14-546-67 3209

Champa, Heidi

From:	Yurich, Kirsten <kyurich@thevistaschool.org>
Sent:	Monday, September 03, 2018 9:44 PM
To:	PW, IBHS
Cc:	Yurich, Kirsten
Subject:	Comments for IBHS regs
Attachments:	IBHS Response Ltr Vista 2018.pdf

To whom it may concern,

Please find comments for the proposed IBHS regulations attached to this email.

Thank you,

--
Kirsten K. L. Yurich, M.A., BCBA, LBS
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Vista

September 3, 2018

Sherry Peters, MSW, ACSW, Director
Bureau of Policy, Planning and Program Development
Office of Mental Health and Substance Abuse Services, Department of Human Services
Commonwealth Tower, 11th Floor;
303 Walnut Street
Harrisburg, PA 17101

RE: 55 PA. CODE CHS. 1155 AND 5240 (Proposed)

Dear Ms. Peters,

Please accept the following submission as the official comments from Vista, an educational and behavioral health organization located in Hershey, PA. Vista has a 16 year history of providing intensive, educationally integrated ABA treatment for children, youth, and young adults with Autism Spectrum Disorder, and as of August 28th, this program is serving over 115 individuals.

In general, we applaud the department for taking on a needed and long awaited project – the regulation and improvement of the Behavioral Health Rehabilitation Services system. This endeavor is not easy or to be taken lightly. We respect the individuals involved who took on this important work.

However, as drafted, Vista fully rejects these regulations. They do not meet the stated objectives. They are in many places (1) unnecessarily and excessively onerous on the provider, (2) list unfunded mandates that will increase costs to the providers, (3) dictate unnecessary and illogical administrative processes, paperwork, and systems that will not result in improved quality but by contrary, will take time, attention, and money away from direct client care, and lastly, (4) they do not sufficiently address core issues with quality.

Vista has successfully operated a BHRS-exception program since 2005 under the 55 PA. CODE CHS. 5210 with *only three permanent waivers.* If these proposed regulations are promulgated, at first read, Vista would petition for *an estimated 20 specific waivers* in order to continue to operate. Year over year Vista programs produce documented and validated client growth via standardized scores (statistically significant with $p<.005$ and $p<.001$) on communication, academic, or measures of adaptive functioning (reference available upon request). These robust and consistent results illustrate the effective design of the Vista program. The burden of proof would therefore be on the Department as to whether or not the intrusive and excessive changes requested by these regulations would produce any level of improvement to the Vista program.

Specific comments related to the proposed regulations are as followings:

Introduction

- The explanation of the process to obtain and vet information from stakeholders was representative to the process. It is unrealistic to think that all perspectives can be

achieved and represented within a regulation draft. The draft must be then a *best version* of all the feedback and perspectives. This draft unfortunately falls short. Standards for clinicians are not internally consistent and the risk of harm exists. For example, a nurse with no national ABA certification can be a Clinical Director for an ABA agency and a BCBA with zero years' experience can be as well; both scenarios are inappropriate.

- The introductory comments that there *will be cost increases* associated with the new regulations but that government will not be responsible for these costs. Then, who is? Without also adjusting FEE FOR SERVICE and MCO funding mechanisms with these regulations you are placing numerous costly burdens on the provider with no remedy for the provider. For example, these regulations mandate an Administrative Director, processes within training and supervision and quality control that will INCREASE the costs on the administrative payroll. However FFS has a flat 10% administrative cap, and redlines any costs not directly tied to delivering services. HOW WILL A PROVIDER RECOUP COSTS ASSOCIATED WITH MANDATED ADMINISTRATIVE EXPECTATIONS?
- The regulations state a pending relationship and reliance upon the "PA CERT BOARD" for creating several future certifications required by these regulations (both for IBHS and IBHS-ABA). The PA CERT BOARD has no experience in the behavioral health or ABA or Autism space, how will they be qualified to certify individuals for this field? Further, as a credentialing body, they themselves are not accredited (e.g., by the National Commission for Certifying Agencies or the American National Standards Institute). We reject the use of this board and recommend the use of an already nationally accredited board who is already certifying professionals within the ABA field – the Behavior Analyst Certification Board.

5240.2 – Definitions

- Applied Behavioral Analysis ***should*** **be** Applied Behavior (no *al)* analysis
- Evidenced Based Treatment: **please add National Standards Project** to your citations list as it contains federally reviewed literature and procedures for the autistic population

5240.22 – Ongoing Responsibilities of Providers

- What is defined as a 'branch' or 'satellite' location for purposes of requiring an additional license? **Please define.**

5240.3 – Provider Eligibility

- **Please address** that should the time between an existing Outpatient or PHP or Family based license expiration date and the adoption of the proposed rulemaking is less then 180 days, *that the provider shall still have 180 days to comply with the IBHS license.*
- Does the department have data to show that 180 days is enough time for a provider to comply with regulations such as these? Is there a process for providers who will need more time to request a waiver?

5240.4 – Organizational Structure

- Please clarify if you are mandating an FTE Administrative Director and FTE Clinical Director or do you wish to see each agency have positions designated "to serve as" these positions or "shall have the responsibility of" these two stated positions. If the department is mandating stand-alone positions, this mandate needs to be accompanied by changes to the RATE SETTING methodology at FFS and MCO that excludes these positions when setting rates. **Please state that you wish to see positions "designated as having administrative or clinical oversight" to the IBHS service lines within the agency or address the unfunded mandate issues.**
- **There is a very large lack of clarity to the extent to which the Department wants to be notified of changes to the organizational chart.** The expectation of *within 10 days* is absolutely unreasonable – especially without further information about what changes the Department is interested in monitoring. For example, as written an agency must notify the Department within 10 days of an administrative secretary whose supervisory relationship has changed or if a new billing staff has been hired and is added to the organizational chart. Is this truly your intent? The level of monitoring requested will add costs to the agency – costs that are thus far unfunded by the department. **Please remove this entire section.**

5240.6 Restrictive Procedures

- **Confirm the definitions of restrictive procedures and their usage terms within these proposed regulations have been reviewed with the PDE regulations to ensure that the least amount of conflict exists** for the BHT and BHT-ABA who deliver services in schools and will be part of teams addressing challenging behavior of children and youth. About 70% of IBHS services are delivered in schools – *for that reason this is a very important place to have good alignment with PDE rules and regulations for the purpose of improved outcomes for kids.* We all know of the issue of "TSS being hands off in schools" to the detriment of the child. What better place to solve this the with the new regulations!
- (e) Update this specific section to match best practice and read: "no longer an imminent danger to self or others" the wording you have: "regain self-control" can be interpreted as the child/youth has to be calm or no longer upset to be released from the restraint, neither of these conditions warrant the continuation of a manual restraint and could be misinterpreted by IBHS agency staff. **Please change this wording to match best practice guidelines.** We have found it effective to use the "imminent danger" language in both the criteria to initiate as well as the criteria to continue a restraint.
- (f-1) **This item should be updated** to read: "including all the prohibitions on all the use of *inappropriate (added) uses of manual restraint"*
- (f-4) **This section should remove** the "self-control" language, see previous comment

5240.7 Coordination of Services

- As your licensing department knows well, the requests for letters of 'coordination of care' often go unanswered. **As long as you continue to accept the *attempts to secure***

these letters **by the IBHS agency as meeting this part of the regulation, we have no comment.**

- Was the logical budget implication to update these letters every five years taken into account and what is the mechanism to build that into the cost of service?

5240.11 Staff Requirements

- (A) Please see earlier comment – **do you intend to mandate an FTE Administrative Director or a 'designation of duties' instead?**
- (B) **Please clarify the PURPOSE or WHY and INTENT behind designating a mismatched conglomerate of activities such as those listed underneath the Administrate Director.** These duties span those that are housed across a myriad of functional areas of an organization such as Compliance department/officer, Quality and Training departments. The mandate of one person to do, or oversee these activities is overly restrictive as a regulation and constitutes a 'form over function' governmental mandate. For example, scheduling of staff is an administrative task that is important, but is rarely completed by a director. Why are State regulations mandating WHO in an agency MUST do this task? **Please clarify if your intent it to truly mandate the assignment of discrete job tasks within IBHS agencies to specific FTE or if you desire something more functional, such as clear lines of accountability for staffing prescribed services (a task more relevant to a director).**
- **Please share your data that supports the mandate of 7.5 hours of Administrative Director time per IBHS agency.** Please define 'agency.' How are you expecting time spent on aggregate activities to be 'counted' across multiple agencies (e.g., monitoring staff injury data, reviewing staff performance dashboards, financial reviews, etc.)
- (F-5) **Remove the mandating of "monthly staff meetings."** This mandate falls well outside a typical scope of State regulations, and appears to be a 'form over function' mistake and should be removed. The assumptions that a monthly staff meeting is (1) *possible* for every type of agency covered by these regulations, (2) *useful* for every iteration of IBHS service type, or a (3) *reasonable* expectation to stem from regulations are improper. Monthly staff meetings *may* by a mechanism by which an agency disseminates information, conducts teaming activities, or delivers annual training – or not. There are just too many variables not accounted for to just simply mandate such a thing. The result will be a costly, "check the box" activity driven solely to avoid a violation. Please remove.
- (7-H) **Please clarify what you mean by: "shall employ a sufficient number of qualified staff to provide the maximum number of service hours identified in the written order."** One interpretation is that as an agency I need to have on staff enough FTE (Vista does not use PRN staff in this program) to fill the highest level of prescribed ours – regardless of client schedules or anticipated utilizations. If true, this comes at an extremely high cost, Vista would have staff sitting around on the payroll without clients to care for. **How is this mandate funded?**

5240.12 Staff Qualifications

- The Administrative director should be able to have an undergraduate degree and a sufficient level of management experience. A Master's degree in a human service field

does not relate to administrative management competency. Finding good people in management is difficult. In our experience, management ability is often learned post-education and with deliberate work and dedication.

- This section does not specifically state whether it does or does not apply to ABA agencies?

5240.13 Staff Training Plan

- **Remove all statements (as written) related to the retention of paper training materials and handouts.** The requirements (as written) in these regulations related to keeping paper copies of every training version and every handout of every training ever delivered to a staff are costly, redundant, and overly-burdensome. **Instead, consider mandating a course syllabus be on file (paper or electronically) for each course that links to a *regulated training*.** Many agencies use Learning Management Systems (LMS) and would need to set up entirely separate and duplicative systems to uphold the regulations as written. Further, trainings are dynamic – updated with new knowledge and understandings of research frequently. As written, the regulations ask for every updated version to be kept – the storage and tracking alone is at least *1 new FTE* for Vista alone to uphold this sections of the regulations. **This type of mandate works directly against the introductory paragraph that indicated the updates to training would save the State and providers money.**
- **Remove the mandate that initial and annual training plans should be based upon date of hire.** This does not represent best practice in the training profession, adds tracking and monitoring overhead, and only complicates an already challenging system that runs on lean resources. If based upon these regulations Vista's training department would be tracking *250 different training cycles* – that serves no useful purpose. Training plans SHOULD run on an annual cycle for the entire agency/program.
- **Remove the mandate that individual training plans should be based upon formal evaluations of staff.** This is not best practice in the training and performance evaluation fields (references available upon request) and takes a very narrow view of all the variables that effect an individuals' performance (e.g., competency of supervisory, saliency of immediate consequences for actions, available resources, robust feedback loops, etc).
- **Provide further information about your intent (and process) to approve trainings.** Is this all trainings? What is the mechanism? Is this before they are delivered? What about when they are updated? How will this be an efficient system? How does the department ensure they have the necessary content experts to provide this approval? Does the department have instructional designers on staff?

5240.14 Criminal History Check

- **Vista requests that you accept either the DHS or the PDE FYI clearance during an audit.** They use the SAME DATABASE for the query and should be considered equivalent. It is a waste of money to mandate the DHS version for employees who have transferred from an educational facility and have a valid FBI clearance – but for it being printed from the PDE website.

5240.23 Service Provision

- **Please specify what "community based" means.** Consider adding Community to the definition section. In the past services have been delivered in the home, school, or other community location. It is unclear if you are keeping or changing the historical use of the definition. What about a community type of clinic location? A daycare?

5240.31 Discharge

- A provider should also be able to discharge from care clients who have been absent from service for 30 calendar days or more (this provision exists within the MCO regulations).

5240.32 Discharge Summary

- If you intend for the provider to note the post-discharge phone calls on the discharge summary AND have the parent sign the summary – the summary will not be completed until 31-45 days after discharge. That seems like a delay in getting the summary to the family and other providers post-discharge. **Perhaps you want to look at this timeline.**
- **Please add** that it may be sufficient to have a Clinical Supervisor (not always a Director) sign a discharge summary – depending on the size and make up of an agency.

5240.42 Agency Records

- (7.A.6) **Remove the mandate to keep a schedule of daily group services.** The mandate as written is excessive and overly restrictive to the agency. Keeping a sample schedule to meet the ITP goals is good enough for both monitoring and auditing purposes.
- (7.B.2) **Remove the requirement to track external Continuing Education Credits for licensed and certified staff.** This is a responsibility of the professional, and is already tracked by the credentialing body. The added duplication by the IBHS agency is unnecessary – costly – and wasted time.
- (7.B.4) **Remove the requirement to have *individual training plans* that are part of the agency or department/program plans.** Certainly it is reasonable to expect individual adjustments within a whole training plan to react to individual or small group deficits; however regulations go beyond their mandate and scope to mandate 100-500 individual training plans (depending on agency size). This simply is *not scalable* nor does it comply with best practice (references available upon request).

5240.61 Quality Improvement

- Quality improvement requirements are brand new and while show great intention, do come with significant costs. **Please state specifically the mechanism for providers to build these costs into the rates as *allowable* or describe some other method for reimbursement.** As stated previously, the introductive paragraph proports that: "Costs to the department, local government, and individuals receiving IBHS are not anticipated." **How is that possible with mandates such as this one?**

5240.71 Staff Qualifications

- (C1) **Please add:** "behavior specialist license, or other recognized license in related area"

5240.81 Staff Qualifications

- Please see previous concerns related to the Administrative Director position
- Clinical Director: **Please add minimum 5 years of experience for this position and mandate a BCBA.** If the top clinician in an ABA agency is not board certified, the rest of the hierarchy you have set forth will fall apart, quality will be at risk, and supervision structures cannot be established.
- (C-3) **Eliminate the use of PA CERT Board for any credentialing of ABA professional or para-professional positions.**
- The created titles for the regulations are confusing and difficult to map against national standards. **Consider just using nationally recognized titles and mapping qualifications to same, for consistency and quality reasons.**
- (e) The 18th month grace period for new BHT-ABA hires to become certified appears to long. That time period is longer than the average retention rate for individuals in these positions statewide. Staff practicing that long without proper base knowledge is detrimental to the clients served. **Consider shortening this grace period to 6 months.**

5240.82 Supervision

- In general the regulations mandate supervision as if every professional and paraprofessional employee were still within their internship/practicum experience. The specific level of monthly supervision (documented and counter signed) is at levels unnecessary once professionals become proficient and competent – typically following a few years in practice. Further, individual supervision is only *one means* to obtaining quality services and outcomes for children – yet the reliance on overly burdensome levels of supervision within these regulations would lead one to believe that individual supervision is the ONLY way to obtain quality outcomes. **The supervision mandated in the regulations must be completely overhauled. It is restrictive, costly, represents 'form over function,' and could backfire.**
- Specifically – in the IBHS, but not in the IBHS-ABA section, a 'clinical supervisor' layer is mentioned. Was this excluded on purpose? If so, why? If not, can it be added? I believe that because these regulations are overly detailed, unnecessarily, this type of issue will occur in multiple places and likely will cause oversight challenges for the Department and agencies in the future.
- **Remove the mandate for a 'narrative, countersigned' supervision note for all supervision sessions between Directors, supervisors, and BSA, etc.** This level of mandated paperwork is unnecessary, overly restrictive, and does not have data to support its impact on quality. The dated signatures indicates a paper-based system which will add strain to an already very lean system.
    - The mandating of such supervision universally for every professional regardless of experience and competency is overly simplistic and restrictive to the agency.

  - **If paper copies do remain in the regulations, they are not appropriate documents to store within HR files – perhaps consult with OA or another entity for best practice guidelines.**
- (B3) **Constitute training, not supervision, because services have not commenced – this should be moved to the training section.** Can this be explained further? How is it different from training? What is to be delivered by a supervisor versus a trainer, and why is the Department mandating that distinction? Do these 6 hours count towards the 20 hours of pre-service training?
- (E) The BCBA allows 10 staff in a group supervision session, what is that reference point for 9?
- (F) **Remove the restriction of how many BHT-ABA staff may be supervised by any BSA or ABSA.** What national models are you following for this? One BSA with 3 clients in homes (each having 3-4 staff in a home) will already exceed your limits. This alone will drive up costs for smaller agencies.
- (F) **Adjust the regulations to account for the separation of clinical (ITP implementation only) versus administrative (HR) supervision of employees.** BSA and ABSA employees are clinical minded individuals and often not trained (nor interested) in fully supervising the activities of employees (e.g., productivity, leave time, professional behavior, etc.). Larger agencies may institute models of supervision that separate clinical from administrative forms of supervision. The mandates in these regulations suggest agencies will only employ only one model of supervisory structure.
- Shared supervision is not mentioned in the regulations. Please be aware that this is a real phenomenon that occurs and likely has implication to the limits associated with "9 FTE" supervision rule.
- (a) (3)ii **Please clarify** that "ITP Implementation status" is referring to progress towards goals.
- (a) (3)iv **Please address** how staff training information constitutes 'evidence' of 'staff person's skills' in implementing interventions during a case review.
- (b) (1)-(2) **Please clarify** if the one hour of supervision per week counts towards the individual face-to face session per month?

5240.83 Staff Training Requirements

- Trainings approved by the BACB are for BCBA or BCaBA professionals. The regulations indicated trainings approved for the BHT-ABA or RBT level. Perhaps there is a misunderstanding but the BACB does not approve trainings for the technician level practitioner. **What is the department's plan to approve all RBT/BHT trainings delivered by agencies?** How would that be an efficient process both in terms of cost and time, does the department have the capacity for this?

5240.85 – Assessment

- **Please clarify the timing of the assessment** in relation to the referral, initiation of services, and development of ITP?
- (c) (4)ii **Please clarify what is included in the treatment history** (FBA, previous response to ITP, behavior plans, etc.)

- (i) **Please clarify that a Clinical Director reviews a sampling of treatment plans as part of quality monitoring.** Other clinical reviews may happen as part of staff training, internal control procedures, etc. For example, if a BSA reports to a Clinical Supervisor that supervisor may review and sign all plans (after ITP meetings – not before). **The regulations as written indicate a cumbersome and overly restrictive process that will overburden a Clinical Director (or result in a rubber stamp).**
- (F) Should the assessment be signed by the parents?
- Some standardized behavioral (and other) assessments cannot be completed until the clinician has known/worked with the child for at least 30 days (references available upon request). That will make this timeline impossible. **Please change timeline to account for best practices in assessment implementation (e.g., 45 days).**
- **Please eliminate the mandate to re-do an assessment for lack of progress on one goal.** While reassessing is *one thing* you may do in response to observing a lack of progress, it is not the first thing you would do (others might include assessing the intervention, check integrity of data collection, etc.). A mandate such as this would lock providers into this one action as a knee-jerk reaction and set in motion extraneous actions by teams resulting in reduced pace of client growth. Do you mean to re-assess a client if a *majority* of goals lack progress? If so, please clarify.

5240.86 – Individual Treatment Plan

- (D.9) **Please add the work "estimated" to the number of hours for each service location within the ITP so that this listing of hours does not become a reason to deny services or otherwise become a problem for families.**
- (G) **Please add "visual display of progress" as expected additions to treatment plan updates.** There exits an overreliance of narrative descriptions throughout this ABA service description.

5240.87 – ABA Services Provisions

- In general, the language used in this section comes across as mainly focused on behavior reduction, as if the main focus of ABA is to deal with aberrant behaviors. **This section requires great emphasis and exemplars of skill building, adaptive development, and assisting individuals to improve socially meaningful behavior.**
    - **Consider:** "A behavior specialist analyst utilizes behavior interventions and environmental modifications to develop skills and effective replacement behaviors aimed at reducing problem behaviors and skill deficits to achieve progress towards a desirable behavioral outcomes."
- Behavior Analysts perform additional actions that are missing from the list of actions sanctioned by the regulations. **Please add to the list of approved actions: (1) the collection of data, (2) direct observation of the client or relevant environments or variables hypothesized to have an effect on the clients' behavior, (3) parent or other caregiver training and consultation, (4) training and consultation to other team members who will implement the ITP or otherwise support the behavior change of the client.**

- **Please add GROUP SERVICES into the list of services within IBHS-ABA.** Group services are a valid method for behavior change in many circumstances and should be within the array of options for a provider (reference available upon request).

5240.93 – EBT Requirements

- It appears that much supervision requirements and agency monitoring requirements are transferred to other entities when an EBT is used and the agency is "approved" or "certified" to use that model. It should be reviewed whether or not this transfer of oversight is valid in these circumstance. A risk observed would be that not all EBT programs mandate across the categories listed within these regulations. For instance, an EBT may mandate for specific procedures, but not for the supervision standards of the individuals delivering the procedures. The transfer of risk from specific regulations to 3rd parties in this case seems to place the consumer/client at risk.
- **What standards do providers adhere to when the regulations are silent on issues such as supervision or minimum qualifications, admissions and discharge criteria?**
- **Why are outcomes for an IBHS program only associated with EBT? Shouldn't all IBHS and ABA programs have outcomes and a fidelity monitoring process?**

5240.104 – Group Services Initiation

- Pursuant to other comments about group ABA services, **please add ABA in the list of specific specialized therapies for which group services may include.**

---End comments---

Thank you for the opportunity to review and provide feedback to the department. Should any comments require further discussion, Vista is an open and collaborative partner for the Department – please contact us. Regretfully however, we do not support these regulations as written and sincerely urge the Department to consider carefully these and other submitted comments, and make appropriate changes.

Respectfully,

Kirsten K. L. Yurich, M.A., BCBA, LBS
Chief Executive Officer

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