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In response to Title 212 – Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Chapter 10- Licensing and General Administration

Subchapter 00

Part 1 – Rules and Regulations for the Licensing of Organizations and Facilities Licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Dear Sir or Madam: First and Foremost, thank you for your effort in reviewing the regulations to meet the needs of the behavioral health landscape as it is today. However, upon review of these regulations it appears not only does it not reflect the behavioral health needs of today nor do they reflect forward thinking of the needs of tomorrow. After a review, it appears the bulk of these regulations are appropriate for the Developmental Delay (DD) population and/or Residential Population. Many of these regulations herein would not be appropriate for outpatient treatment, especially, Opioid Treatment Programs. This leaves me questioning the following:

- At licensing audits would we be required to somehow meet regulations which are not necessarily applicable to an outpatient setting?
- If we are not required to meet certain regulations set forth, how would this be determined, and would this information be included in the promulgation of new regulation to ensure agencies are protected from being cited on a regulation which does not pertain to their individual setting?

Please accept the following questions and comments:

Section 1.17 When reviewing the proposed regulations, it appears the Governance section regarding Board composition, activities, etc. is much more prescriptive than in the past, at least for the Opioid Treatment Programs. Worthy of note is 4 of the 5 organizations are private, for-profit facilities which may not have the type of active board a non-profit would have. Also, as a for-profit entity it would also be inconceivable that 25% of the board would be made up of individuals who are receiving treatment within an OTP. This requirement could also be in direct conflict with 1.21 as the majority of our patients could have a past which prohibits employment by a licensed agency, therefore, why would we appoint them to the board? Lastly, discussion of actual finances would not be appropriate in a for-profit setting with 25% of the board receiving treatment within an OTP, again, non-profit entities do not have public documents such as a 990. Our agencies

are Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Most, if not all, have received the highest accreditation outcome (3 years) each time we have had our surveys. For CARF accreditation, it is not mandatory to apply the Governance Standards if you are a for-profit entity. We respectfully ask this be removed for the for-profit entities.

Section 1.17.B.2 Due to the fact for-profit organizations do not receive grant money or other federal and state monies which are set aside to be administered to non-profits and accounted for by each individual grant, an audit is not necessary as we only receive money on a fee for service basis. It is my belief the original regulations were drafted when all agencies were not-for-profit agencies. Not-for-profit agencies are required by most funders to prepare audits to protect the public from misappropriation of grant funds. Considering many agencies are now private for-profit agencies the original intent of the regulation isn't needed. The exorbitant cost of an audit versus the review is also a key consideration considering the for-profit does not have multiple funding streams to justify this cost. While reviews are one step below an audit it still satisfies many of the concerns of internal controls and stable record-keeping. While an audit requires the CPA to gather sufficient and reliable evidence regarding the information provided in the financial statement and helps assure the public that money invested in a publicly held company is being put to use as stated instead of those funds going to other purposes or activities, a review of an organization's financial statements still provides a report issued by a CPA which expresses that the financial statements are free from material misstatement. Based on the above as well as the fact our accreditation body allows for a review, we respectfully ask you add "or review" to the regulation.

Section 1.20.3 Does this section apply to only DD organizations? Opioid Treatment Programs do not have a DD population.

Section 1.21 Do we now need both a BCI and NCIC? Historically, our agency was required to have a BCI. Requiring both increases the cost by as much as 500%.

In addition, oftentimes OTP's hire individuals who have lived experience. Therefore, they have often had criminal pasts due to their substance use disorder. The way this section is written, some individuals would automatically be excluded from employment. This regulation is in direct conflict with the Governor's plan to ensure employment for those individuals in recovery. This regulation continues to discriminate and promote stigma associated with addiction. We respectfully request you remove this from regulation or allow for the Leadership of an agency to determine who is and who is not appropriate for hire.

Section 1.22 which of these would be applicable in an outpatient setting? Many of these appear to be for a residential facility.

Section 1.24 is this applicable for the outpatient setting?

Section 1.25.2 Individual summary sheet, we don't always have information family, advocate, dentist, pharmacy, employer, etc. as we are an outpatient facility they visit daily, weekly or bi-weekly. Would we now be required to meet this regulation as an outpatient facility?

Section 1.25.3 A great deal of the information may not be applicable or collected in an outpatient setting. While some of it is it is contained in the biopsychosocial or physical. It would be burdensome to create another document to pull this together into one place. Outpatient facilities have hundreds of individuals in treatment at any given time and not just several like residential or long-term residential facilities. Trying to gather this information from multiple sources on 6,500 patients across the state is not possible.

1.25.5 Fire Safety Requirements in this section appear appropriate for residential facilities where patients live. While each patient in an outpatient facility is provided information on health and safety, it is not always within 24 hours of admission and each individual's ability to evacuate is not assessed, reassessed or documented except for fire those patients which are in the building during any drills conducted. In addition, all staff are trained in emergency procedures including fire and safety according to accreditation requirements which includes annually. Is the requirement for 4 hours of fire specific training for residential? All of our agencies need to provide training to staff on an annual basis in fire safety for accreditation. This appears to be excessive for outpatient treatment and we respectfully request you remove the 4 hour of fire training for outpatient facilities.

OTP leadership spent months participating in various committees reviewing and revising the regulations to meet the Governor's request of reducing the number of burdensome regulation and creating regulation which was not in conflict with accreditation or duplication of other State and Federal regulation. However, what was posted for review is drastically different from the draft regulations from those meetings. Without changes to the regulations as submitted before being approved, OTP providers will be in a difficult position for the round of licensing audits which will begin in early 2019.

The Opioid Treatment Association of Rhode Island, which is made up of the 5 agencies and 16 locations, treating over 6,500 individuals on a daily basis is

asking you review our recommendations and incorporate them into final regulation.

Sincerely,

Wendy M. Looker, RN, BS
Chair
Opioid Treatment Association of Rhode Island