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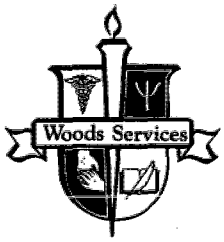

Woods Services

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INDEPENDENT REGULATORY
REVIEW COMMISSION

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Founded in 1913

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5/14/8

Dear Ms. Dixon,

Thank you for the opportunity to review the proposed rulemaking for Individual Support Plans for Individuals with Mental Retardation. I understand that this proposed rulemaking will affect programs operating under the 6400, 6500, 2380, and 2390 regulations under Chapter 55 of the Commonwealth Code of Regulations. On behalf of Woods Services and relying on input from senior administrators at Woods Services, I would like to offer some broad general observations, followed by more detailed specific feedback.

I. Multiple Plans for a Single Individual

From the information provided in the Pennsylvania Bulletin, it is not clear whether there is to be a single planning document for each individual or whether there is to be a separate planning document for each type of service. The introductory portion of the document would lead one to believe that there will be a single integrated document, however, revisions to the four separate sets of regulations seems to suggest otherwise. A slight disparity in time frames for completion of the first planning document also tends to suggest the retention of multiple planning documents (2380s require 30 day plan, but 2390 and 6400 require 60 day plan). The problem is that your intent is not clear. A reader can't really determine whether ODP intends to have a single planning document or plans to retain the separate documents. Please clarify.

Woods Services would like to endorse the notion that programming should be consistent across all of the areas, rather than unique for each area.

We would like to see the bulletin make clear that there is to be but a single planning document for each individual, regardless of the number of different services and supports he/she receives. On those same lines, there should be a single coordinator of these supports, not one for each service. Not only will this integrated approach reduce paperwork, it will help ensure that the various service and support areas are working in a consistent manner on behalf of the consumer.

Recommendation: Woods Services strongly recommends that, consistent with the integration of the 4 sets of regulations, that each individual have but a single, coordinated Individual Plan.

II. Supports Coordinator

This is an extremely troublesome area. Perhaps the regulations might be enhanced by clarifying who is to have a Supports Coordinator and who is not. Our agency supports many out of state individuals in our 6400, 2380, and 2390 programs. We would assume that the Commonwealth of Pennsylvania is not going to provide a Supports Coordinator for these individuals. While it seems pretty clear that a Supports Coordinator will be provided for individuals funded under a CMS waiver, what about those individuals whose supports are funded directly by the Commonwealth? Will they also have a Supports Coordinator? We would submit that the regulations could be enhanced by clarifying who is supposed to have a Supports Coordinator. Rather than writing a regulation that says the program specialist will complete the plan in the absence of the Supports Coordinator, delineate who is to have a Supports Coordinator, and for those programs, it should always be a Supports Coordinator who completes the plan. If whatever agency employs the Supports Coordinators is unable to fill a position, it should not fall to the provider to complete this task. To make that sort of request is to impose an unfunded mandate.

The role of the current program specialist has been changed drastically. A new primary role seems to be doing quality control on the work of the Supports Coordinator. They have to check the Supports Coordinators' work for accuracy and completeness, yet they have no supervisory control over the Supports Coordinator.

There have been significant problems with some of the Supports Coordinators with whom we have dealt. They do not complete paperwork in a timely manner. They don't really know the individual being served. They do not have the daily contact with consumers that our Program Specialists have. We simply cannot rely on them. The problem is that we, as a licensed provider agency, are held accountable for the work of a Supports Coordinator who does not work for us. If the Supports Coordinator does not complete a plan in a timely manner, it is our license that is placed in jeopardy. We have no supervisory control over the Supports Coordinator, but we are accountable

for their work. To avoid licensing deficiencies, our program specialists have taken to producing individual plans for individuals even if there is a supports coordinator.

Recommendation: It is the strong preference of Woods Services that the use of Supports Coordinators be entirely dropped. Barring that, let's limit their use to only those programs that are funded under a CMS waiver.

Recommendation: Provide specific clarification as to which individuals are to receive the services of a Supports Coordinator and which ones are not.

Recommendation: The regulations should clearly specify that a provider agency cannot be held accountable for the work of the Supports Coordinator. A provider's license cannot be jeopardized by someone who is not accountable to the provider.

III. Program Revision for lack of progress

Each of the sets of revisions contains the new provision that the individual plan will be revised when there is lack of progress towards an outcome. While this is clearly good program management, as it is written, it is too vague. Who is to determine what constitutes lack of progress, and by what criterion are they to make that judgement? Our concern is that this standard will become operationalized via the subjective impressions of licensing inspectors, and that the standard will vary from inspector to inspector and consumer to consumer. Also to be considered is that it is conceivable that some teams will write underestimated goals, such that progress will always appear satisfactory. This was the experience in various programs that attempted to implement Goal Attainment Scaling as a means of evaluating programs.

Recommendation: State that the program is to be revised when in the judgement of the team, progress is unsatisfactory.

IV. Use of the Language

These comments may seem picayune, but there are a couple of minor points regarding the use of language that were particularly irksome.

Use of the word "Outcome" - Throughout the regulations, the word, "outcome," is used a most curious way. One does not implement outcomes. One implements services, programs, and supports. The product of implementing said services, programs, and supports is an outcome. One might argue that ODP is unnecessarily complicating the language by using the term 'outcome' in a novel manner. Consider that when a physician prescribes an antibiotic to fight an infection and restore your health, he/she is not implementing your good health (i.e., the outcome), but rather a treatment that leads to your good health (the outcome). One cannot implement an outcome. Goal is a more accurate term. The attainment or non-attainment of a goal is an outcome.

Use of Acronyms – We are pleased to see the demise of the I_P acronyms for our service plans, however, it is not clear that adopting the acronym IP is really any better. We obscure so many simple things with our penchant for letters rather than names – Wouldn't it work just as well to call the document a "service plan?" Or better yet, a "plan?" Wouldn't it help family members if we entirely banned the use of acronyms and required the use of simple English?

Use of outdated terms - In your title, you refer to the plan as an individual support plan, but you have eliminated this term everywhere else in the draft regulation. In the title, you also use the outdated term, mental retardation, instead of the more current intellectual disability.

Recommendations: 1) use the word "goal" rather than 'outcome," 2) avoid all use of acronyms as if they were fleas carrying bubonic plague, 3) use contemporary language when referring to persons with intellectual disability, even if this use requires a parenthetical explanation to be consistent with commonwealth laws.

Specific Comments on revisions to 6400 programming Changes

6400.44 – Program Specialist – First off, congratulations for getting rid of the non-word – ensurance. In this section, ODP has basically modified the responsibilities of the program specialist.

- What specifically do you mean by the word "supervising" in responsibility #1? Does the word refer to a general responsibility, or are we talking about direct supervision? Is it implied that the program specialist must be part of the provider's management structure, such that they may order and direct the activities of direct care staff? Given that a program specialist may work in multiple sites and typically for only 8 hours a day, it would be impossible for a program specialist to "supervise" the provision of supports and services. They could monitor or oversee this, but not supervise.

- #6 – It seems that a significant function for the program specialist is to be a watchdog for the supports coordinator. Program specialists, who will have absolutely no supervisory authority over Supports Coordinators, should not be asked to perform what amounts to supervisory activities with regard to Supports Coordinators.

- #7 – One does not implement outcomes. One implements services, programs, and supports. The product of implementing said services, programs, and supports is an outcome. This new usage of the word

"outcome" is unnecessarily confusing. The misuse of the word outcome also appears in #11.

Recommendation: Because the word "supervise" may carry some precise meanings to Human Resource professionals, we would suggest that it be replaced with "oversee" or "monitor."

Recommendation: Eliminate the use of Supports Coordinators. Barring that, make the supervision of Supports Coordinators a responsibility of the agency that employs them, rather that the provider's program specialist.

Recommendation: Replace "outcome" with "services, programs, and supports." One does not implement an outcome.

6400.45 Staffing – Sections d and e are kind of intimidating because they leave no room for error. If a team says that an individual needs 1:2 staffing, we have to provide it no matter what. It won't matter if there are call outs, emergencies, hospitalizations or anything else. In fact, one could argue that a provider would not be allowed to increase supervision levels for a temporarily suicidal client without being in violation of his/her plan. These regulations force a provider to guarantee a staffing level. Under current conditions, we have always well exceeded the minimum staffing ratios, but retained the flexibility to adjust as needed. This regulation takes away all of our flexibility. Thus, we not only have the legal liability for our staffing, but we will now have a licensure liability. On the other hand, I suppose that we could simply write that a given client needs at least 1:8 staffing and thus always be in compliance.

Another problem is that this regulation places staffing level decisions in the hands of the teams rather than the administrators. This may be fine in a Pennsylvania waiver program where there is a plan to link support needs to funding levels, but one must recognize that there are a number of agencies licensed under the 6400 regulations who serve individuals not funded under the Pennsylvania waiver plan. For these individuals, there is no provision to link support needs to funding level. Our concern derives from the experience that teams are often quick to request additional staffing as a solution to a problem, rather than making program support and service changes. You have vested sole authority for determining staffing levels with the team members. This regulation has the potential to be a massive fiscal drain on non-waiver programs when teams gradually come to realize that they can order increased levels of staffing to resolve every issue.

At a final and more practical level, let us consider the 3 person CLA, in which the teams have concluded that one person needs 2:1 staffing, one needs 1:3, and another needs 1:2. How many staff would I have in the building? Clearly, I could meet the needs of the 2:1 individual by assigning two staff to that individual, but if

I add a single additional staff, I would be over-supervising the individual who needs 1:3.

Recommendation: Establish minimum staffing ratios and hold the providers accountable to these minimum ratios. Providers will be able to increase staffing level based on need. Do not place the determination of this need solely in the hands of team members.

6400.122 Development of the Individual Plan – In this section, you state that in the absence of the Supports Coordinator, the program specialist will develop the plan. Why would the employee of a provider agency take on the unfunded responsibility that per regulation belongs to some other agency? In a sense, the employer of the Supports Coordinator would be getting paid for the work of the provider agency's program specialist. There is a complete lack of clarity regarding the relationship between Supports Coordinators and Program Specialists. It is not even clear who is to have a Supports Coordinator.

It is a little difficult to ascertain what the Supports Coordinator really brings to the process. The program specialist still does the bulk of the written work (and in the absence of the Supports Coordinator, does the work of the Supports Coordinator), and they must check on the accuracy of the Support Coordinator's work. In what way does the Supports Coordinator enhance this process?

The regulation notes that medical specialists must be listed as team members. The regulations then later state that all team members must receive a copy of the plan. Does this mean primary physician, psychiatrist, and other specialty physicians? That seems excessive and unnecessary. One of our psychiatrists has a caseload of over 170 individuals, and I can't imagine what he would do with 170 plans, other than report our agency to Al Gore for having such a large carbon footprint.

Recommendation: The Program Specialist should not be responsible for completing or checking the work of the Supports Coordinator. The provider agency employs the Program Specialist is not being paid for this work, but the agency that employs the Supports Coordinator is being paid for the work.

Recommendation: Eliminate the position of Supports Coordinator. It is redundant with the program specialist.

Recommendation: Specify that medical specialists do not have to be provided with a copy of the plans, unless they specifically request to be copied.

6400.123 – Review

- On c1 and c2 and c3, ODP has continued the unusual use of the word outcome, and it makes things unnecessarily confusing.

- On C1, ODP notes that the Individual Plan shall be revised if there has been no progress on an 'outcome.' How is the absence of progress to be defined? This seems like are area that will be beset by subjectivity and provider-licensing inspector dispute. Let us also consider that there are some situations in which we are seeking an outcome of maintaining current levels of functioning. Would maintenance be seen as a lack of progress? The issue is that different people will define progress in different ways. I think the idea is most admirable – if the program, service, or support isn't working, change it. This is really just a restatement of the old Marc Gold "try another way.' The problem is that absent a clear definition of what is meant by no progress (and who gets to define what is no progress), this creates a threatening position for providers. Would it not make sense to add, when in the judgement of the team, there has been no progress on an 'outcome' (sic).

- We note that the responsibility for these reviews falls to the program specialist, rather than the Supports Coordinator. We would suggest that a Supports Coordinator could not effectively do his/her job without conducting such reviews, and that if a Supports Coordinator exists, they should conduct the reviews.

Recommendation: Please avoid using the word 'outcome' to reference processes.

Recommendation: Please clarify that it is the team and only the team that can make a determination of the lack of progress. The notion of changing programs, services, or supports in the face of unsatisfactory outcomes is appropriate, but the evaluation of an outcome can only be done within the context of a thorough knowledge of the individual.

Recommendation: If a Supports Coordinator exists, all monthly, quarterly, and other program reviews should be done by that individual.

6400.124 – participation in the development of the IP

- As written, the program specialist is responsible for doing the invitations to team meetings. If there is a Supports Coordinator, it would seem to be the responsibility of the Supports Coordinator. It is their meeting.

Recommendation: If there is to be a Supports Coordinator position, change the responsibility for sending invitations to team meetings from the Program Specialist to that Supports Coordinator.

6400.125 – Content of the Individual Plan

- a1 – This unusual use of the word "outcome" is distracting. Outcomes don't address needs. They may reflect satisfied or unsatisfied needs, but they certainly don't address them. ODP is inadvertently complicating the English language, and some of our staff have trouble understanding it as it

is.

- 5 – Just how formal is ODP looking for a schedule of periods of time to be without supervision? ODP has taken out all the opportunities for creativity. 'Well, we were all going to go to a movie, but you can't come because you have to be unsupervised now.' There has to be a little more flexibility here. Having a schedule will eliminate spontaneity if adherence to the schedule will be monitored by licensing inspectors.

- Somewhere in this section, it is absolutely imperative that mention is made that goals (or as ODP would say, outcomes) should be objective, observable, and measurable. Without that statement, you'll end up with the fuzzy meaningless language of the mental health system.

- It would seem that the best program to reduce the use of a restrictive procedure is exactly the program that is designed to reduce the frequency of the behavior that legitimately requires the implementation of a restrictive procedure. As written, the regulation implies that staff are routinely abusing consumer by applying restraints and other restrictive procedures in an unnecessary manner. This has not been established as the case. Why not just say that for any individual who have a restrictive procedure in his/her program, there must be a program to reduce the frequency of the target behavior for which the restrictive is applied? While we all may wish to eliminate the use of restraint and restrictive procedures, achievement of that goal would be empty if the behaviors that legitimately warrant restraint use remain. The goal must be to eliminate behaviors that legitimately warrant restraint use, and in doing so, we will eliminate restraint use.

- General question – if you have a supports coordinator and they are not performing up to regulatory standards, what are the ramifications for the provider? It seems that the provider still will get in trouble during licensing inspections. They can't control the work of the support coordinator, but if the supports coordinator fails to perform at a satisfactory level, the price will be paid by the provider. Based on our experience with Supports Coordinators, a provider agency is well advised to do all the work themselves. It is the only way to control their risks.

Recommendation: Please use the word 'outcome' to refer only to the products or results of programs, services, or supports, and please avoid using the term to refer to programs, services, or supports.

Recommendation: Clarify what is meant by a schedule of periods of time without supervision. Instead of saying that there must be a schedule, why not say that the provider shall schedule periods of non-supervision as appropriate.

Recommendations: Add a statement that specifies that goals must be objective, observable, and measurable. This is an imperative!

Recommendation: In reference to individuals with restrictive behavior modification procedures, please change the requirement from having a plan to reduce the use of the restrictive procedure to having a plan to reduce the frequency of the behavior that necessitates the use of the restrictive procedure. Arguably, it would be neglect to fail to implement an emergency procedure when situations legitimately warrant the use.

Recommendation: The regulations should specify that the provider agency cannot be held accountable for the misdeeds and inactions of a Supports Coordinator.

6400.163 - Use of prescription medications – The term 'maladaptive' is a bit of an anachronism with respect to behavior. Most people now recognize all behavior (good, bad, indifferent) as being adaptive. That is why people adopted the euphemistic word, "challenging."

Recommendations: Delete all references to maladaptive behavior. Replace maladaptive with challenging, socially devalued, socially unacceptable, dangerous, or assaultive.

Comments of Proposed Revisions to the 2380 and 2390 Regulations

I've already put you through reading an exceptionally long document. There is considerable overlap among the 6400, 2380, and 2390 regulations. In an effort to minimize your eyestrain, I'm not going to repeat comments from above that would pertain to all three sets of regulations. I shall only offer comments on points that are unique to these regulations.

2380.103 –

- I note that in the 2380 regulations, the plan must be developed within 30 days, whereas under the 6400 regulations and the 2390 regulations, the plan must be developed within 60 days. Would there not be a good reason to have the same time frames, particularly for those people who live in a 6400 home and attend a 2380 program?

Recommendation: Adopt the 60 day time frame across all of the sets of regulations

2380.123 – Use of prescription medications

- Please clarify the applicability of this regulation. Unless the medication were to be administered at the 2380 program, why would the 2380 program even know that the person was on medication? The medication standard seems to be more of a residential standard. My concern here is that it is conceivable that the 6400 team will develop one place to address the social, emotional, and environmental needs of the client, while the 2380 team will address something entirely different.

Recommendation: Please clarify that there will be a single plan in effect for each individual, and that this plan will encompass all areas of his/her life.

2390.97 – Review

- This standard proposes more frequent reviews than the other plans. While I think the training program review frequency makes some sense, for those clients who basically just have a job, why do we need to review their work performance more frequently than we have to review psychotropic medication?

Recommendation: adopt a common time frame for all reviews unless a specific need is identified for more frequent reviews.

Once again, let me thank you for the opportunity to offer feedback on these proposed changes, and let me apologize for the length of the document. Please feel free to contact me at 215-750-4015 with any specific questions you may have about this feedback.

Sincerely,

Scott Spreat

Scott Spreat, Ed.D.
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