

SERIES 11 BEHAVIORAL HEALTH CENTERS LICENSURE

§ 64 CSR 11

WEST VIRGINIA BEHAVIORAL HEALTHCARE PROVIDERS ASSOCIATION

COMMENTS ON THE PROPOSED RULE, JULY 24, 2007

1.6 Purpose:

The new words added to this section “traumatic brain injuries” have not been included in previous rules. The majority of behavioral healthcare providers has not served individuals with traumatic brain injuries in the past, and would not know how to meet their special needs unless described elsewhere in this Rule.

3.1.a. Physical Abuse:

This definition should be made consistent with definitions of physical abuse which are already in statute under the DHHR protective services requirements.

3.13. Consumer Record:

Language which allows only a written and signed record should be adjusted to allow for the evolution to electronic medical and clinical records.

3.15 Critical Incident:

The language here should be changed to reflect that the requirements would be consistent with incidents occurring in a 24 hour licensed residential setting. Critical incident reporting would not be an appropriate requirement for those who access services for short period of times during the day or month on an outpatient basis. Nor is there any distinction drawn between requirements related to incapacitated individuals or individuals emancipated.

3.15.j. Dietary or Medication Errors:

The word ‘potential’ should be removed. It is too subjective a term. A single dietary error for instance does not generally cause true harm to an individual.

3.25. Individual Support Plan:

The language here models language elsewhere in the Rule related to requirements for treatment plans. However, it does not allow for fewer documentation and record keeping requirements now recognized by the Bureau for Medical Services and APS Healthcare reviewers for what are known as ‘low end services’.

3.31 Neglect:

1) The definition here is not consistent for neglect as found elsewhere in Code related to DHHR protective services requirements.

2) This definition of neglect is too subjective, and will result in undue hardship for agencies and staff. A proper definition of neglect should include mention that the wrongful act or acts resulted in placing the consumer at risk for injury or for death.

3) In addition, neglect should not apply only to a single incident, but rather should be applicable to 'intent,' to 'repeated instances,' or to a 'pattern' of findings.

3.31.a. Failure to carry out an individual support plan:

A pattern of findings should support the determination of neglect, rather than single instances of not following through on the individual support plan.

3.31.b. Failure to provide adequate nutrition, clothing or health care:

A pattern of findings should be required rather than single instances.

3.31.d. Failure to follow written center policies and procedures:

More definition or examples are needed here, or else there should be a pattern established of failing to follow policies and procedures. If one fails, for instance, to fill out internal paperwork as specified in policy, this constitutes neglect?

3.49 Staff:

This needs to be clarified. Staff on the agency's payroll is different than individuals having a contractual relationship. Nor does the section make a distinction regarding 'difficulty of care' payments recognized by State and Federal officials in years' past.

3.54 Treatment Plan:

Treatment Plan requirements should differ for those who are enrolled in 24 hour services or for individuals for instance with developmental disabilities who would have specific habilitation requirements tied to measurable goals and objectives. This language at 3.54 does not make accommodation for those receiving low end services on a limited outpatient basis.

3.55 Triage:

Triage is typically reserved for inpatient medical clinics and hospitals but not for licensed outpatient behavioral healthcare sites.

4.2.a. License Application: Costs:

It is nearly impossible for not for profit agencies to demonstrate six months' of operating expenses are on hand, either to open a new program, or to renovate or expand an existing center. This is excessive.

4.2.a. Licensing Application: General Requirements:

Licensing staff should not address these issues as found listed here. These are requirements already with the Health Care Authority application process to make a determination before finding that a service is needed or necessary. It is duplicative of HCA requirements.

4.2.b. Licensed Sites:

The Rule should define which kinds of sites, for instance, individual's own homes, do not have to be licensed by the State even though in homes services such as those related to the MR/DD Waiver are delivered there.

4.2. d. The new fee schedule being proposed is too high compared to the current fee. Who sets the fee and on what basis is the fee schedule set?

4.2.e.3. Renovations or conversions of facilities should be the purview of the Health Care Authority, not licensing. This is duplicative.

4.2.f. The penalty proposed here should be the purview of the Health Care Authority. They issue Orders to close or to cease operations if healthcare entities have exceeded the terms of the service being offered or the sites offering those services.

4.3.c. Licensing fee:

The licensing fee here of \$ 500 is excessive compared to the current \$ 10 fee which is paid only every two years. Why is this increase necessary?

4.3.d. Cost per bed:

The proposed fee of \$ 25 per bed in addition to the fee for centers without beds is excessive and will force providers to consider closing community based beds in which case more individuals will end up in state hospitals or in diversionary beds in private hospitals.

4.5 Construction and Renovation:

Some of the requirements in this section should be regulated by the Health Care Authority, not licensing which is responsible for health and treatment services.

The added cost implied for contracting architectural and structural and engineering services, not previously required in this Rule, particularly for renovations, will all but preclude small, not for profit licensed behavioral healthcare centers and agencies from renovation or improving any existing properties due to cost considerations. Under the existing Rule we believe licensed contractors are acceptable for additions and renovations.

4.5.b. Conducting a safety risk assessment or an infection control assessment, for instance, for renovations such as new carpeting in offices or in the building is excessive to say the least.

4.5.c.1. It is fine to require licensed agencies to conform to existing state or local zoning requirements or to state Code requirements. It is not practical in a rural state such as ours to locate needed services in approved sites close to centers of population or near medical staff or facilities, or existing transportation services. Many licensed centers have satellite offices in very small communities in their rural counties in addition to the main center office and service sites.

4.6.f. Inspectors sometimes seek to inspect private residences. This Rule should specify that private residences are not to be considered licensed sites operated by the centers.

4.6.j. Contested findings:

Clear rules should exist in writing in this section regarding the informal dispute resolution process: Providers need to know who can be present for each side, if lawyers may participate, if a statement of deficiencies or plan of correction must be agreed upon before the proceedings can be initiated, and timelines for all of the appeals and required documentation should be in writing in this Rule.

4.7.c. Complaint investigations:

Providers are not always advised of the general nature of the complaint being investigated. This violates their due process right to know the concern rather than to be subjected to something little more than a fishing expedition. In earlier Rules this section required Health Facilities staff to specify the actual reason for the complaint so that the scope of the review remained focus on that circumstance, and that the review of operations did not become a fully involved licensure review.

4.9 Plans of Correction:

4.9.a. Please delineate what ‘variance’ means and on what basis, or under what circumstances a provider might request one, or the Secretary might grant one.

4.9.b. Directed Plans of Correction:

Directed Plans of Correction are sometimes made a requirement for providers in this section of the Rule. However, this Rule never previously, nor does it currently, propose any language regarding a 'directed plan of correction.' Rather we believe this is a concept borrowed from Federal certification activities applicable in nursing home settings, and regulated under Federal Rules. This Rule is a state-only, behavioral healthcare licensing Rule. Certification activities do not apply to licensed WV behavioral healthcare sites.

4.9.g. Findings Available for Review:

It is fine to require centers to post notice that official records are available for review upon request. However, results of investigations, particularly internal investigations, are not public record and should not be posted for review. This would create an undue liability issue.

4.11.a. Penalties:

'Civil penalties' is something which has never appeared in this licensure Rule in the past. We also believe the concept was meant to be 'civil monetary penalties.' However at any rate it is a concept borrowed from the Federal certification activities related to the regulation of Medicare or Medicaid-participating nursing facilities. In addition, no civil monetary penalty amount or range of amounts is specified in this section of the Rule making the assessment of a civil monetary penalty a completely subjective determination.

5.2 Governing Body:

The governing body should not 'set policy' as stated in this portion of the Rule. The Governing body should hire an administrator who is required to carry out the day to day operations as specified by the Board. Boards should govern only, and this role should be distinguished from the operations role which is given to center management. In the previous Rule, this description of Governing Body responsibilities was instead found under the section entitled "Administration" which we believe is where it rightfully belongs.

5.2.d.7. Governing bodies should not have to see to it that a policy and procedure manual is maintained. That is the role of 'administration'.

5.2.d.8. Governing bodies should not have to see that policies and procedures are available to all staff in all programs. That is the role of 'administration.'

Policies should be available to all staff in all programs as appropriate to their assigned duties. Fiscal and business policies for instance, would not routinely be made available to direct care program staff.

5.5. Fiscal Protections:

Centers should be protected from being placed in the position of being accused of ‘abuse’ as has happened with licensure visits in instances where incidents occurred related to writing checks on behalf of clients, or otherwise managing their funds. The Rule here does not distinguish under fiscal protections what is abuse as compared with what is an incident.

5.5.a. Purchase of Insurance:

Centers should not be required to purchase automotive liability. Centers instead should be required to assure that those who drive vehicles on behalf of work, and as related to their job functions, are in compliance with state vehicular insurance laws.

5.6.f. Bonding:

The Rule should require only that bonding is obtained in an amount sufficient to handle client funds. The Rule goes too far when requiring ‘in an amount not less than \$ 2500.’

5.7.e. Discrimination:

The Rule language here should reflect the same language as is currently required by Federal definition of protections to be afforded under ‘equal employment opportunities.’

5.7.g. Reporting:

Reporting should be limited to reports as required by state law. This section of the Rule has been over-interpreted to the extent that ‘every thing’ is reported, leaving providers to guess what is reasonable to report and what is excessive when having to report.

5.7.h.1. Release of Information:

The Rule should seek to specify the effective date of the release, when the release expires, to whom information can be released, and under what circumstances. It should also specify when the release expires, requiring the renewal of the release.

5.8. Relationships with Other Centers:

The Rule here should require that centers ‘demonstrate’ good faith effort to obtain written agreements or contracts. In some instances centers cannot compel external organizations to enter into signed agreements.

Parts of the language in this section appear to apply to individual contractors, not other licensed healthcare facilities although the section of the Rule conveys that it should apply to ‘other centers’ only.

5.8.a.9. External Entities:

The proposed Rule here is unreasonable. In some instances, independent contractors are not employees of a licensed center. The Rule language should be adjusted to reflect that independent contractors conform with licensing standards as established by their state regulating Board or Authority, such as the Board of Nursing.

5.8.b. “Contracted Employees:”

The language proposed in this section is erroneous. One cannot be a ‘contracted employee’. Contractors have independent status while employees are governed by licensure requirements. Contractors and employees are viewed in different fashion by employment law and by IRS determinations regarding ‘employees’.

5.8.c.3 Refusal to Provide Services:

The proposed language in this section of the Rule is failing to recognize that individuals sometimes engage in what is known as ‘doctor shopping.’ Refusal to provide additional services would be appropriate.

In addition, some consumers receive services at other agencies as authorized by the APS Healthcare prior authorization process under Medicaid. If consumers have received the maximum allowable amount of service under the authorization at another center, there should not be an expectation that they can continue to approach other centers to receive care which would not be reimbursed at all by Medicaid.

5.9.a. Employment and Personnel Policies:

Licensure staff should not be regulating workers comp and unemployment rules. This is the purview of other state agencies overseeing employment law in West Virginia.

5.9.c. Background Checks:

It is unreasonable to expect background checks from all 50 states. There is no known mechanism for doing a national background search. In WV the State Police background check is limited to WV residents. The cost of checking with 50 states would be prohibitive.

5.9.c. ‘Contracted Employees:’

This is an incorrect term. One cannot be an external contractor and an employee.

5.9.c.1. Proposed List of Convictions or Offenses:

1) Some of the items on the list would not limit one’s ability to work in a billing office for instance, and not having client contact.

2) Other items on the list, if the conviction occurred 10- 20 years ago, would no longer be relevant, such as ‘domestic battery’ for instance.

3) Centers should not be asked or expected to conduct background checks on independent contractors who also happen to be the parents of individuals for whom they receive state funds to delivery care or oversight. If a parent does have a past conviction, what then would the center be expected to do in the way of a remedy?

4) The applicable list used by Health Facilities licensing requirements should be exactly the same as already recognized and placed in state statute for purposes of Adult Protective Services and Child Protective Services oversight activities.

5.9.d. National Sex Abuse Registry:

There is no national registry.

5.9.e.3. References:

This proposed Rule is too restrictive. Some agencies may not require references for every level of staff. The Rule should propose that each center have and follow its own policies as regards references.

5.9.e.5. Verification of Job Requirements:

The Rule here is too prescriptive. Being qualified to do one’s job should be the role of internal and external peer review, or payor requirements. The Rule here is outdated and does not reflect state of the art practice.

5.10.a. Orientation:

The words ‘these shall be kept current’ should be omitted. Orientation only occurs on a one-time basis.

5.10.b. Direct Care staff:

Please define what is meant as ‘direct care staff.’ In the past this has been the subject of disagreement.

5.10.g.2. Qualifications:

The Rule here is overly prescriptive. It is in conflict in some regards with other standards already in place under WV Medicaid rules regarding those permitted to conduct clinical evaluations, or those permitted to offer supportive counseling.

5.10.3. Qualified Practitioners:

It would be sufficient here to say ‘qualified’. It is not necessary to say ‘or fully credentialed.’

5.11.c. Timely Access to Records:

The Rule is too vague and subjective. What would be considered ‘timely?’ In addition, records are to be made accessible to whom?

5.11.d. Record Retention:

The Rule should reflect medical records’ retention requirements elsewhere already in WV Statute, or else by national HIPPA requirements governing records.

5.11.h. Records Safe from Loss:

Until electronic records are fully permitted in WV, there remains the possibility of loss due to fires, explosions, and flooding.

5.12.a. Quality Assurance:

The proposed Rule is too prescriptive when requiring peer review, health and safety review of all facilities, reviews of outcomes. The Rule should allow individual centers latitude to interpret ‘quality assurance’ measures.

6.1.b. Evidence of Adequate Insurance:

The Rule is too prescriptive. It is already a requirement under WV Law that drivers be licensed and have insurance coverage. Centers cannot continue to monitor employees on a daily and monthly basis one’s evidence of insurability.

6.2 Physical Environment:

1) Although the standards prescribed herein may be applicable in the current year, they are sure to change in future years. It would be better not to prescribe use of 2001 Guidelines, and rather to say only ‘the applicable Code or Guideline.’

2) In addition, applying these Rules to renovations may be cost prohibitive and result in a decision not to make future renovations.

3) It would be more desirable rather than to be so prescriptive, for the Rule to say instead, meets the applicable State building, zoning, fire and environmental codes.

6.2.c.1. Square Footage:

This is a new addition to the Rule and will pose a hardship for some providers. Previously rooms could be smaller in terms of total square footage. Is this a Code requirement?

6.2.c.5. Bedrooms:

This is a new section. Is it required in Code that each bedroom be accessible to a main corridor, and each bedroom have an exterior window?

6.2.c.14.b. Dietitians:

Requiring the involvement of dietitians in simple meal planning is cost prohibitive and is not normalizing.

6.2.c.15. Food Handler's Card:

The proposed Rule is too broad. Current practice in WV allows the supervisor to have the valid food handlers' card, and permits them in turn to train staff accordingly.

6.2.c.18 Emergency Operations Plan:

This is a new requirement. The Rule does not specify enough detail. What if a center already addresses emergencies in its policy and procedures manual as most already have?

7.1.c. Individual Support Plan:

Requiring each consumer to have an individual support plan, or a treatment plan fails to recognize current practice in Medicaid regarding the minimum which may be in place in order to serve what are known as 'low end consumers'. The word 'plan' should be replaced by 'identified needs.'

7.2.a.and b. Retention of Screening Records:

The Rule is too prescriptive. Centers do not currently maintain records of screenings for two years' time because it is not required by any federal or state law. Centers would have no way to access records of screenings conducted two years ago.

7.3.c. Health Facilities' Contact Information:

The Rule is too prescriptive. It should require only that the center have an approved grievance procedure which would bring matters eventually to the attention of the Administrator. Centers should not be required to offer the external remedy only of Health Facilities to the exclusion of other bodies such as the WV Advocates, legal representation of their own choosing, and the like.

7.4.a. Consumer Discharge:

7.4.a. Requiring a ‘treatment plan’ for each consumer is no longer a requirement in Medicaid for ‘low end’ consumers. The language here should be changed to ‘based upon the consumer’s needs.’

7.5.d.2. Reports to Health Facilities:

Not all allegations of abuse and neglect should be reported to Health Facilities. Only those substantiated upon internal review or those substantiated by external review such as by Adult Protective Services staff should be reported.

7.5.e. Investigative Policies and Procedures:

This section of the Rule is too prescriptive. Health Facilities has prepared, in its own words, guidelines for investigating incidents. Therefore they are not in any Rule, and exist as training and technical assistance. It is unrealistic therefore for Health Facilities to then expect agencies to develop policies and to carry out procedures which follow items offered up as guidelines.

7.5.f. Appeal of Investigative Findings or Results:

- 1) This section is overly prescriptive. It should suffice to say that clients are to be advised of their rights, including the right of appeal, and the right to avail themselves of the center’s grievance policy.
- 2) Centers currently must follow the WV Code requirements regarding notices and the grievance processes under client rights.
- 3) Governing bodies govern, and do not become involved in day to day operations. It is not appropriate that consumers can take appeals directly to the governing body.

7.6. Medical Information:

Most of the listed items in this section such as recent medical complaints, routine lab reports, or sexual and reproductive health records are not appropriate for outpatient behavioral health settings and records. These requirements are typical of records in medical labs and clinics and personal doctors’ offices. This list of requirements should be deleted, and require only necessary health information as prescribed by HIPAA.

8.1.b. Assessments:

Not every client seen on an outpatient basis will require all of these items to be assessed. For instance, those on medication management only will not need to be assessed regarding family supports, or guardianship, or daily living skills. The language should be changed to ‘clients/consumers will be assessed according to the consumer’s particular needs’.

8.1.c. Frequency of Assessments:

Assessments may differ from screenings. The Rule should make a distinction between requirements for in depth assessments and for routine screenings. Assessments are expensive and should be geared to consumer needs and preferences.

Additionally, requiring a preliminary assessment prior to admission is an outdated practice. Centers would not admit someone into service unless there was an indication that the service is needed. What would a preliminary assessment entail? Is a preliminary assessment required of someone experiencing a psychiatric crisis?

8.1.c.3. Long Term Assessment:

What is meant by a 'long term assessment?' The Rule needs to include an appropriate definition. What this be a longitudinal study of some sort?

8.1.c.4. Annual Assessment:

It is inappropriate for the Rule to specify that assessments should be conducted annually. Rather it should be at the discretion of the professional practitioner, or determined by consumer need.

8.1.e.1. Record of Assessments:

Assessments or screenings should be entered into the record prior to the delivery of regular services. In the event that assessments were not indicated, the record would indicate a reason.

8.1.f.2. Individual Support Plan Implementation:

Not every consumer will require an individual support plan. Medicaid no longer requires this for those who are receiving 'low end services.'

8.1.f.4.K. Physician Notes as Part of the Treatment Plan:

Treatment Plans are not required for every consumer. In addition, treatment plans should not have to be re-done in their entirety each time a physician changes a dosage or makes similar changes in overall medication management for instance. Rather the physician's regular notes and the medication sheets maintained by the center should be sufficient.

8.1.g. Program Plan Review:

Depending upon whether the consumer receives 24 hour services in a residential licensed setting or whether they receive low end services only, some consumers would have a

program plan review, while others would have only case notes. The requirement in this section is too prescriptive given the range of service options available.

8.1.g.2. Frequency of Reviews:

We do not know why the language here specifies 360 days. We assume it is in reference to an annual review. However, it would be better to insert language which conforms to existing industry standards such as reviews at ‘critical junctures’, or else to be less prescriptive by allowing reviews to occur as consumer individual needs vary.

8.2. Residential Services:

Please clarify if ‘residential services’ refers only to 24 hour services licensed under the center’s umbrella license such as an ICF/MR group home.

8.2.a. Emergency Medical and Psychiatric Services in Residential Facilities:

‘Assure’ should be removed from this draft language. Centers cannot ‘assure’ availability as listed. They can make the same accommodation as would be available to any resident in any community, that emergency response or emergency vehicles would be accessed via local community response, dialing 911, or, or transport to hospital or other local medical facilities.

8.2.a.4. Policies Regarding Committing or Threatening Assault:

Centers should not be expected to develop a separate policy for threatened or actual assaults by consumers. Rather, the center’s regular policy and procedure for emergencies probably contains sufficient protective measures to assure protection and oversight.

8.2.b.2. Medical Examinations for Those in Licensed Residential Settings:

- 1) Please clarify if this applies to crisis residential units in local communities as well.
- 2) This should be part of the consumer’s routine medical care with the local medical practice. Our own physical examinations’ records and medical charts are not kept in our own homes but rather at the doctor’s office.

8.2.b.5. Menus Planned by Dietitians:

This is overly prescriptive and not normalizing. We do not have menus at home prepared by licensed dietitians, but we remain well nourished. Annual reviews of menus by dietitians, in addition, will be cost prohibitive.

8.3.a. Medical Management:

This section is overly prescriptive. Medical management of center clients is within the purview of their personal physicians in medical clinics and physical healthcare facilities.

8.5.b. Orders for Medications Reviewed Each 90 Days:

This is too prescriptive. Our own physicians do not review our medications every 90 days, but rather when new symptoms develop, or the medication begins to lose its previous effectiveness.

8.3.b. Medical and Dental Care:

Centers cannot be expected to be medical or dental clinics. It is cost prohibitive to employ general practitioners or dentists. The wording in this section should be changed to eliminate the word 'provide'. In addition, the wording should be altered to allow that there is sufficient evidence that the center attempted to 'arrange' medical and dental care for consumers based upon their individual needs.

8.5.c. Medications Listed on Treatment Plans:

Not all consumers have a treatment plan if receiving 'low end' services as allowed by existing Medicaid rules. In addition, physician regular notes and medication sheets should satisfy any documentation requirements.

8.5.h. Medication Administration Record:

This is not realistic for outpatient services, but rather only for 24 hour residential sites.

8.6.b. Assessment of Capability to Self Administer:

This is not realistic for an outpatient service, or with those who are not incapacitated. Assessments are expensive, and must be appropriate for the type of licensed setting under consideration.

8.6.c. Medications are Double Locked:

This is an antiquated requirement carried forward from the licensing of state hospital settings. Medical practitioners these days are adequately trained by their professions to safe guard the storage of medications appropriately. Double locking would be cost prohibitive in our multitude of sites.

8.6.d. Refrigeration of Medications:

Some medications are required to be refrigerated. The rule should not be so prescriptive as not to allow licensed agencies to develop their own procedures to safeguard medications which must be refrigerated.

8.7.b. Behavior Intervention:

The Rule needs to specify or to define the terms ‘routine,’ ‘problem,’ or ‘reasonably’ when combined with the term ‘behaviors’.

8.7.c. Functional Analysis:

The proposed Rule in this section is completely over stated and overly prescriptive, and does not allow behavioral intervention strategists or psychologists the necessary latitude to do the job for which they were hired, nor does it afford the client an individually customized intervention suited to his particular needs. In addition, there is reference to an interdisciplinary team which may or may not exist with every consumer entered into service. Nor are there always minutes of treatment team meetings, but rather a treatment plan is generated as the result of a team meeting.

9.2 Consumer Protections:

Please provide more definition regarding a ‘consumer’. If an agency provides ‘low end services’ only, for instance, to thirty or fewer individuals must it have a three-member human rights committee?

9.3 Eligible Individuals:

For small agencies it would be helpful if family members as well as consumers themselves could be allowed to serve on a human rights committee.

10.1 Consumer Rights:

Consumer Rights under this Rule should be consistent with consumer rights in any healthcare setting already established in law and in Code by the WV Legislature. This Rule should be no different.

10.1.a.5. Rights in General:

The rights specified in this section should be no different than those recognized under Federal and State law.

10.1.c.2. Move About Freely:

This is new language, to allow individuals to move about freely in a day services setting. It might be counter therapeutic to allow an individual to wander in a facility when treatment should be occurring instead. It might also hinder the right to treatment by others receiving services if they are interrupted by the wandering, and it might violate their right to confidentiality.

10.1.c.7. Acceptable Standards:

More definition is needed here. What are defined as acceptable standards of behavioral and medical practices? Without definition, subjective determinations will be made.

10.2.b. Advance Directives:

Consumers should be advised to seek qualified legal advice in preparing an advance directive. Centers should not be asked to provide legal advice.

10.4.i. Participation in Plan Development:

The mention of the words treatment plan and individual support plan in this section does not allow the recognition that Medicaid considers some individuals to be 'low end' and not to have requirements for written plans.

10.4.m. Outdoor Exercise and Activity Programming:

Exceptions should be allowed here in cases of individuals who are extremely suicidal for instance, and the team believes they should remain indoors and under supervision.

