**OPRA Comments on Draft Behavior Support Rule**

The Ohio Provider Resource Association (OPRA) is a statewide association of providers of services to individuals with developmental disabilities. Our mission is to support and provide advocacy for community-based service providers to ensure the availability of programs, services and funding adequate to support and assist individuals with developmental disabilities as they strive to achieve a life of increasing independence, productivity, and integration.

We appreciate the opportunity to comment on the April 9th draft and again want to formally recognize the time and effort that has been devoted to the development of this rule. We thank you for taking our previous comments into consideration when working on this latest draft. The advisory committee has struggled with challenging and complex issues. The discussions have been productive and we believe this version of the rule mandates respectful and person centered services; while at the same time allowing for reasonable interventions to prevent harm. Below is a summary of responses from the OPRA membership.

**(C)(11)(a): Manual Restraint:** This provision stipulates that the individual in restraint must be under constant visual supervision by staff. Is more than one staff person necessary in this scenario since the person implementing the restraint will be able to see the individual?

If a staff person steps in between 2 people who are becoming aggressive with one another (with or without a wheelchair), is this considered “blocking” under this rule? This has not historically been considered a manual restraint.

**(C)(11)(b): Mechanical Restraint:** “except a seat belt of a type found in an ordinary passenger vehicle or an age appropriate child safety seat” is too narrow a definition and doesn’t take into account mechanical supports necessary for proper positioning and/or safety. As it is worded, a seatbelt or harness in a swing (for example) meets the definition of mechanical restraint as do many other devices used specifically for support/safety.

**(D)(2): Manual, Mechanical, Chemical and Time-Out:** Should this provision also include the possibility of legal sanctions?

**(D)(8)(b):** This provision requires written submission to the HRC of a written rationale that indicates risk or likelihood of sanction in observable and measurable terms. In practice, it might be difficult to construct a rationale that contains measurable terms, but we do understand the underlying concept for the rationale to be as objective as possible.

We have stated our opposition to the inclusion of ICF’s in previous comments. We would prefer that ICF’s continue to operate under federal standards and remain concerned about additional and onerous regulations that add no value to the services. We believe that ICF’s should operate under a different set of standards as is being contemplated by the DODD/ODH Streamlining Work Group. That being said, this version of the rule does comport more closely with ICF regulations than previous versions. We offer the following comments specific to ICF’s.

**(C)(11):** The term “of last resort” gives the impression that restrictive measures are always used when nothing else has proven successful. There are certain behaviors that are extremely dangerous and require immediate intervention in order to keep people safe. The distinction as to when a restrictive measure is appropriate is based on assessment and team discussion, not an arbitrary end of the line option. We request some clarification.

**(C)(11)(a)(b):** The CMS regulations state: “The use of restraint for health-related protection must be prescribed by a physician and used only during the time the active medical condition exists”. This language could be substituted for the “does not include” language in the current draft.

**(C)(11)(c):** We request that language be added indicating that any use of time out exceeding the stated limits need to be reported as an MUI. Although the rule does state this in another section, we believe it is important to stress this point.

**(C)(11)(d):** CMS uses the following language regarding chemical restraint: “Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team and be used as an integral part of the individual’s program plan which is directed specifically toward the reduction of and eventual elimination of the behaviors for which the drugs are employed”. This is a slightly different take on medication from the chemical restraint definition used in the current draft and the definition that ICF’s use.

**(D)(6)(a)(b) Development of a behavioral support strategy that includes restrictive measures:** ICF regulations give the responsibility for writing behavior support plans to the QIDP. Industry standards require the ICF to have a contracted psychologist, but the QIDP is responsible for authoring the plans. QIDP’s may not meet the requirements of (D)(6)(a) or (b). Therefore we propose the addition of:

***(c) For ICF/IID, meets the requirements of a “Qualified Intellectual Disability Professional” as defined in 42 C.F.R. 483.430.***

**(F): Human rights committees:** As we have stated in previous comments, the HRC membership requirements as listed are simply not attainable. Members consistently report great difficulty in meeting the current requirements, which are considerably less onerous than those listed in the draft. We recommend keeping the HRC structure as it currently exists in federal regulations. There was some confusion regarding the involvement of county boards on ICF HRC’s. Is the interpretation that they are separate and distinct - not joint committees - correct?

**(F)(4)(5): HRC department approved training:** Again, there were numerous comments on this provision. The language does not specify the length of training, which could be extremely problematic once DODD develops parameters. As the rule currently exists, it is difficult enough to find volunteers for HRC’s. Adding additional time for a volunteer seems counter-productive to the establishment of full and functioning committees as it will make it that much harder to recruit and retain members. What is the expectation for training of individuals receiving services who serve on HRC’s? Is DODD going to specify a curriculum or are providers free to develop their own?

**(J) Analysis of behavioral support strategies:** This imposes yet another set of requirements on volunteers and adds yet another regulatory based process for ICF’s. We agree that individual plans need HRC oversight but disagree that this over-arching analysis will benefit the system or those receiving services.

**Additional DODD ICF reporting and oversight:** As noted above, ICF’s are currently regulated by ODH via CMS regulations. We oppose any additional reporting, oversight or conflicting regulatory provisions that are contained in the draft rule.

Again, thank you for the opportunity to comment. We look forward to working with you to ensure that quality supports can be provided while lessening the administrative burdens and reducing and/or maintaining the current costs of behavior support planning and implementation.