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Sent: Thursday, August 30, 2018 1:18 PM
To: PW, IBHS
Subject: IBHS Comments- CGRC
Attachments: CGRC IBHS Regulation Questions Comments.docx

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Independent Regulatory Review Commission

August 30, 2018

Child Guidance Resource Centers

Questions and Requests for Clarification on the Proposed IBHS Regulations

Overall, We are in agreement with the increases in training, supervision, the specifying of numbers of supervisees, the increase in quality data collection, analysis, and reporting requirements if with the implementation of these regulations there are corresponding increases in rates that will be increased yearly to accommodate for cost of living increases, infrastructure changes, and technology upgrades. Without increases in rates that support the quality improvements for IBHS there will be no change in the ability to recruit and retain these qualified employees in our organization. Individuals unable to make a living providing a much needed service will seek employment in other areas of mental health or in other service systems leaving this level of care underserved.

Comments/Clarifications Requested:

- Allowing for rapid re-initiation of services within 60 days of discharge is a positive. Understanding that in most community behavioral health organizations when an individual is discharged the clinician that was on the case is assigned a new case. **Is it the understanding that the individual would potentially be assigned a different clinician and/or may not be able to be re-instated due to a lack of clinician availability?**
- Training being portable from one position to the next will only work is the employee has copies of all of their trainings. The issue has not been whether they have had the trainings it is whether they can obtain them from their current employer in order to provide to their new or additional agency. **Is there any thought being given to a centralized repository for these documents so that they can be accessed by employees or employers?** This will still be a barrier to immediate movement into employment and starting clinical work otherwise.
- Clarification is needed on the initial and on-going Assessment based on the specific information indicated does the 15 days start with the date of the written order or from the first date of service. Also is it re-administered every 6 months or yearly for ABA (not clear).
- The annual quality report is stated to be financially neutral due to the removal of ITMs. This however is incredibly misleading. ITM's are completed by clinicians and are a billable service so providers are collecting revenue for this process. The annual quality plan will require organizations to invest financial capital in data collection and analysis programs which is not reimbursable or at all accounted for in the rates provided. It also is completed by infrastructure employees in quality and compliance departments or administrative employees which are also not part of consideration with the rate system currently in place. It is short-sighted at best to consider these financially neutral and therefore should not be referred to in that way.

Questions:

- 2 Phone calls post discharge. **Do these phone calls need to be made by the clinician? What type of documentation will need to be done for a family that is unable to be reached? How many attempts will be necessary? How are the attempts and phone calls reimbursed? If this is**

a clinician it would not be a great use of time, especially if they are unable to reach the family. Are these call only for successful discharges or for any discharges?

- **What are the specifics that need to be in a written order for initiation of service and for a re-initiation post-discharge?**
- **Can the 30 minutes of direct supervision of IBHS staff every 3 months be via visual technology?** When supervising 9 FTEs which could be up to 18 people. That would mean traveling for the supervisor for extensive miles dependent upon the area served by the clinicians. For 18 clinicians it would be 5.4 hours of direct observation with potential 30 minutes to and from for each client (1 hour times 18 clinicians=18 hours. Over a 3 month period that is 7.8 hours per month dedicated to just the direct observation alone.