14-546-02 3209

Champa, Heidi

From: MaryEllen Robinson <MaryEllen.Robinson@phila.gov>
Sent: Friday, August 03, 2018 3:03 PM
To: PW, IBHS
Cc: Joan Erney; Donna Bailey; Kamilah Jackson; Tamra Williams; dennyob169@gmail.com; Julia Hinckley
Subject: Intensive Behavioral Health Services Comments

Good Afternoon,

Community Behavioral Health supports the proposed IBHS regulations and the intended positive impact on quality of treatment services for our youth.
We have a few operational and clinical points of clarification around implementation that we would very much appreciate feedback on.

Which recommendation will medical necessity be based on? The written order that initiates service or the comprehensive assessment that follows? What credentials will be required to deny requests that do not meet Medical Necessity Criteria?

What is the expected timeline for state credentials for behavior health technicians? In addition, will there be an opportunity for input into those standards/curriculum?

While we agree the RBT training and competency assessment process create a strong clinical foundation, we fear that the logistics of requiring the credential itself may be prohibitive to sustainable practice.

What criteria will be used to determine whether an intervention developed by an IBHS agency can be a model intervention? Under what circumstances would an agency not just use an existing Evidenced Based Treatment?

Does anything in the IBHS regulations pertaining to ABA services affect the attestation process? Since the IBHS regulations clearly stipulate training requirements and credentials, will the attestation process still be necessary?

From the Regulatory Analysis Form: "The proposed regulations remove some of the requirements that were in place for initiating BHRS, which will reduce the time between the request for services and the initiation of services." Many providers have expressed that challenges attracting, hiring and maintaining staff lead to delays in initiation of services. How do the proposed regulations address this? Services may be requested but without adequate staffing to provide the services. Similarly, how does increasing credentials and supervision of IBHS staff improve already strained access given global staffing shortages across the state for at least 2 years?

How is regression measured and defined and by whom? Some regression in behaviors is clinically expected as a result of treatment fading and termination. Has any thought been given instead to brief booster intervention by clinical treatment lead in instances in which regression to a predetermined threshold has occurred? Typically as part of IBHS fade, and termination continued treatment in a least restrictive setting would be part of the discharge plan. What mechanism is in place to ensure collaboration between the IBHS provider and the lower level of care provider before reinitiating services? Conversely, if a child is transitioned to a higher level of care such as Family Based Services or Partial Hospital Program which are standalone services, and regression occurs, how would reinitiation of IBHS be managed?

We are interested in your thoughts about lowering the credentials of evaluators due to difficulties we have with appropriate diagnostics, which is compounded in specialty populations such as ASD, social language disorder, and even

depression, reactive stress, PTSD, and attachment disorder all masked by externalizing symptoms. If we do not diagnose accurately, how to we treat accurately and optimally?

Thank you in advance.

Mary Ellen Robinson, M.S.
Manager of Internal Compliance and Risk Management
Community Behavioral Health
215-413-7118