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Champa, Heidi

From:	Antonia Allsman <AALLSMAN@devereux.org>
Sent:	Tuesday, September 04, 2018 4:36 PM
To:	PW, IBHS
Subject:	Comments from Devereux Advanced Behavioral Health, IBHS Regulations
Attachments:	OMHSAS IBHS.pdf

Ms. Pride,

On behalf of Carl E. Clark II, President and CEO of Devereux Advanced Behavioral Health, please accept the attached letter and document as the organization's response to the request for comment on proposed rulemaking for IBHS regulations.

If you have any questions regarding this submission, please don't hesitate to reach out to me at the contact information below.

Thank you for the opportunity to provide comment on this important component of our commonwealth's service continuum for children.

Antonia

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September 4, 2018

3209

Tara Pride
Bureau of Policy, Planning and Program Development
Commonwealth Towers, 11th Floor, PO Box 2675
303 Walnut Street
Harrisburg, PA 17105

Re: Comments, Intensive Behavioral Health Services Regulations

Ms. Pride:

Thank you for the opportunity for Devereux Advanced Behavioral Health to offer comments on the proposed rulemaking for Intensive Behavioral Health Services Regulations.

Devereux joins with the department in championing the growth of community-based services, as well as the importance of continued integration of evidence-based practices into these supports. We appreciate the department's efforts to ensure services, through regulatory oversight, are provided at the highest level of care and execution as possible. With that said, we do have questions and concerns related to the proposed regulations, which are enumerated below.

Of greatest concern are the proposed new regulatory requirements regarding supervision and training and the intersection of rates paid by the Commonwealth for IBHS. If the proposed regulations are approved, many agencies may be forced to convert from the independent contractor structure currently utilized to employee status, resulting in increased costs and administrative responsibilities that may jeopardize the financial stability of IBHS programs.

We are not suggesting that supervision and training are not critical; they are hallmarks of Devereux's philosophy of advanced care. However, we believe there is a balance that can be achieved between these crucial goals and the fiscal and human capital realities of the service model. If they are not, we fear the very people the regulations aim to help, particularly children on the autism spectrum, will see reduced access to community-based services.

If you would like additional information regarding these comments, or to discuss recommendations in more detail, please do not hesitate to contact me.

Thank you again for the opportunity to provide comment, and for your service to the citizens of the Commonwealth of Pennsylvania.

Sincerely,

Carl E. Clark II

Carl E. Clark II
President and CEO

Devereux Advanced Behavioral Health

Comments, Intensive Behavioral Health Services Regulations

August 31, 2018

5240.6 Restrictive Procedures – The proposed guidelines allow manual restraints to be used in emergency settings. This brings on an increase in additional training, oversight and risk for providers. Can providers still have agency polices that state they do not use any manual restraints?

5240.7- Coordination of Services – IBHS agencies will be required to have written agreements to coordinate services with the following: psychiatric inpatient facilities, partial hospital programs, psychiatric outpatient clinics, crisis intervention programs and mental health and intellectual or development delayed case management programs. If a provider offers a continuum of care, does the IBHS agency need to have written agreements with their own agency?

5240.21. Assessment – Proposed regulations are requiring a comprehensive face-to-face be completed by behavioral specialist or mobile therapist within 15 days of the initiation of service and reviewed and updated every six months. Is this in place of the psychological evaluation or would the psychological evaluation and the comprehensive assessment still both be needed? At times, our psychologists will make diagnosis changes. If they are no longer completing the psychological evaluation, who will make these changes, as the behavioral specialist and mobile therapist are not qualified to do so? In addition, Devereux would recommend allowing 30 days to complete this assessment as we feel 15 days does not provide sufficient time for completion.

524.31. Discharge; 5240.32. Discharge Summary – Proposed regulations state that provider must make and document two telephone contacts within 30 days after discharge to monitor status. This will be an added burden to the agencies in terms of staffing, monitoring and tracking. Would this be a billable function?

Also the proposed regulations state that an IBHS agency may continue to serve a child, youth or young adult after discharge for up to 90 days if youth, young adult or parent request re-initiation of services within 60 days of discharge. What administrative paperwork will be needed to start services for the individual? Additionally, once an individual is discharged from care, providers need to assign new cases to staff as they need to provide billable services. Providers will not be able to keep caseloads unstaffed for 90 days in case families want to re-initiate services with the same staff member. Providers, especially smaller organizations, will not be able to always guarantee they will be able to re-staff the case with the staff member who provided the services.

5240.41. Individual Records – Proposed regulations are requiring that records should be reviewed for quality every six months. Will all agency records for IBHS need to be reviewed, or will a random sample of records meet this requirement? It would not be feasible, particularly for large IBHS programs, to review all records every six months. Our recommendation would be that an agency be required to review a set percentage of their caseload within the six month period, so that it equitable to agency size.

5240.71. Staff Qualifications – Proposed regulations require BHTs that are providing services to obtain a current RBT, BCAT or other behavior analysis certification accredited by the National Commission for Certifying Agencies or American National Standards Institute within 18 months of being hired as BHT. Devereux proposes that instead of RBT certification, the equivalency is obtained (all requirements except the RBT test) due to the stringency of supervision requirements for RBTs. This requirement would impact the capacity for providers to hire and retain sufficient staff, which is already an issue.

5240.72. Supervision – Supervision for BHTs will include: six hours of on-site supervision prior to providing services independently; on-site supervision during provision of services to individuals at least quarterly for minimum of 30 minutes; and one hour of supervision each week if working at least 37.5 hours per week, or one-hour supervision two times per month if working less than 37.5 hours per week.

Case-specific supervision is tied directly to quality of care. We recommend that supervision requirements, in terms of location, be flexible such that an hour of supervision can be delivered by the supervising BSC. In terms of quarterly supervision, we recommend that the training focus on general, relevant topics to IBHS service provision.

Additionally, the aforementioned increase in supervision, training and monitoring of schedules does not support the independent contractor model most agencies utilize because of the rates paid for the service provision. Agencies may be forced to convert their contractors to employees, resulting in increased costs and administrative responsibilities that may jeopardize the financial stability of IBHS programs.

Additionally, the proposed regulations require that an IBHS supervisor may only supervise a maximum of nine full time BHT staff. This will increase the number of supervisors an agency will need, as there is no maximum standard currently.

5240.73. Staff Training Requirements – Proposed regulations have increased the overall training requirements per staff. Currently the BSC and MT are required to have eight hours of department approved training annually. The proposed regulations would require an increase to 16 hours annually. In addition, the proposed regulations would require BHTs to have 30 hours of approved training prior to providing services independently and an additional 24 hours of approved training within six months of hire. Finally, BHTs will need 20 hours of approved training annually.

This is a significant increase from the current regulations and will have a significant financial impact to providers as they are not reimbursed for training. We recommend that the increased department approved training hours be set at 12 for BSCs and BHTs, with 20 hours prior to providing services and an additional 24 hours, but within 12 months after hire. This schedule would ensure that trainings are tied to relevant subject matter, particularly in response to new requirements, emerging best practices or trends in service provision, throughout the BHT's first year. This level of support can serve to aid in employee retention.

Applied Behavioral Analysis

5240.81. Staff Qualifications – The proposed regulations would require Behavioral Specialists (BSA) to have a license (LBS, LCSW, Psychologist) and one of the following: BCBA; BCaBA; 12 credits of ABA from a University and one full-time year experience in ABA; Certificate in ABA from the Pennsylvania Certification. Board; or one year of full-time experience supervised by a BCBA. Devereux is proposing to allow this requirement to be obtained within a period of 12 months.

5240.82. Supervision – The Proposed ABA regulations require that the ABA clinical director provide supervision to all behavioral specialists to include one hour supervision two times per month and one individual face-to-face supervision. Devereux recommends a hybrid approach using the ABA clinical director as well as a clinical coordinator. Ideally, the clinical director would provide a two-hour group training once per month for all BSCs. Individual supervision would be provided by a clinical coordinator, who is a licensed BSC. This structure ensures the best and most responsive training and supervision structure possible and provides coordinators with supervisory experience under the mentorship of the clinical director – an important step in building the next generation of clinical directors.