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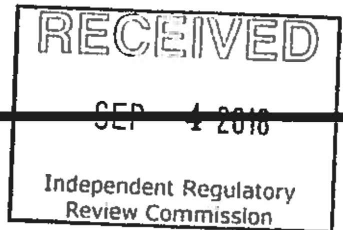

Kathy Cooper

From:	David Gates <dgates@phlp.org>
Sent:	Tuesday, September 4, 2018 4:16 PM
To:	RA-PWIBHS@pa.gov
Cc:	IRRC
Subject:	Comments to Regulation No. 14-546- Proposed IBHS Regulations

Comments of the PA Health Law Project to Regulation No. 14-546- Proposed IBHS Regulations

Our comments focus on two areas: ABA and Restrictive Procedures

First, as to ABA, we believe having regulations establishing ABA as a service separate from traditional BHRS is essential (as well as a requirement of the Sonny O settlement). We also recognize that OMHSAS has attempted to advance the qualifications of those providing ABA while addressing the fears of some providers that increased qualifications will cause shortages of staff and thereby diminish access to services. Unfortunately, as to the proposed qualifications of ABA staff, we are concerned that there are at least two areas regarding staff qualifications where the proposed qualifications are seriously deficient. They are:

Qualifications of Clinical Director §5240.81(b)(2)
This section allows an individual who is not a Board Certified Behavior Analyst (BCBA) to serve as Clinical Director of an ABA program for 3 years without being a BCBA. We understand the idea was to provide time to enable individuals not yet certified to become BCBAs. For that reason, it may be reasonable to provide additional time before this provision becomes effective. However, at some specific date, it is critical that ALL Clinical Directors be BCBAs if they are going to direct the clinical aspects of an ABA program. We understand the theory that giving each individual a 3 year period to become a BCBA provides a career path for people to become BCBAs. However, we believe that the Clinical Director position is just too critical for on-the-job training. Second, how will a Clinical Director who is not a BCBA be able to clinically direct a Behavior Specialist Analyst who is a BCBA? §5240.82(a) requires that the "ABA Clinical Director shall provide supervision to all behavior specialist analysts". Doesn't this preclude anyone in the ABA program from being a BCBA if the Clinical Director isn't since there would be no one who could supervise Behavior Specialist Analysts who are BCBAs? Third, since to become a BCBA, an individual needs supervision by a BCBA. If the Clinical Director is not a BCBA, what BCBA will supervise him/her to enable them to become a BCBA within 3 years? Certainly it can't be a Behavior Specialist Analyst who is a BCBA as the Clinical Director is responsible for supervising all Behavior Specialist Analysts. Lastly, while we could see that allowing non-BCBAs to be Clinical Directors for 3 years will create a career path for individuals to become BCBAs, we fear that this career path will just become a training ground for those individuals seeking to go into more lucrative private practice or the education system once they obtain their BCBA. Why would any Medical Assistance provider pay a higher rate to a Clinical Director after they obtain their BCBA if they could replace that individual with a new individual without a BCBA who could work as Clinical Director for less pay for another 3 years. This provides a financial incentive for high turn over in the Clinical Director position.

Use of PA Certification Board to certify Behavior Specialist Analysts and BHTs §5240.81(c)(3)&(e) and §5240.83(d)
The PA Certification Board does not yet have any certification related to ABA and has not yet developed any standards or training requirements. It is not acceptable to recognize the certification of a Board with no

experience in ABA and no current standards for ABA practitioners on faith that sometime in the future, this Board will create standards when we have no idea what those standards may be or the qualifications of those who will be establishing them.

We also believe that a clarification of the ABA services provision §5240.87 is needed to avoid recurrence of previous problems.
This section specifies the scope of practice of a Behavior Specialist Analyst. It mentions "reduce or eliminate...skill deficits" as one of the primary roles of a Behavior Specialist Analyst. The term "skill deficits" is too vague without further clarification. The history of coverage of ABA under Medical Assistance in PA has been plagued by disputes over which skills may be addressed through ABA. The two major areas of dispute have been whether communication skills and toileting skills can be addressed by ABA under Medical Assistance. These skills are essential for effective participation in community activities and socializing with peers and the regulations should include them specifically. This was acknowledged by OMHSAS in its OMHSAS-17-02 Bulletin which states:
"It [ABA] can also be used to reduce or ameliorate the presence of a child's or adolescent's maladaptive or restricted behaviors, impairments in communication, or impairments in social interactions or relationships or assist a child or adolescent with achieving or maintaining the skills needed for maximum functional capacity in performing activities of daily living." P.2

Lastly, we comment on Restrictive procedures §5240.6
We are pleased to see this provision that recognizes that some manual restraints may be used an emergency situation to prevent self-injury or to prevent injury to others. We have heard from families for whom residential placement of a child who is physically aggressive or has self injurious behaviors is the only option when their BHRS staff are told they can only watch the child assault a younger sibling when de-escalation fails. We believe the proposed regulation sets out proper guidelines for the use of restrictive procedures. However, to best ensure safety of the child, staff and family members, we believe there should be an option for 2:1 staffing where needed to safely implement restrictive procedures specified in the child's ITP. The proprietary safety training programs used by IUs and residential providers require 2 staff to safety use certain manual restraints. We believe that §5240.21 and .22 should be amended to give assessors and treatment planners the option of requesting 2:1 staff where manual restraints are needed and they believe 2:1 staffing to be necessary for safety. We also believe that §5240.6 should be amended to require providers who use manual restraints to also provide full training (de-escalation & manual restraints) to families/caregivers of children for whom manual restraints are part of their ITP.

Thank you for giving us the opportunity to provide these comments.

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