certified investigation vs. protective services agency).
6100.46	Protective services - (c)(1-5) – Please clarify whether the reporting mechanism will still be thru HCSIS or if there be an additional method of reporting added.
6100.46	Protective services - (c)(3,4,5) – If a provider is completing a report on EIM, then this should suffice for notifications unless it is a report that needs to be submitted to APS or Office of Aging.
6100.47	Criminal history checks – (a)(1)and(b) – These two provisions overlap – the first seems to cover every single staff person imaginable. Please review what the department is trying to accomplish and rewrite to do it.
6100.47	Criminal history checks – (b)(1) – Please clarify whether there is an age requirement, since it is believed that criminal history checks may not be completed on children.
6100.47	Criminal history checks – (b)(3) – Please clarify who is responsible for getting the criminal history check if the consultant is billing ODP directly (the consultant, SC, etc.?).
6100.47	Criminal history checks – (d) – Please consider rewording as follows: "Individuals providing paid or unpaid supports with direct contact with the individual in services." If the department keeps the "natural supports" reference, please consider changing to "Individuals delivering

6100.49	Child Abuse History Certification. Rather than requiring each provider to interpret the Child Protective Services Law, please insert language in this section for what is required and not required. At a minimum, please clarify whether providers who do not provide services for individuals under age 18 need to now begin to require child abuse clearances.
6100.50	Communications - (b) – Please clarify who provides this assistive technology. Presumably if it is indicated in the PSP, it would be something provided and reimbursed, but the language as written does not reference the PSP. Please clarify whether each provider must provide it independently and/or regardless of the PSP, if the individual is responsible for the cost of the technology, etc. Also, please clarify which provider is responsible when there are multiple providers involved in supporting an individual.
6100.51	Grievances – There should be a definition in the regulations of a grievance.
6100.51	Grievances – (h) and (i) These are not realistic timeframes. Resolving a grievance in 21 days is not likely, depending on what is considered a grievance. Please consider revising.
6100.51	Grievances - (i) – Please clarify how a provision is to comply with this provision if a grievance is made anonymously.
ENROLLMENT	
6100.82	HCBS Provider Requirements – (b)(3) – There is a concern that providers are being asked to agree to this provision without knowing what such trainings are, what is involved, how much time and cost may be involved, etc.
6100.85	Ongoing HCBS Provider Qualifications – (b) – Please clarify how frequent the interval is.
6100.86	Delivery of HCBS - (d) – Please clarify what is meant by the statement "in accordance with the individual's PSP". There is confusion as to whether this is a reference to the Frequency & Duration statement and/or staffing ratios in residential. Compliance may be hard to achieve without greater specificity.
TRAINING	
6100.141	General comments. It is positive that there will be greater consistency to the training requirements. Also, it is positive that the training is intended to provide more protection for the individuals served.

	Also, it is positive the mandatory training requirement topics (e.g., the removal of the requirement to train on ODP's mission and vision) have been simplified and/or reduced and providers have been given greater control over the orientation and annual training plans. Thank you for reducing to 24 hours from 40 the required training for SCs and SC Supervisors
6100.143	Annual Training – Please clarify whether SCO training is same as other providers.
INDIVIDUAL RIGHTS	
6100.182	General comment – Generally and overall, the changes to these rights are positive - they were in need of being updated. However, there is concern that many of the rights articulated cannot be regulated because
6100.182	Rights of the Individual – (f)(g)(i) – Please consider allowing exceptions for individuals with special circumstances when it comes to individual health and safety and community safety.
6100.182	Rights of the Individual - (f) -While we strongly support the philosophy of this provision, please clarify how this provision is supposed to be implemented in light of the department's plan to eventually require all individuals in day program to spend at least 75% of their time outside of a licensed facility (e.g., if one person refuses, and there isn't staff to take the others, wouldn't the rights of the others be violated?). Please consider modifying the language so that, if the individual does agree to enroll in a group community participation service, then they are committing to participate in those activities. If the individual is not interested in a group activity, then he/she should reduce or discontinue services, so as not to affect programming for other individuals in that service.
6100.182	Rights of the Individual – (g) – While we strongly support the philosophy of this provision, there is strong concern about how, as a practical matter, this will play out in the real world. Again, please consider how a provider is supposed to meet the requests of three individuals who all want to participate in different activities in the community at the same time when the rate cannot support triple staffing. And please clarify whose rights in that case are to be honored when 3 individuals want to pursue 3 different schedules.
6100.183	Additional Rights of the individual in a residential facility - (a) – While the philosophy of being free to make choices is supported, there are practical concerns with the how this provision will be implemented. For example, there are many documented instances of individuals who have been

PERSON-CENTERED SUPPORT PLAN	
6100.221	Development of the PSP – General comment - The general language change and focus on person-centered planning are very positive. Also, streamlining the PSP by adding "auxiliary" plans such as "restrictive" plans and behavioral plans into the PSP is very positive for coordination of services/provisions.
6100.221	Development of the PSP – (b) – "Service implementation plan" is not defined or mentioned anywhere. Please add definition.
6100.221	Development of the PSP – (c) – Please define "Supports Coordinator" and "Targeted Supports Coordinator".
6100.221	Development of the PSP - (f) – Please clarify what assessment and who is responsible for this assessment. (This may be clear for residential settings who are required by 6400s to complete an assessment summary; however, it is not clear from those not in a residential
6100.222	The PSP Process - (b)(4) – The inclusion of the phrase "to the maximum extent possible" is very positive - this is a key phrase, useful to clarify the needs, and it would resolve many of the issues raised in other sections.
6100.222	The PSP Process - (b)(5) – Please clarify how providers will demonstrate compliance.
6100.222	The PSP Process - (b)(9) – Please clarify which guidelines.
6100.222	The PSP Process – (b)(11) – Please clarify how compliance will be demonstrated.
6100.223	Content of the PSP - General comment – Please clarify whether guidelines to the PSP following the waiver amendments will assure more consistency among AEs in approving/authorizing PSPs. Experience suggests that ISPs are very rigid and less person-centered now because of the compliance driven philosophies of the AEs.
6100.223	Content of the PSP - (8) - The wording "provide sufficient flexibility to provide choice by the individual" is very positive. It will be interesting to see how this plays out in the PSP itself, in terms of how the frequency & duration statement is written and in the monitoring of supports being provided.

6100.223	Content of the PSP - (8) – Experience suggests that the phrase "amount, duration and frequency" may be causing more problems for providers than any other single requirement. Some of the issues that have been raised: (1) The ISP should specify the number of units within the time frame, i.e. 125 units weekly. (2) The ISP should specify days and times of service, i.e. Monday, Tuesday Wednesday, Thursday, Friday from 9 am to 2 pm. (3) the ISP should specify Monday, Tuesday, Wednesday, Thursday, Friday, 5 hours per day. (4) The ISP should just list total units for the year i.e. 4600 units. And on and on and on. Every AE reviewing the ISP has their own idea as to which is more appropriate. Where this becomes a problem is the requirement that any variation from the schedule must be explained in the documentation. For some programs, attendance hours are often dictated by transportation or other factors that are beyond the provider's control. For example, Tom is scheduled to attend Monday through Friday, from 9:00 am to 2:30 pm according to the ISP. Tom arrives consistently around 9:30 am and leaves by 2:00 because those are the hours his transportation provider can transport. Neither Tom nor the provider has control over this, yet the provider has to document every day why he is short 1 hour in service, because there is a variance from the amount and duration. Another example: Tom is scheduled to attend the program service Monday through Friday, but his attendance is sporadic, sometimes due to medical appointments or family obligations, and sometimes he just doesn't show up and no information is provided. Once again, the provider has to document this because it is a variation in amount, duration and frequency. In fact, a simple attendance document is used to track this (i.e. absent or present) but it is not considered sufficient. So the provider ends up documenting not only when services are provided, but documenting when they aren't as well. There has to be some way of resolving this so that documentation isn't so overburdening. We have been in the situation when, as the result of our lead AE provider monitoring, we have had to change our documentation as to how to record amount, frequency and duration, only to have another AE recommend it be changed back in a subsequent monitoring. Depending on the AEs involved, it may or may not have to be changed back. It is similar in licensing - one year something is changed as the result of non-compliance, but next year it is changed back as the result of yet another non-compliance.
6100.223	Content of the PSP – Please clarify what (11) means relative to (10) or other items. Please clarify whether the phrase "before other activities or supports are considered" refers to those related to employment or vocational training only, or all other activities or supports.
6100.223	Content of the PSP – Please clarify that, if an individual has a health and safety issue with access to food, this is where it can be described and an exception to the rights section is allowed.

6100.223	Content of the PSP – (17) – Please delete. It is not clear why this is included in the regulations, unless this is where the PSP team is permitted to determine that certain things otherwise required by the regulations are not appropriate or necessary for a particular individual based on their needs.
6100.223	Content of the PSP - (19) – This language is a better clarification of who needs a "back-up" plan than what is currently in the Chapter 51 regulations, but it is still too open-ended. For example, an argument could be made that all of our clients are "at risk" in the absence of their designated support person – so are we returning to back-up plans for all?
6100.223	Content of the PSP - (21) – Please clarify how signatures are included in the PSP.
6100.224	Implementation of the PSP – Please clarify who the "identified" provider is in the PSP (e.g., the agency, a staff by title, a staff by name, etc.). Staff by name is very difficult because often there is more than one staff providing the support or turnover of staff is so frequent that maintaining accurate information in the PSP is impossible, requiring too many revisions.
6100.225	Support coordination and TSM - (a) - This is the first indication that a PSP will have an annual review. Earlier language just speaks to "initial and updated PSP". Please be sure this is clearly indicated in the regulations.
6100.225	Support coordination and TSM - (6) (7) (and throughout that section). It is greatly appreciated that the timeframes were removed. This also involved removing them from the licensing tools, which would have been a challenge for providers. Great change.
	.
6100.226	Documentation of support delivery - (b) – Please delete references to the "service implementation plan" as another plan does not need to be created. However, if the term is left in, please clarify whether there will be guidance or requirements related to the "service implementation plan" (which is also referenced in 6100.221[b]) or if the format and content of this plan will be left solely
6100.226	Documentation of support delivery – (c) – Please clarify what it means to document "each time a support is delivered". Please clarify whether it relates to the amount, frequency and duration, or if it relates to units, etc. For example, if a service is authorized in 15-minute units, the

6100.226	Documentation of support delivery – (e) (5) - Requiring documentation that reflects amount, frequency and duration for a residential service doesn't make sense. Please clarify.
6100.226	Documentation of support delivery - (f) - This seems to be the same as the 3-month PSP review required by the licensing regulations (see 6400.186[a-b-c]), except the 3-month review in the 6100s is to be done "in cooperation with the support coordinator." Please clarify what exactly that means and if the quarterly PSP review in the licensing regulations will satisfy the requirements of this 6100 regulation. Also, please clarify if this be considered a quarterly "progress note". Also, in the 6400s, etc., in sections like this, the language seems to flip back and forth between ISP and PSP. Please make consistent.
TRANSITION	
6100.301	Individual Choice – (a) – Add "or supports coordinator" in addition to provider.
6100.302	Transition to New Provider – (b (1) Transportation should be part of mutual agreement between the current and new provider. Each provider should take some responsibility for this. It could be added to the transition plan, including specific dates.
6100.302	Transition to a New Provider - (b) (2) - We agree with the requirement that transportation be arranged if included in the service for a person to visit potential new providers. To implement the Everyday Lives'
6100.303	Reasons for a Transfer or a Change in Provider – (a) - Discharges and transfers have occurred due to irreconcilable differences with family members. This section should either be changed to allow transfers when there are conflicts with family that are detrimental to the individual and/or other program participants and reasonable efforts to resolve the conflict have been exhausted,
6100.303	Reasons for a Transfer or a Change in Provider – (a) (2) – Add clarity who determines if the individual's needs are not being meet.

6100.303	Reasons for a Transfer or a Change in Provider - (a) – There needs to be a clause that allows the provider as an autonomous entity to refuse service without having to prove it meets one of the grounds listed. There are numerous possibilities as to when an individual may choose something that the provider is unwilling to provide for any number of reasons beyond "requiring a significant alteration of the provider's program or building" as listed in (3). Liability is a major one, but not the only one.
6100.303	Reasons for a Transfer or a Change in Provider – (b) – Add clarity as to what is considered a "support provider".
6100.303	Reasons for a Transfer or a Change in Provider – (b) – Do not agree with this statement as written. This would mean the provider cannot change a direct support professional or behavioral support professional or transfer to another home without individual's permission? Instead, it should say that the provider will make every effort to accommodate the wishes of an individual; however, changes in location of services or those performing the service may occur and the provider shall make every effort to assist the individual in the transition.
6100.303	Reasons for a Transfer or a Change in Provider – Another reason should be added, which is that the provider is closing the home and there is no available place to transfer within the agency.
6100.303	Reasons for a Transfer or a Change in Provider – (b) – Consider moving the word "retaliation" from the third line to the second line, replacing "response".
6100.304	Written Notice – Overall, this requirement is excessive. It makes much more sense to require a PSP review team meeting to discuss the issues of the individual's service needs and the appropriate changes. All of the items identified as requirements in the written notice would be
6100.304	Written Notice (a) – Please add clarity as to who on the PSP team is responsible for writing the letter when the individual initiates or chooses the transition. It should be clear that the current provider is not responsible even though it is a member of the PSP team. Consider
6100.304	Written notice – (a) – It is positive that the individual has to give a 30-day notification.
6100.304	Written notice – (a) and (b) – There should no difference between how many days an individual must give and how many a provider must give. Change to make it consistent – 30 days for an individual and 30 days for a provider.
6100.304	Written notice – (b) – Add language that says the x-number of day notification does not apply to emergency situations and/or where an individual's immediate health and safety may be at risk and/or
6100.305	Continuation of support – While we agree that the current provider continuing support during the transition period is essential for assuring the person's needs are being met without lapses in service and a smooth transition, please include a reasonable limit as to how long a provider is forced to continue services after they have given notice. There would have to be a very good

	Also, based on the phrasing, there is no requirement on the part of the Department or designated managing entity to make a decision quickly. Please add language requiring the department to make a decision in a timely manner.
6100.307	Transfer of Records – (a) - Recommend adding "Upon receipt of signed releases", before "The provider shall transfer a copy of the individual record..."
6100.307	Transfer of Records – As written, this section implies that a copy of the entire record has to be provided to the new provider. An individual's record can include items not generated by the agency (e.g., a copy of a psychiatric evaluation if one was conducted). In such a case, the provider does not have the legal right to give a copy of the document since it does not "own it." There are also additional concerns under HIPAA that affect how information can be released that would impact this requirement. Finally, since the ISP and the ISP reviews (as the primary documentation) are maintained by the SC, and given that the SC should be providing this to any provider chosen by the individual, there should be no need for every provider to transfer copies of their files to new providers.
6100.307	Transfer of Records – Add clarity as to what parts of the record and how far back they should go. This could be an exceptional amount of information and providers do not have the right to give any information to another provider unless the individual signs a release.
POSITIVE INTERVENTION	
General comment	Overall, this section should be reviewed and rewritten by a person with a clinical background. As written, it is lacking best practice. Please define as much of the terminology as possible.
6100.341	Use o Consi

6100.342	PSP – Please be sure the department provides instruction or a format as to how this information is to be entered to the PSP? It is not clear whether this replaces the SEEP or crisis or behavior plan.
6100.342	PSP - Character limits will need to be expanded in the PSP in order to accommodate the level of detail required in items 1-5. At present, ISP field length for the BSP is 8000 characters. The limitation requires the SC to edit down to the character limits or split the
6100.342	PSP – (2) "Functional analysis" is a clinical term. It is unclear whether the language as written requires a formal functional analysis by someone certified or specially trained. It might not be reasonable in all circumstances; for example, the person who endangers him/herself by eating non-edibles because of Pica. Please either define functional analysis and suggest instead
6100.342	PSP – This section is missing baseline of behavior - missing what has been attempted and results.
6100.342	PSP – (7) – It is not clear what this means (e.g., in regard to the behavior?). This is confusing.
6100.343	Prohibition of Restraints - It is commendable that PA is taking an assertive position regarding the use of restraints. We support the inclusion of the Positive Intervention section, but especially value
6100.343	Prohibition of Restraints – (1) - This section defines seclusion as when the individual is verbally directed from leaving an area. It is possible that, to keep an individual safe from someone else,
6100.343	Prohibition of Restraints – (3) - The language should be clarified so that a compliance issue is not founded because of interpretation. For example, bites are typically released by pressing on the jaw – there are not a lot of ways to release a bite – either hold nose or press jaw at joint. This may be considered "application of pain" by a compliance person.
6100.343	Prohibition of restraints – (5) (i) – "support of the achievement of functional body position" is a good addition – while this should cover things like seat belts in wheelchairs that are designed to keep the person from falling out of the chair because of balance issues, etc., please add a reference to seatbelts as allowable for use in wheelchairs for safety to avoid future interpretation issues.
6100.343	Prohibition of Restraints - (5)(i and ii) – Please consider and clarify how the prohibition against a mechanical restraint interacts with restrictive procedures? (In other words, will mechanical restraints (such as bed rails), which are currently allowed to be used as long as there is a restrictive procedure plan, still be allowed?)
6100.343	Prohibition of Restraints – (5)(ii) – As written, devices such as a helmet for drop seizures, or seatbelts for balance, would only be allowed if the individual "can easily remove the device". In reality, many individuals do not have the physical skills to remove such things as a helmet.
6100.343	Prohibition of Restraints – (6) - Wording is not correct – a manual restraint defined as a . . . or "for more than 15 minutes with a 2 hour period". Should read "for more than 30 seconds." Then add – "A manual restraint cannot be used 'for more than 15 minutes in any 2-hour period'"

6100.344	Permitted interventions – (a) – Please add clarity whether staff giving verbal prompts would make it involuntary.
6100.344	Permitted Interventions – Out of this entire section, it seems only voluntary exclusion and physical protective restraint are the only permitted interventions. There are many others. This section is not written well. Please consider adding clarity.
6100.344	Permitted Interventions – (g) – While this mentions that physical protective restraint can only be used by a staff who has completed the annual training requirements and the content of the PSP, language elsewhere is lacking that states what the staff must be trained in, what
6100.344	Permitted Interventions - (b) through (g) refers to a "physical protective restraint" - this is defined in (h) but it also seems to be the same as a "manual restraint" as defined in 6100.343(6). It would be better and less confusing if the same term throughout was used.
6100.344	Permitted interventions – (c) and (g) seem to be redundant.
6100.345	Access to or the Use of an Individual's Personal Property - (b) - Personal funds or property should be used if it is ordered as part of a legal proceeding; e.g., an individual causes damages to a hotel room - the hotel presses charges and the individual is ordered to make restitution. In this instance, it should be the individual who bears the cost as a natural consequence of the behavior.
6100.345	Access to or the Use of an Individual's Personal Property - (b) - Unless this is applied specifically to provider-owned or operated property, this will be a challenging section to enforce and could
6100.345	Access to or the Use of an Individual's Personal Property - At times access to personal items may need to be limited as using then may involve self-harm or harm to others. While the language says that access may not be used as a "reward" or "punishment", the worry is that this will be interpreted to violate rights. Please add clarity to avoid misinterpretation.
INCIDENT MANAGEMENT	
6100.401-405	General comment: Incident Management detail should be in policy and procedure rather than regulation so that necessary adjustments can be made in a reasonable manner and with reasonable timeliness. Does the information in this section currently reconcile with both ODP and BAS IM policy & procedures?
6100.401	Type

6100.401	Types of Incidents and Timelines for Reporting – (a)(16) – Please clarify. Medical errors are currently reported and finalized within 72 hours. Including this incident type in this list will mandate the report within 24 hours and because of the way the EIM system works the finalization would be done at the same time (or, would it still be 72 hours for finalization, or would it be the same 30 days as required for all other incident types – 6100.404(a)?).
6100.401	Types of incidents and timelines for reporting – (a)(16) – If an over-the-counter medication is not prescribed by a physician, then it is not clear how it can be an error. If it is prescribed, then is it
6100.401	Types of incidents and timelines for reporting – (a)(16) Adds medication administration errors to be reported in the 24 hour time frame. But this entire list is mentioned in the next section 6100.402 to be investigated. Please clarify whether the intent is to now investigate every medication error. We hope it is not.
6100.401	Types of incidents and timelines for reporting – (a)(17) This is a new addition to reportable incidents in EIM (there is not currently a category in EIM where "critical health and safety event that requires immediate intervention such as a significant behavioral event or trauma" are reported). This could be interpreted many ways - and it would also be included in the list
6100.401	Types of Incidents and Timelines for Reporting - (b) – "Immediately" is not possible. Please include a
6100.401	Types of Incidents and Timelines for Reporting - (d) - requires incident reports to be shared if requested. Please either delete or rewrite considering the amount of confidential information that is contained in some reports (especially when staff are involved). Also, notification to the individual and family when an incident is discovered and notification of the conclusion of an investigation is the current practice. Experience suggests that very few if any requests for incident reports are made by families but this requirement may "open the floodgates". Also, the family is often the target of many of the reports SCOs complete, and giving them a copy of the report will be a problem. Also, provider reports of allegations that are not found to be confirmed would be a concern. Those completing the reports may hesitate to include confidential information in these reports. To require families to get a copy of all reports would be an unreasonable risk due to the fact that all allegations are reported regardless of whether there are facts to support them. The standard for what is reportable will need to be modified. Also, the system will need be set up so that it is possible to print a report with redacted information.
6100.402	Incident Investigation – (b) and (c) - the two together imply that every incident must be investigated by a certified investigation since it specifically states incidents listed in 401(a) without exclusion. At this time, only certain incidents require investigation by a CI; to have

	incident investigated by a CI will be unreasonably burdensome on the provider. It is not reasonable to require that every injury, fire alarm requiring the fire department (which currently includes false alarms); emergency closure (even when due to weather), every medication error, etc. to be investigated by a Certified Investigator, with (presumably) an investigation report. Certainly they should be reviewed as part of quality management, but not investigated.
6100.403	Individual Needs – (a) – Please clarify. The phrase "investigating an incident" is used, which could mean these requirements are being added to a certified investigation. Even if they are not, this section could be really overwhelming if site-level incidents are included such as fire or law
6100.403	Individual Needs - (b) – This seems unnecessary since corrective action plans already have to be implemented, and 6100.405 requires analysis of incidents both individually and in aggregate. Also, please clarify who decides whether either action is appropriate. If it is left to the provider to decide, then it is not necessary to add this as a regulation to eventually be monitored. Also, please clarify whether this duplicates or supersedes the regulation already found in PA Code 6000.901 Subchapter Q.
6100.403	Individual Needs - (c) – Please delete. This entire statement seems unnecessary. This already occurs as part of the corrective action and PSP process. Therefore, adding it here adds more documentation requirements and a burden for the provider to show that they "cooperated."

6100.404	Final incident report – Please add a bullet allowing for an extension due to external concurrent investigation or inability to get witness statements, etc.
6100.405	Incident Analysis - Many of the activities listed here for incident analysis should really be the function of the individual's PSP team who is most familiar with the individual and what might help reduce incidents.
6100.405	Incident analysis – (a) – Please replace "incident" with "investigation". The term "confirmed incident" is not a term that is commonly used or defined. And, if "confirmed" is simply struck
6100.405	Incident analysis - (a)(1) – Concern that "analysis to determine the root cause" may be confused with "root cause analysis", which is a technical term and has specific meaning. It would not be a good use of provider resources and time to perform a root cause analysis for each confirmed incident, nor would it be possible to do so. In fact, ODP gives specific guidance explaining this in
	Cause Analysis as a Preventive Strategy. A link to the transcript is here: http://documents.odpconsulting.net/alfresco/d/d/workspace/SpacesStore/018521be-cd4a-
6100.405	4d90-b75e-48f61b017558/Core Function 3 Preventive Strategies Transcript.pdf
6100.405	
6100.405	Incident Analysis – (a)(2) - Sometimes a corrective action is not appropriate, but required
	Incident Analysis – (b) – It is hoped that ODP will provide more tools such as training or EIM feature
6100.405	Incident Analysis - (b) and (e) – one says "shall review and analyze incidents every three months" and the other says "continuously". Please clarify which it is. Also, the word "continuously" is problematic. It is not clear how providers will demonstrate compliance. Also, continuous incident analysis and constant efforts to mitigate risks seem contradictory to ensuring greater integration and community participation and an Everyday Life. Also, this mandate is duplicative and unnecessary and should be deleted. ODP's IM/RM/QM system is exceptional. More effort could be better placed on creating a more integrated system rather than over-analyzing incidents or micro-managing a process that is already working. When providers are given the tools and opportunities, they will use them to improve analysis and quality, where needed. Adding these types of mandates wastes time on unnecessary application, documentation, and oversight.
FEE SCHEDULE	

6100.571	Fee Schedule Rates - (a) - The language should be written to obligate the department to actually use rates that reflect whatever changes result from the refresh discussed in (b) (i.e., as written, the department seems to be able to refresh the data but then keep rates the same).
6100.571	Fee S requi every
6100.571	Fee Schedule Rates - (c) - Language should be added that requires the department to be transparent about the method it used to "consider" the factors indicated. Also, language should be added that requires the department to be transparent about the sources of data and information used.
6100.571	Fee Schedule Rates – (c)(2) - Language should be added that requires the department to consider US Department of Labor and PA Department of Labor and Industry statistics for relevant
	industries, such as the health care industry, as well as labor statistics for non-health care or human service industries with which ODP-funded HCBS providers are in direct competition for workers (e.g., fast food, retail, etc.).

DEPARTMENT-ESTABLISHED FEE FOR INELIGIBLE PORTION	
6100.711	Fee Schedule Rates - (a) - The language should be written to obligate the department to actually use rates that reflect whatever changes result from the refresh discussed in (b) (i.e., as written, the department seems to be able to refresh the data but then keep rates the same).
6100.711	Fee Schedule Rates (b) – RCPA is pleased that the department has proposed language that requires it to refresh the market-based data used to develop rates. However, instead of every three years, it should be done every year. Also, the word "refresh" should be changed to "rebase" or "rebased".
6100.711	Fee Schedule Rates - (c) - Language should be added that requires the department to be transparent about the method it used to "consider" the factors indicated. Also, language should be added that requires the department to be transparent about the sources of data and information used. Also, if the department does not include language requiring an annual refresh (or rebasing) of market data, then the language ought to say the department will apply a cost-of-living-adjustment based on the federal home health market basket index.
6100.711	Fee Schedule Rates – (c)(2) - Language should be added that requires the department to consider US Department of Labor and PA Department of Labor and Industry statistics for relevant industries, such as the health care industry, as well as labor statistics for non-health care or human service industries with which ODP-funded HCBS providers are in direct competition for workers (e.g., fast food, retail, etc.).
SPECIAL PROGRAMS	
6100.803	SC, TSM, and Base-Fund Support Coordination - (e)(1) - note training requirements for the 1st year (i,ii,iii,iv,v) for a Supports Coordinator - these trainings are in addition to the provider required orientation training in section 143 as well as all mandated SC trainings that had been or will be offered by ODP in that year. This would surely demand a Supports Coordinator in their first year have more than 24 hours of training. Please be sure this is considered in rate setting for the expense of additional non-billing time for new staff.
6100.803	SC, TSM, and Base-Fund Support Coordination – (2) – Please clarify whether the standard for incident reporting changed has changed. Incidents reported to SCs will only be reportable if directly observed or if SC is directly involved in an incident. Please clarify if that means that only incidents reaching the standard of protective services would be reported upon discovery from another source. If so, that interpretation is supported.

6100.803 (3) and (4)	SC, TSM, and Base-Fund Support Coordination – (3) and (4) - While Supports Coordination will no longer have to do the 6-month review for residential, it looks like they are being required to document the continued need every 6 months. Please clarify where and how. Please clarify whether a service note is acceptable or doing something more in the plan is required. Section (4) goes through enhanced staffing – please clarify if ODP is doing away with the checklist altogether and if this will be the criteria followed. It is similar to what is being done now – please clarify the method to be used to answer these questions.

Lenape Valley Foundation Supports Coordination Organization

Section	Comment / Recommendation
General comment	What was proposed by ODP November 5, 2016 are an improvement and a step in the right direction. There is a consistent focus on person-centered outcomes based on personal preferences.
General comment	Overall, these regulations will increase paperwork, documentation and analysis. While this information may be valuable, there is significant concerns that the rates DHS is paying do not provide the level of funding to support the increased documentation and analysis.
General Comment	Please use PSP throughout the regulations as ISP is used in some parts and PSP is used in other places.
General Comment	Please change "Support Coordinator/Support Coordination" to Supports Coordinator/Supports Coordination.
GENERAL PROVISIONS	
6100.1 6100.2	Purpose - (a) and Applicability (c) – There is a concern that base-funded programs are subject to these same regulations without the ability for exceptions, given that base funds are the safety net for circumstances that require some flexibility. For example, in section 6100.221, it is required that an individual have a PSP in order to receive services. If there is an emergency that comes up with an individual previously unknown to the Administrative Entity/SCO and as a result the person does not have a PSP, how could a provider offer emergency respite services? Please give counties/AEs the authority temporarily waive sections of the regulations when necessary to meet emergency, unexpected, or extraordinary situations.
6100.3	Definition of "Family" – If there is no reason to include "natural", please remove. Also, the definition overall is not clear. If the department wants a definition that is outside what is typical, then it needs to be clear and define who is considered family, especially when it comes to Life Sharing and who gets paid for providing services.
6100.3	Definition of "Natural Support" – Please consider changing this definition. The problem is with the word "reimbursed". Not all natural supports are voluntary/with no reimbursed support. For example, a babysitter is a natural support but is typically paid. Volunteers often work with a paid Volunteer Coordinator. Please change the definition to "...provided to the individual with no waiver, state plan, or base funding reimbursement."
GENERAL REQUIREMENTS	
6100.221	D – Supports Coordination in this instance is not a reimbursed service then since it would have to be provided prior to the PSP being developed and approved. F – what is the 'initial assessment" – please specify

6100.44	Innovative project - The introduction of Innovation projects is very positive, as it will allow for ideas that might not fit cleanly in the definitions. This is an excellent way to enable providers and families to pioneer new programming that could advance the development of best practice that better serve individuals with disabilities.
6100.45	Quality Management – The proposed definition of quality management is better than the existing one because the existing definition is too open ended. Also, providing examples of low-cost tracking tools or ones that are developed as a statewide initiative will be helpful. ODP has issued a QM Bulletin with requirements for the areas providers must address in their QM plans, and it was based on state priorities – please clarify whether that bulletin still be applicable.
6100.46	Protective Services – (b) – Please add the word "involved" after "the" and before the second reference to "staff".
6100.46	Protective Services - (b) – In the third line, please clarify whether the word "an" should instead be "the" or "any" when referring to "individual". As written, it is not clear which individual or individuals the provision is talking about. It is recommended that it say "any individual", which would make it clear. Also, if the abuse is confirmed, this regulation as written seems to usurp the providers' right and flexibility to determine staff disciplinary action. It is recommended that the sentence in (b) end after the word "concluded", and the rest of that sentence be changed to read "Once concluded, the provider would initiate internal disciplinary action as appropriate." Also, when it says "until...the investigating agency has confirmed that no abuse occurred", please clarify what happens if the investigation is inconclusive, which agency is meant, and what happens in the event that different "agencies" come to different conclusions (e.g., agency doing a certified investigation vs. protective services agency).
6100.46	Protective services - (c)(1-5) – Please clarify whether the reporting mechanism will still be thru HCSIS or if there be an additional method of reporting added.
6100.46	Protective services - (c)(3,4,5) – If a provider is completing a report on EIM, then this should suffice for notifications unless it is a report that needs to be submitted to APS or Office of Aging.
6100.47	Criminal history checks – (a)(1)and(b) – These two provisions overlap – the first seems to cover every single staff person imaginable. Please review what the department is trying to accomplish and rewrite to do it.
6100.47	Criminal history checks – (b)(1) – Please clarify whether there is an age requirement, since it is believed that criminal history checks may not be completed on children.
6100.47	Criminal history checks – (b)(3) – Please clarify who is responsible for getting the criminal history check if the consultant is billing ODP directly (the consultant, SC, etc.?).
6100.47	Criminal history checks – (d) – Please consider rewording as follows: "Individuals providing paid or unpaid supports with direct contact with the individual in services." If the department keeps the "natural supports" reference, please consider changing to "Individuals delivering

6100.49	Child Abuse History Certification. Rather than requiring each provider to interpret the Child Protective Services Law, please insert language in this section for what is required and not required. At a minimum, please clarify whether providers who do not provide services for individuals under age 18 need to now begin to require child abuse clearances.
6100.50	Communications - (b) – Please clarify who provides this assistive technology. Presumably if it is indicated in the PSP, it would be something provided and reimbursed, but the language as written does not reference the PSP. Please clarify whether each provider must provide it independently and/or regardless of the PSP, if the individual is responsible for the cost of the technology, etc. Also, please clarify which provider is responsible when there are multiple providers involved in supporting an individual.
6100.51	Grievances – There should be a definition in the regulations of a grievance.
6100.51	Grievances – (h) and (i) These are not realistic timeframes. Resolving a grievance in 21 days is not likely, depending on what is considered a grievance. Please consider revising.
6100.51	Grievances - (i) – Please clarify how a provision is to comply with this provision if a grievance is made anonymously.
ENROLLMENT	
6100.82	HCBS Provider Requirements – (b)(3) – There is a concern that providers are being asked to agree to this provision without knowing what such trainings are, what is involved, how much time and cost may be involved, etc.
6100.85	Ongoing HCBS Provider Qualifications – (b) – Please clarify how frequent the interval is.
6100.86	Delivery of HCBS - (d) – Please clarify what is meant by the statement "in accordance with the individual's PSP". There is confusion as to whether this is a reference to the Frequency & Duration statement and/or staffing ratios in residential. Compliance may be hard to achieve without greater specificity.
TRAINING	
6100.141	General comments. It is positive that there will be greater consistency to the training requirements. Also, it is positive that the training is intended to provide more protection for the individuals served.

	Also, it is positive the mandatory training requirement topics (e.g., the removal of the requirement to train on ODP's mission and vision) have been simplified and/or reduced and providers have been given greater control over the orientation and annual training plans. Thank you for reducing to 24 hours from 40 the required training for SCs and SC Supervisors
6100.143	Annual Training – Please clarify whether SCO training is same as other providers.
INDIVIDUAL RIGHTS	
6100.182	General comment – Generally and overall, the changes to these rights are positive - they were in need of being updated. However, there is concern that many of the rights articulated cannot be regulated because
6100.182	Rights of the Individual – (f)(g)(i) – Please consider allowing exceptions for individuals with special circumstances when it comes to individual health and safety and community safety.
6100.182	Rights of the Individual - (f) -While we strongly support the philosophy of this provision, please clarify how this provision is supposed to be implemented in light of the department's plan to eventually require all individuals in day program to spend at least 75% of their time outside of a licensed facility (e.g., if one person refuses, and there isn't staff to take the others, wouldn't the rights of the others be violated?). Please consider modifying the language so that, if the individual does agree to enroll in a group community participation service, then they are committing to participate in those activities. If the individual is not interested in a group activity, then he/she should reduce or discontinue services, so as not to affect programming for other individuals in that service.
6100.182	Rights of the Individual – (g) – While we strongly support the philosophy of this provision, there is strong concern about how, as a practical matter, this will play out in the real world. Again, please consider how a provider is supposed to meet the requests of three individuals who all want to participate in different activities in the community at the same time when the rate cannot support triple staffing. And please clarify whose rights in that case are to be honored when 3 individuals want to pursue 3 different schedules.
6100.183	Additional Rights of the individual in a residential facility - (a) – While the philosophy of being free to make choices is supported, there are practical concerns with the how this provision will be implemented. For example, there are many documented instances of individuals who have been

PERSON-CENTERED SUPPORT PLAN	
6100.221	Development of the PSP – General comment - The general language change and focus on person-centered planning are very positive. Also, streamlining the PSP by adding "auxiliary" plans such as "restrictive" plans and behavioral plans into the PSP is very positive for coordination of services/provisions.
6100.221	Development of the PSP – (b) – "Service implementation plan" is not defined or mentioned anywhere. Please add definition.
6100.221	Development of the PSP – (c) – Please define "Supports Coordinator" and "Targeted Supports Coordinator".
6100.221	Development of the PSP - (f) – Please clarify what assessment and who is responsible for this assessment. (This may be clear for residential settings who are required by 6400s to complete an assessment summary; however, it is not clear from those not in a residential
6100.222	The PSP Process - (b)(4) – The inclusion of the phrase "to the maximum extent possible" is very positive - this is a key phrase, useful to clarify the needs, and it would resolve many of the issues raised in other sections.
6100.222	The PSP Process - (b)(5) – Please clarify how providers will demonstrate compliance.
6100.222	The PSP Process - (b)(9) – Please clarify which guidelines.
6100.222	The PSP Process – (b)(11) – Please clarify how compliance will be demonstrated.
6100.223	Content of the PSP - General comment – Please clarify whether guidelines to the PSP following the waiver amendments will assure more consistency among AEs in approving/authorizing PSPs. Experience suggests that ISPs are very rigid and less person-centered now because of the compliance driven philosophies of the AEs.
6100.223	Content of the PSP - (8) - The wording "provide sufficient flexibility to provide choice by the individual" is very positive. It will be interesting to see how this plays out in the PSP itself, in terms of how the frequency & duration statement is written and in the monitoring of supports being provided.

6100.223	Content of the PSP - (8) – Experience suggests that the phrase "amount, duration and frequency" may be causing more problems for providers than any other single requirement. Some of the issues that have been raised: (1) The ISP should specify the number of units within the time frame, i.e. 125 units weekly. (2) The ISP should specify days and times of service, i.e. Monday, Tuesday Wednesday, Thursday, Friday from 9 am to 2 pm. (3) the ISP should specify Monday, Tuesday, Wednesday, Thursday, Friday, 5 hours per day. (4) The ISP should just list total units for the year i.e. 4600 units. And on and on and on. Every AE reviewing the ISP has their own idea as to which is more appropriate. Where this becomes a problem is the requirement that any variation from the schedule must be explained in the documentation. For some programs, attendance hours are often dictated by transportation or other factors that are beyond the provider's control. For example, Tom is scheduled to attend Monday through Friday, from 9:00 am to 2:30 pm according to the ISP. Tom arrives consistently around 9:30 am and leaves by 2:00 because those are the hours his transportation provider can transport. Neither Tom nor the provider has control over this, yet the provider has to document every day why he is short 1 hour in service, because there is a variance from the amount and duration. Another example: Tom is scheduled to attend the program service Monday through Friday, but his attendance is sporadic, sometimes due to medical appointments or family obligations, and sometimes he just doesn't show up and no information is provided. Once again, the provider has to document this because it is a variation in amount, duration and frequency. In fact, a simple attendance document is used to track this (i.e. absent or present) but it is not considered sufficient. So the provider ends up documenting not only when services are provided, but documenting when they aren't as well. There has to be some way of resolving this so that documentation isn't so overburdening. We have been in the situation when, as the result of our lead AE provider monitoring, we have had to change our documentation as to how to record amount, frequency and duration, only to have another AE recommend it be changed back in a subsequent monitoring. Depending on the AEs involved, it may or may not have to be changed back. It is similar in licensing - one year something is changed as the result of non-compliance, but next year it is changed back as the result of yet another non-compliance.
6100.223	Content of the PSP – Please clarify what (11) means relative to (10) or other items. Please clarify whether the phrase "before other activities or supports are considered" refers to those related to employment or vocational training only, or all other activities or supports.
6100.223	Content of the PSP – Please clarify that, if an individual has a health and safety issue with access to food, this is where it can be described and an exception to the rights section is allowed.

6100.223	Content of the PSP – (17) – Please delete. It is not clear why this is included in the regulations, unless this is where the PSP team is permitted to determine that certain things otherwise required by the regulations are not appropriate or necessary for a particular individual based on their needs.
6100.223	Content of the PSP - (19) – This language is a better clarification of who needs a "back-up" plan than what is currently in the Chapter 51 regulations, but it is still too open-ended. For example, an argument could be made that all of our clients are "at risk" in the absence of their designated support person – so are we returning to back-up plans for all?
6100.223	Content of the PSP - (21) – Please clarify how signatures are included in the PSP.
6100.224	Implementation of the PSP – Please clarify who the "identified" provider is in the PSP (e.g., the agency, a staff by title, a staff by name, etc.). Staff by name is very difficult because often there is more than one staff providing the support or turnover of staff is so frequent that maintaining accurate information in the PSP is impossible, requiring too many revisions.
6100.225	Support coordination and TSM - (a) - This is the first indication that a PSP will have an annual review. Earlier language just speaks to "initial and updated PSP". Please be sure this is clearly indicated in the regulations.
6100.225	Support coordination and TSM - (6) (7) (and throughout that section). It is greatly appreciated that the timeframes were removed. This also involved removing them from the licensing tools, which would have been a challenge for providers. Great change.
	.
6100.226	Documentation of support delivery - (b) – Please delete references to the "service implementation plan" as another plan does not need to be created. However, if the term is left in, please clarify whether there will be guidance or requirements related to the "service implementation plan" (which is also referenced in 6100.221[b]) or if the format and content of this plan will be left solely
6100.226	Documentation of support delivery – (c) – Please clarify what it means to document "each time a support is delivered". Please clarify whether it relates to the amount, frequency and duration, or if it relates to units, etc. For example, if a service is authorized in 15-minute units, the

6100.226	Documentation of support delivery – (e) (5) - Requiring documentation that reflects amount, frequency and duration for a residential service doesn't make sense. Please clarify.
6100.226	Documentation of support delivery - (f) - This seems to be the same as the 3-month PSP review required by the licensing regulations (see 6400.186[a-b-c]), except the 3-month review in the 6100s is to be done "in cooperation with the support coordinator." Please clarify what exactly that means and if the quarterly PSP review in the licensing regulations will satisfy the requirements of this 6100 regulation. Also, please clarify if this be considered a quarterly "progress note". Also, in the 6400s, etc., in sections like this, the language seems to flip back and forth between ISP and PSP. Please make consistent.
TRANSITION	
6100.301	Individual Choice – (a) – Add "or supports coordinator" in addition to provider.
6100.302	Transition to New Provider – (b (1) Transportation should be part of mutual agreement between the current and new provider. Each provider should take some responsibility for this. It could be added to the transition plan, including specific dates.
6100.302	Transition to a New Provider - (b) (2) - We agree with the requirement that transportation be arranged if included in the service for a person to visit potential new providers. To implement the Everyday Lives'
6100.303	Reasons for a Transfer or a Change in Provider – (a) - Discharges and transfers have occurred due to irreconcilable differences with family members. This section should either be changed to allow transfers when there are conflicts with family that are detrimental to the individual and/or other program participants and reasonable efforts to resolve the conflict have been exhausted,
6100.303	Reasons for a Transfer or a Change in Provider – (a) (2) – Add clarity who determines if the individual's needs are not being meet.

6100.303	Reasons for a Transfer or a Change in Provider - (a) – There needs to be a clause that allows the provider as an autonomous entity to refuse service without having to prove it meets one of the grounds listed. There are numerous possibilities as to when an individual may choose something that the provider is unwilling to provide for any number of reasons beyond "requiring a significant alteration of the provider's program or building" as listed in (3). Liability is a major one, but not the only one.
6100.303	Reasons for a Transfer or a Change in Provider – (b) – Add clarity as to what is considered a "support provider".
6100.303	Reasons for a Transfer or a Change in Provider – (b) – Do not agree with this statement as written. This would mean the provider cannot change a direct support professional or behavioral support professional or transfer to another home without individual's permission? Instead, it should say that the provider will make every effort to accommodate the wishes of an individual; however, changes in location of services or those performing the service may occur and the provider shall make every effort to assist the individual in the transition.
6100.303	Reasons for a Transfer or a Change in Provider – Another reason should be added, which is that the provider is closing the home and there is no available place to transfer within the agency.
6100.303	Reasons for a Transfer or a Change in Provider – (b) – Consider moving the word "retaliation" from the third line to the second line, replacing "response".
6100.304	Written Notice – Overall, this requirement is excessive. It makes much more sense to require a PSP review team meeting to discuss the issues of the individual's service needs and the appropriate changes. All of the items identified as requirements in the written notice would be
6100.304	Written Notice (a) – Please add clarity as to who on the PSP team is responsible for writing the letter when the individual initiates or chooses the transition. It should be clear that the current provider is not responsible even though it is a member of the PSP team. Consider
6100.304	Written notice – (a) – It is positive that the individual has to give a 30-day notification.
6100.304	Written notice – (a) and (b) – There should no difference between how many days an individual must give and how many a provider must give. Change to make it consistent – 30 days for an individual and 30 days for a provider.
6100.304	Written notice – (b) – Add language that says the x-number of day notification does not apply to emergency situations and/or where an individual's immediate health and safety may be at risk and/or
6100.305	Continuation of support – While we agree that the current provider continuing support during the transition period is essential for assuring the person's needs are being met without lapses in service and a smooth transition, please include a reasonable limit as to how long a provider is forced to continue services after they have given notice. There would have to be a very good

	Also, based on the phrasing, there is no requirement on the part of the Department or designated managing entity to make a decision quickly. Please add language requiring the department to make a decision in a timely manner.
6100.307	Transfer of Records – (a) - Recommend adding "Upon receipt of signed releases", before "The provider shall transfer a copy of the individual record..."
6100.307	Transfer of Records – As written, this section implies that a copy of the entire record has to be provided to the new provider. An individual's record can include items not generated by the agency (e.g., a copy of a psychiatric evaluation if one was conducted). In such a case, the provider does not have the legal right to give a copy of the document since it does not "own it." There are also additional concerns under HIPAA that affect how information can be released that would impact this requirement. Finally, since the ISP and the ISP reviews (as the primary documentation) are maintained by the SC, and given that the SC should be providing this to any provider chosen by the individual, there should be no need for every provider to transfer copies of their files to new providers.
6100.307	Transfer of Records – Add clarity as to what parts of the record and how far back they should go. This could be an exceptional amount of information and providers do not have the right to give any information to another provider unless the individual signs a release.
POSITIVE INTERVENTION	
General comment	Overall, this section should be reviewed and rewritten by a person with a clinical background. As written, it is lacking best practice. Please define as much of the terminology as possible.
6100.341	Use o Consi

6100.342	PSP – Please be sure the department provides instruction or a format as to how this information is to be entered to the PSP? It is not clear whether this replaces the SEEP or crisis or behavior plan.
6100.342	PSP - Character limits will need to be expanded in the PSP in order to accommodate the level of detail required in items 1-5. At present, ISP field length for the BSP is 8000 characters. The limitation requires the SC to edit down to the character limits or split the
6100.342	PSP – (2) "Functional analysis" is a clinical term. It is unclear whether the language as written requires a formal functional analysis by someone certified or specially trained. It might not be reasonable in all circumstances; for example, the person who endangers him/herself by eating non-edibles because of Pica. Please either define functional analysis and suggest instead
6100.342	PSP – This section is missing baseline of behavior - missing what has been attempted and results.
6100.342	PSP – (7) – It is not clear what this means (e.g., in regard to the behavior?). This is confusing.
6100.343	Prohibition of Restraints - It is commendable that PA is taking an assertive position regarding the use of restraints. We support the inclusion of the Positive Intervention section, but especially value
6100.343	Prohibition of Restraints – (1) - This section defines seclusion as when the individual is verbally directed from leaving an area. It is possible that, to keep an individual safe from someone else,
6100.343	Prohibition of Restraints – (3) - The language should be clarified so that a compliance issue is not founded because of interpretation. For example, bites are typically released by pressing on the jaw – there are not a lot of ways to release a bite – either hold nose or press jaw at joint. This may be considered "application of pain" by a compliance person.
6100.343	Prohibition of restraints – (5) (i) – "support of the achievement of functional body position" is a good addition – while this should cover things like seat belts in wheelchairs that are designed to keep the person from falling out of the chair because of balance issues, etc., please add a reference to seatbelts as allowable for use in wheelchairs for safety to avoid future interpretation issues.
6100.343	Prohibition of Restraints - (5)(i and ii) – Please consider and clarify how the prohibition against a mechanical restraint interacts with restrictive procedures? (In other words, will mechanical restraints (such as bed rails), which are currently allowed to be used as long as there is a restrictive procedure plan, still be allowed?)
6100.343	Prohibition of Restraints – (5)(ii) – As written, devices such as a helmet for drop seizures, or seatbelts for balance, would only be allowed if the individual "can easily remove the device". In reality, many individuals do not have the physical skills to remove such things as a helmet.
6100.343	Prohibition of Restraints – (6) - Wording is not correct – a manual restraint defined as a . . . or "for more than 15 minutes with a 2 hour period". Should read "for more than 30 seconds." Then add – "A manual restraint cannot be used 'for more than 15 minutes in any 2-hour period'"

6100.344	Permitted interventions – (a) – Please add clarity whether staff giving verbal prompts would make it involuntary.
6100.344	Permitted Interventions – Out of this entire section, it seems only voluntary exclusion and physical protective restraint are the only permitted interventions. There are many others. This section is not written well. Please consider adding clarity.
6100.344	Permitted Interventions – (g) – While this mentions that physical protective restraint can only be used by a staff who has completed the annual training requirements and the content of the PSP, language elsewhere is lacking that states what the staff must be trained in, what
6100.344	Permitted Interventions - (b) through (g) refers to a "physical protective restraint" - this is defined in (h) but it also seems to be the same as a "manual restraint" as defined in 6100.343(6). It would be better and less confusing if the same term throughout was used.
6100.344	Permitted interventions – (c) and (g) seem to be redundant.
6100.345	Access to or the Use of an Individual's Personal Property - (b) - Personal funds or property should be used if it is ordered as part of a legal proceeding; e.g., an individual causes damages to a hotel room - the hotel presses charges and the individual is ordered to make restitution. In this instance, it should be the individual who bears the cost as a natural consequence of the behavior.
6100.345	Access to or the Use of an Individual's Personal Property - (b) - Unless this is applied specifically to provider-owned or operated property, this will be a challenging section to enforce and could
6100.345	Access to or the Use of an Individual's Personal Property - At times access to personal items may need to be limited as using then may involve self-harm or harm to others. While the language says that access may not be used as a "reward" or "punishment", the worry is that this will be interpreted to violate rights. Please add clarity to avoid misinterpretation.
INCIDENT MANAGEMENT	
6100.401-405	General comment: Incident Management detail should be in policy and procedure rather than regulation so that necessary adjustments can be made in a reasonable manner and with reasonable timeliness. Does the information in this section currently reconcile with both ODP and BAS IM policy & procedures?
6100.401	Type

6100.401	Types of Incidents and Timelines for Reporting – (a)(16) – Please clarify. Medical errors are currently reported and finalized within 72 hours. Including this incident type in this list will mandate the report within 24 hours and because of the way the EIM system works the finalization would be done at the same time (or, would it still be 72 hours for finalization, or would it be the same 30 days as required for all other incident types – 6100.404(a)?).
6100.401	Types of incidents and timelines for reporting – (a)(16) – If an over-the-counter medication is not prescribed by a physician, then it is not clear how it can be an error. If it is prescribed, then is it
6100.401	Types of incidents and timelines for reporting – (a)(16) Adds medication administration errors to be reported in the 24 hour time frame. But this entire list is mentioned in the next section 6100.402 to be investigated. Please clarify whether the intent is to now investigate every medication error. We hope it is not.
6100.401	Types of incidents and timelines for reporting – (a)(17) This is a new addition to reportable incidents in EIM (there is not currently a category in EIM where "critical health and safety event that requires immediate intervention such as a significant behavioral event or trauma" are reported). This could be interpreted many ways - and it would also be included in the list
6100.401	Types of Incidents and Timelines for Reporting - (b) – "Immediately" is not possible. Please include a
6100.401	Types of Incidents and Timelines for Reporting - (d) - requires incident reports to be shared if requested. Please either delete or rewrite considering the amount of confidential information that is contained in some reports (especially when staff are involved). Also, notification to the individual and family when an incident is discovered and notification of the conclusion of an investigation is the current practice. Experience suggests that very few if any requests for incident reports are made by families but this requirement may "open the floodgates". Also, the family is often the target of many of the reports SCOs complete, and giving them a copy of the report will be a problem. Also, provider reports of allegations that are not found to be confirmed would be a concern. Those completing the reports may hesitate to include confidential information in these reports. To require families to get a copy of all reports would be an unreasonable risk due to the fact that all allegations are reported regardless of whether there are facts to support them. The standard for what is reportable will need to be modified. Also, the system will need be set up so that it is possible to print a report with redacted information.
6100.402	Incident Investigation – (b) and (c) - the two together imply that every incident must be investigated by a certified investigation since it specifically states incidents listed in 401(a) without exclusion. At this time, only certain incidents require investigation by a CI; to have

	incident investigated by a CI will be unreasonably burdensome on the provider. It is not reasonable to require that every injury, fire alarm requiring the fire department (which currently includes false alarms); emergency closure (even when due to weather), every medication error, etc. to be investigated by a Certified Investigator, with (presumably) an investigation report. Certainly they should be reviewed as part of quality management, but not investigated.
6100.403	Individual Needs – (a) – Please clarify. The phrase "investigating an incident" is used, which could mean these requirements are being added to a certified investigation. Even if they are not, this section could be really overwhelming if site-level incidents are included such as fire or law
6100.403	Individual Needs - (b) – This seems unnecessary since corrective action plans already have to be implemented, and 6100.405 requires analysis of incidents both individually and in aggregate. Also, please clarify who decides whether either action is appropriate. If it is left to the provider to decide, then it is not necessary to add this as a regulation to eventually be monitored. Also, please clarify whether this duplicates or supersedes the regulation already found in PA Code 6000.901 Subchapter Q.
6100.403	Individual Needs - (c) – Please delete. This entire statement seems unnecessary. This already occurs as part of the corrective action and PSP process. Therefore, adding it here adds more documentation requirements and a burden for the provider to show that they "cooperated."

6100.404	Final incident report – Please add a bullet allowing for an extension due to external concurrent investigation or inability to get witness statements, etc.
6100.405	Incident Analysis - Many of the activities listed here for incident analysis should really be the function of the individual's PSP team who is most familiar with the individual and what might help reduce incidents.
6100.405	Incident analysis – (a) – Please replace "incident" with "investigation". The term "confirmed incident" is not a term that is commonly used or defined. And, if "confirmed" is simply struck
6100.405	Incident analysis - (a)(1) – Concern that "analysis to determine the root cause" may be confused with "root cause analysis", which is a technical term and has specific meaning. It would not be a good use of provider resources and time to perform a root cause analysis for each confirmed incident, nor would it be possible to do so. In fact, ODP gives specific guidance explaining this in
	Cause Analysis as a Preventive Strategy. A link to the transcript is here: http://documents.odpconsulting.net/alfresco/d/d/workspace/SpacesStore/018521be-cd4a-
6100.405	4d90-b75e-48f61b017558/Core Function 3 Preventive Strategies Transcript.pdf
6100.405	
6100.405	Incident Analysis – (a)(2) - Sometimes a corrective action is not appropriate, but required
	Incident Analysis – (b) – It is hoped that ODP will provide more tools such as training or EIM feature
6100.405	Incident Analysis - (b) and (e) – one says "shall review and analyze incidents every three months" and the other says "continuously". Please clarify which it is. Also, the word "continuously" is problematic. It is not clear how providers will demonstrate compliance. Also, continuous incident analysis and constant efforts to mitigate risks seem contradictory to ensuring greater integration and community participation and an Everyday Life. Also, this mandate is duplicative and unnecessary and should be deleted. ODP's IM/RM/QM system is exceptional. More effort could be better placed on creating a more integrated system rather than over-analyzing incidents or micro-managing a process that is already working. When providers are given the tools and opportunities, they will use them to improve analysis and quality, where needed. Adding these types of mandates wastes time on unnecessary application, documentation, and oversight.
FEE SCHEDULE	

6100.571	Fee Schedule Rates - (a) - The language should be written to obligate the department to actually use rates that reflect whatever changes result from the refresh discussed in (b) (i.e., as written, the department seems to be able to refresh the data but then keep rates the same).
6100.571	Fee S requi every
6100.571	Fee Schedule Rates - (c) - Language should be added that requires the department to be transparent about the method it used to "consider" the factors indicated. Also, language should be added that requires the department to be transparent about the sources of data and information used.
6100.571	Fee Schedule Rates – (c)(2) - Language should be added that requires the department to consider US Department of Labor and PA Department of Labor and Industry statistics for relevant
	industries, such as the health care industry, as well as labor statistics for non-health care or human service industries with which ODP-funded HCBS providers are in direct competition for workers (e.g., fast food, retail, etc.).

DEPARTMENT-ESTABLISHED FEE FOR INELIGIBLE PORTION	
6100.711	Fee Schedule Rates - (a) - The language should be written to obligate the department to actually use rates that reflect whatever changes result from the refresh discussed in (b) (i.e., as written, the department seems to be able to refresh the data but then keep rates the same).
6100.711	Fee Schedule Rates (b) – RCPA is pleased that the department has proposed language that requires it to refresh the market-based data used to develop rates. However, instead of every three years, it should be done every year. Also, the word "refresh" should be changed to "rebase" or "rebased".
6100.711	Fee Schedule Rates - (c) - Language should be added that requires the department to be transparent about the method it used to "consider" the factors indicated. Also, language should be added that requires the department to be transparent about the sources of data and information used. Also, if the department does not include language requiring an annual refresh (or rebasing) of market data, then the language ought to say the department will apply a cost-of-living-adjustment based on the federal home health market basket index.
6100.711	Fee Schedule Rates – (c)(2) - Language should be added that requires the department to consider US Department of Labor and PA Department of Labor and Industry statistics for relevant industries, such as the health care industry, as well as labor statistics for non-health care or human service industries with which ODP-funded HCBS providers are in direct competition for workers (e.g., fast food, retail, etc.).
SPECIAL PROGRAMS	
6100.803	SC, TSM, and Base-Fund Support Coordination - (e)(1) - note training requirements for the 1st year (i,ii,iii,iv,v) for a Supports Coordinator - these trainings are in addition to the provider required orientation training in section 143 as well as all mandated SC trainings that had been or will be offered by ODP in that year. This would surely demand a Supports Coordinator in their first year have more than 24 hours of training. Please be sure this is considered in rate setting for the expense of additional non-billing time for new staff.
6100.803	SC, TSM, and Base-Fund Support Coordination – (2) – Please clarify whether the standard for incident reporting changed has changed. Incidents reported to SCs will only be reportable if directly observed or if SC is directly involved in an incident. Please clarify if that means that only incidents reaching the standard of protective services would be reported upon discovery from another source. If so, that interpretation is supported.

6100.803 (3) and (4)	SC, TSM, and Base-Fund Support Coordination – (3) and (4) - While Supports Coordination will no longer have to do the 6-month review for residential, it looks like they are being required to document the continued need every 6 months. Please clarify where and how. Please clarify whether a service note is acceptable or doing something more in the plan is required. Section (4) goes through enhanced staffing – please clarify if ODP is doing away with the checklist altogether and if this will be the criteria followed. It is similar to what is being done now – please clarify the method to be used to answer these questions.