**OPRA Comments on the Draft Behavior Support Rule: 5123:2-2-05**

We appreciate the opportunity to provide feedback on the draft Behavior Support Rule. This is being extracted from the County Board Administration rule and proposed as a stand-alone rule. Are there additional changes to the County Board Administration rule? If so, we would like to review those as well. It is our understanding that this is not a licensure rule. If that is true, in what settings would this apply? ICF’s are regulated by both state and federal laws and regulations. The addition of another set of conflicting rules does not comport with our goal of realizing efficiency and simplification of the service system.

**Comments on Specific Provisions:**

(C) (9) Specialized Services: Language has been added that differs from the definition in other rules. What is the purpose of a DODD determination? Is this meant to be a euphemism for behavior support services? H/PC? Waiver? ICF?

(C) (11) Trauma informed care: This is a new concept that is not widely understood. Need DODD training and standardized training materials for providers to use.

(D) (2) (b) (ii) We received numerous comments on this provision. The two tier dichotomy between entirely positive and “restrictive” techniques is too simplistic. This rule seeks to lump all restrictive techniques together, which equates risky techniques like restraint with low risk techniques like some forms of rights restrictions, which often involve logical and natural consequences. Some rights restrictions can be justified even when they do not involve “imminent risk of harm”, and can be used successfully to help people achieve a good quality of life. If low level rights restrictions are in essence regulated out of existence, associated learning cannot take place. One solution would be to consider an intermediate level of risk, where some restrictive measures can be implemented, but must be regulated, in situations where there is not an imminent risk of harm. Who will make the determination of “very likely to begin causing physical harm”?

(E) (1) Need to refer to and clarify the parameters for the add-on. There have been issues wherein if included in the plan, it was not considered a BSP and therefore not eligible for the add-on.

(E) (2) It appears as though this provision adds another QIDP and SSA responsibility – the writing of the BSP. The language “shall” eliminates the ability of this to be delegated to others? We received numerous comments on this clause. It is highly problematic in that it seems to hand over the development of the BSP exclusively to personnel who are not typically prepared or trained to develop them, while at the same time preventing trained and qualified personnel (such as psychologists and behavior support specialists) from BSP development. A later section of this rule (E) (7) (c) (i) through (v); stipulates that assessments must be done by persons with clinical credentials, such as psychologists. While maybe not intended, the proposed rule pretty much guarantees that those who conduct the assessment are not the same people as the ones developing the plan. This adds complexity and cost. We recommend as best practice, that the assessor and plan developer be one in the same when at all possible.

(E) (4) Getting cooperation across all settings has its challenges. This concept needs to be included in any DODD training. Is the intent to have a single plan across all service settings?

(E) (4) (d) This provision appears to eliminate the requirement that BSP’s be approved by a Behavior Support Committee. We understand and support the review by the HRC, but have found the technical/clinical perspective of the BSC’s to be valuable.

(E) (4) (f) Why is an administrative resolution necessary? Individuals and guardians have the right to refuse to consent to the plan. This process seems unnecessary and time consuming.

(E) (7) (c) (i) through (v) The proposed qualifications for conducting behavioral and risk assessments are overly restrictive and costly. It is difficult to find people with the qualifications as detailed, especially in smaller counties. The requirement that the behavioral assessment be conducted by “persons who have the experience necessary to perform psychometric tests” is not understood. Psychometric tests typically measure knowledge, abilities, attitudes and traits and these tests are often irrelevant to the task (conducting a functional behavioral assessment) and they often have limited or no application to persons with intellectual disabilities. Persons who do these assessments should have the experience and training necessary for the specific assessment. Rather than requiring both assessments, we recommend requiring a functional behavioral assessment that includes some description of risk issues. We also request clarification as to the type, extent and frequency of evaluation required.

(E)(7)(d) If the BSP is becoming less restrictive, why is there a need to seek approval by the HRC? This is time consuming and unnecessary provision.

(E) (7) (g) Not sure what this means. Under what circumstances is the department to be notified? When the team approves? Every time the plan is implemented? This is an additional requirement and the reasoning is not at all clear.

(G) (8) It is probably more accurate to label this as “exclusionary time out”. There are forms of time out that do not involve confining an individual to a room and which should not necessarily be prohibited.

(G) (11) We believe that some rights restrictions can be justified, providing the necessary safeguards are in place, even when there is no imminent risk of harm. In addition, we request clarification as to physician recommendations/orders as to smoking schedules and diets.

(I)(2)(a) Our members report that sometimes getting one individual who receives services on a HRC can be difficult, especially if the population served is medically fragile or non-verbal. It is also difficult to find guardians who have time and are willing to participate. How is this to be accomplished? How will this work for ICF’s who have historically had their own internal committees and do not have county representation? Will ICF’s be permitted to maintain their own HRC’s?

(I)(3)(c) This is an overly burdensome requirement. Is the intent to include restrictive interventions that occur at dental/medical visits? These visits happen infrequently. Many committee members are volunteers who are not going to be able to commit to a quarterly review schedule. Reviews held this frequently are not likely to add enough value to justify the time involved. We recommend annual, rather than quarterly reviews.

(I)(3)(e) Some restrictive techniques may in fact be needed for years. It is appropriate to assume that they are not needed for life, but “temporary” is ill-defined and open to inconsistent interpretation. Are items such as bus vests considered restrictive and subject to quarterly reviews?

(I)(6) Department approved training is a new mandate. Who is providing and how will the cost be covered? Finding family members and other volunteers willing to do this will be difficult.

(J)(3) We ask that this be deleted and completed as part of compliance reviews.

**General Comments**

There are 3 different provisions for review. (E) (6) “at least every 12 months” (E) (7) (h) “at least every 60 days” (I) (3) (c) “on a quarterly basis” Can these be re-drafted to allow for better coordination of the review teams?

There are several provisions in the draft that conflict with federal ICF regulations. One example is:

*ICF Condition of Participation: Facility Staffing*

1. *Standard: Qualified Intellectual Disability Professional. Each client’s active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who –*
2. *Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and*
3. *Is one of the following:*
4. *A doctor of medicine or osteopathy*
5. *A registered nurse*
6. *An individual who holds at least a bachelor’s degree in a professional category specified in paragraph (b)(5) of this section*

Federal regulations defer to the provider for the provision of active treatment and behavior support services. Please clarify if and how this rule might impact ICF’s.

There are many new requirements outlined in this rule that will add cost and administrative time to the provider community. We look forward to working with you to insure quality behavioral supports are provided while lessening the administrative burdens and reducing and/or maintaining the current costs of behavior support planning and implementation.