Southwest Behavioral Health Management, Inc.

A collaboration of Armstrong/Indiana, Butler, Lawrence, Washington, and Westmoreland Counties

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2878

To: Valerie Vicari
CC: Scott Pino
From: David McAdoo
Date: November 19, 2010
Subject: Draft Regulations #2878 addressing Residential Treatment Centers

The enclosed response to Draft Regulations #2878 addressing Residential Treatment Centers is submitted on behalf of Southwest Behavioral Health Management, Inc. (SBHM). SBHM serves the Counties of Armstrong, Butler, Crawford, Indiana, Lawrence, Mercer, Venango, Washington and Westmoreland.

The effort to standardize expectations for providers of residential treatment for children is greatly appreciated and it is our hope that the feedback provided assists the Committees in finalizing the regulations.

SBHM and the nine counties that we represent have concerns that without modification, youth, families, and communities will be adversely impacted by the restrictions/expectations of the current draft regulations. The following impacts have been outlined in detail in the enclosed document:

- Impact on Families
  - Families will face economic hardship in managing the increased medical expenses medical expenses and travel costs associated with accessing residential treatment.

- Public health, safety
  - Youth will benefit from the clinical strength of those supporting them in the RTF, and welfare.
  - The youth will be negatively impacted as they must travel further from their community of origin in order to access an RTF, given the limitations set on capacity.
  - There will be fewer resources available to the youth during period of Therapeutic Leave and transitional visits home.
  - The regulations fail to acknowledge the individual treatment needs of each youth and family. This failure will result in safety concerns not only for the youth receiving treatment at the RTF, but also families, classmates, and members of the community.

2520 New Butler Road
New Castle, Pennsylvania 16101

Telephone (724) 657-3470 www.sbhm.org FAX (724) 657-3461

- Clarity, feasibility, and reasonableness
    - Many standards presented in the draft regulations are precise, feasible and reasonable.
    - There are areas that should be more clearly defined. Without further clarification the current document leaves much to interpretation, which will result in requests for clarification in the future.

We greatly appreciate the efforts of the Commonwealth toward improving the treatment and care for the youth of our communities, as well as the opportunity to have input into this effort. Please feel free to contact us with questions or any necessary clarifications on our attached response.

RTF Bulletin Draft:
A new draft bulletin has been released with many significant changes that will impact regional providers. The purpose of this draft is to focus on the dignity of the child and to teach the child self management and self care. Smaller, non institutional settings are preferable, as they more closely resemble communities. Small institutions can be licensed as group homes, rather than maintain the RTF, if they are unable or unwilling to meet the standards outlined in the bulletin. I have outlined an executive summary of the significant points, and encourage you to consider these when drafting your response to the proposed regulations:

Adverse Effects Section 15

- Note: Mandatory accreditation might lead to increased costs, or conversion to a CRR.
- Requested: Independent confirmation of number of facilities impacted by accreditation requirements and/or capacity limitations

"No fiscal impact is anticipated as a result of these changes". Section 19

- Request: Consideration should be given not only to the increased costs to the RTF in meeting the increased standards, but also to the local economy, and how capacity limits (downsizing), will affect the local businesses, tax base, unemployment, etc.
- Note: CRR operations have expressed concern that youth in high levels of need will now be placed in the CRR level of care, and these providers are concerned that their operation costs might increase, as additional referrals are made, and as their staffing/training plan is adjusted to meet the clinical and supervision needs of the youth.

Rate-setting Section 21

- Note: Rate-setting is negotiated between the facility and the MCO that authorizes payment for an individual. One RTF might have various rates, based on the agreement with the individual MCOs. There is no minimum standard, expectation, of reimbursement rates for the daily treatment at an RTF.
- Note: (Outcomes?) The suggestion that youth will experience shortened Lengths of Stay in treatment at an RTF should be individualized, based on the needs of the youth and family. The ability of each youth's community of origin to support him/her locally will vary, and this document has not outlined how those community supports will be strengthened in order to support the youth outside of an RTF. These concerns have been expressed at gatherings with county, state, and MCO representatives.

Information-gathering Section 22

- Request: Input from children, families, advocates, providers, county and state government, and MCOs was noted as communications over the past decade in preparation for drafting the regulations. These communications, gatherings, workgroups, forums, should be available for review.

Rate-setting / Increased Expenses Section 27

- Request: It is again suggested that rate-setting policies will absorb the increased costs associated with the increased credentialing/staffing/facility requirements. Rate setting is a negotiation between the MCO who contracts with the county of residence (of the youth receiving RTF level of care), and the treatment facility. There is no guarantee that these negotiations will reflect the increased costs associated with these regulations.

3800 Exemption, Page 1

- Note: Current draft regulations will exempt RTFs, as well as CRRs, from 3800 regulations. All other regulations are limited to RTF's, and including CRRs in the exemption through this document is confusing.
- Request: Should it be in the best interest of DPW to modify standards for CRR's, then it makes sense to address those changes through draft regulations specific to CRRs that outlines those changes/expectations?

Family/Community Feedback, Page 2

- Note: The draft regulations reference the "input through numerous stakeholder meetings and comments to draft proposals prior to draft publication."
- Request: Schedule, minutes/summaries of these meetings and comments from stakeholders should be made available.

Expectations for out-of-state RTF's who provide treatment to residents of PA Page 9

- Note: Under General Provisions: "This chapter applies to RTF's that operate in the Commonwealth..."
- Request: How will the Commonwealth ensure that RTF providers that are located out-of-state are held to the same regulations, standards of care, as this is based on the intention of the Department to "enhance the quality of care provided in RTF's"? (pg 2)
- Note: RTF's located out-of-state are not currently held to the same standards for treatment, crisis intervention, progress reporting. **This discrepancy in expectations may lead insufficient care of youth receiving treatment out-of-state. The downsizing of RTF's within the Commonwealth might lead to an increase in out-of-state placements, resulting in even greater exposure to sub-par treatment, and youth returning to his/her community of origin without the necessary skills for successful community integration.**

Waivers, page 15

- Request: An RTF may submit a written request for a waiver. It should be noted that **a waiver is NOT a "grandfather clause".** The waiver will include a plan for alternative actions to address the same need, and demonstrating how adjusting the requirements will benefit the youth. There is a limit number of sequential waivers, before the facility is expected to have transitioned into the standardized expectations. **Therefore, suggesting that an RTF can simply request a waiver for capacity limits is misleading.**

Maximum Capacity of RTF, page 17

- Note: Restriction of RTF's to a maximum of 12 beds per unit, and a maximum of 4 units per facility.
- Request: How is "RTF" defined?
- Request: If each cottage/unit is licensed, then can each cottage/unit stand alone as an RTF?
- Request: If the RTF operates at different addresses, based on the location of the units/buildings, can each unit become licensed as an individual RTF?
- If each licensed building can be deemed a stand-alone RTF, will each building have to meet all regulations of this draft, or can the umbrella agency absorb the regulations into the larger structure?
- Request: What is the clinical rationale for this regulation? It does not refer to attendance/census within each unit, but rather, capacity. RTF's organize the "units" based on gender, age, presenting needs.
- Note: This regulation limits the RTF's ability to reallocate beds based on the presenting population being referred at any one time. This can result in the facility restructuring the program, limiting admissions criteria. Thus, providing treatment to diverse populations based on gender, age, presenting needs will be replaced with "specialized" facilities that cater to particular youth.

Incident Report, page 21

- Language clarification: This document indicates that with certain founded incidents, the RTF will notify "the affected child and other children who could be *potentially* harmed, and their family".
- ***"potentially"* needs to be defined.**
- "An RTF shall notify the...custodian of a child who has been restrained *as soon as possible* after the initiation of each emergency safety intervention".
- ***"as soon as possible"* needs to be defined.**
- "...including the name of the person to whom the incident was *report*".
- This should state "...the name of the person to whom the incident was ***reported***".

Retaining Medical Record, page 23

- Note: Draft regulations state that records shall be maintained for 6 years.
- **Request: Federal regulation states that medical records will be maintained for a minimum of 7 (seven) years. These draft regulations need to meet minimum federal standards.**

Rights, page 28

- Note: Communication: The RTF shall communicate all information within the youth and family's primary mode of communication. **This will result in increased cost related to translators and printed materials.**

Family Participation, page 33

- "An RTF shall *ensure* that an onsite meeting with the parents… is arranged within the first 7 days…"
- Note: The facility can **schedule** an onsite meeting with the parents, but there are times when this cannot occur within 7 days due to work schedules, transportation, childcare, etc.
- Request: This expectation should be re-worded to reflect minimum standards.

Staffing, page 35-38

- "Pre-employment physical and drug screening for all prospective staff who will be responsible for providing direct care to a child."
- Note: This regulation may increase costs associated with hiring and retaining staff. It may also decrease the employment pool.
- Request: Are there any standard expectations regarding the physical health or drug screen results?
- Request: To follow up on the pre-employment health screen, should there be ongoing screens to demonstrate that employees are in good health?
- Note: Minimum ratios for RTF's is reasonable, based the expected clinical/supervision needs of the youth receiving treatment in those facilities.

Primary Contact, page 39

- Note: It is ideal for the family and community based support systems to have one point of contact for a youth.
- Request: It is unreasonable to expect one person (the "primary contact") to be available 24-7 to the youth and family. A team approach to managing the care of youth is more reasonable.
- Language clarification: It is suggested that the following language be inserted into line (b1): **"Liaison activities for coordination and collaboration with other individuals and systems involved with the family, including, *but not limited to*, the following: …**
- **The inclusion of a specific model, (high-fidelity wraparound), is too specific. An alternative to this statement would reflect that there is an expectation that the primary contact participate in all interagency team meetings and be available to consult with members of the interagency team.**
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Family Advocacy, page 41

- We at SBHM, Inc., are aware that families benefit from accessing advocates.
- One concern is the possible conflict of interest if the families are interacting with an "advocate" who is an employee of the RTF, rather than an independent agent or a county employee.
- The expectation that the Family Advocate is available to participate in interagency team meetings and debriefing sessions, both of which might occur during non-traditional hours, will result in the need to employ more than one Family Advocate.
- This position is not a reimbursable expense. This might increase the administrative costs of the RTF.
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Staff Training, page 42

- Preparatory training, as well as ongoing training maintenance, is valued by us here at SBHM, Inc.
- Note: The expectations of the content to be addressed within the first 30 hours of training is **unreasonable.**
- Request: A time-study needs to be conducted to determine the hours involved with the trainings outlined in the draft regulations. (Certification in CPR and First Aid will require at least half of the total hours).
- Note: This expectation might result in pre-employment standards that include certification in the training areas. This would result in fewer qualified applicants.
- An RTF that abides by the completion of training requirements might be overwhelmed with non-reimbursable training costs.
- An RTF that remains within the confines of 40 hours of initial training might not be adequately training on each topic, leaving the employee unprepared for their role.
- Language clarification: (page 42 and 43), "**Heimlich techniques**".
- According to the New Castle Chapter of the American Red Cross, The term "Heimlich" used in relation to clearing a blocked airway is a violation of copyright laws.
- American Red Cross uses the following terminology when describing the technique: **Abdominal Thrusts, Back Blows, or Chest Thrusts, depending on the age, size and position of the individual receiving care.**

Ongoing Annual Training, page 43

- Ongoing training for all employees, to maintain their current skill set as well as increase their competency and build staff retention, is vital to the RTF's.
- Request: It is questioned how these training topics were determined, and if it is linked to outcomes through research.
- Request: It is also questioned if a time-study has been conducted to determine the true investment in completing these annual trainings in a responsible manner.
- Note: Fire Safety Training: Minimum Standards: If staff of an RTF that services 20 or fewer youth can demonstrate competency in fire safety through a "Train the Trainer" model, then why must the staff of an RTF serving more than 20 youth receive training directly from a fire safety expert.
- Request: If it is an issue of competency, then all staff should be trained directly by the expert, regardless of the capacity of the RTF.
- Note: High-Fidelity Wraparound: minimum standards. High fidelity wraparound is not available in all counties, to all youth. The youth who are receiving treatment in an RTF most likely have prior/current involvement with various treatment models, both EVP, and Promising Practices.
- Request: Rather than identifying a specific model to train on, please include trainings on the differences between Evidence Based Practices, Promising Practices, and general guides for best practices among unproven models of care.

Restrictive procedure Training, page 45

- Note: In partnering with trauma informed care, it is imperative that the staff involved in crisis prevention, de-escalation, and restrictive procedures is not only competent in the training curriculum adopted by the facility, but is also familiar with the individualized needs of the youth with whom they are engaged.
- Request: Therefore, it is recommended that included in this section is an expectation that no one shall engage in the implementation of restrictive procedures with a youth unless that staff has reviewed and signed off on the youth's crisis plan.

Physical Site, page 48

- Language Clarification: (23.84 d)
- "...prevent the penetration of **insections** and rodents."
- This should state, "...prevent the penetration of *insects* and rodents."

First Aid Supplies, page 51

- Note: Outlining the minimum expectations for supplies to be included in a first aid kit is helpful.
- Request: This section should include that a first aid kit should be stored in an easily-accessible, marked location, in a labeled container.
- Request: Each supply type should be labeled and organized in a uniform manner, identical to the first aid kits located in other areas of the RTF.
- Request: The RTF should have a minimum of one first aid kit located in each unit, as well as the kitchen, infirmary, and gymnasium.

Child Bedrooms, page 52

- Note: Outlining requirements for the youth's bedroom space is appropriate.
- Note: Setting the expectation that a maximum of two youth will sleep in the same bedroom is appropriate.
- Note: It is reasonable to expect that only same-gendered youth will share a bedroom.
- Request: Is it reasonable to set limitation of the maximum age span of two youth who share a bedroom? (for example, youth's chronological age must be within two calendar years in order to share a bedroom)

Exits, page 55

- Request: The draft regulations state that the expectations for exits from the upper-level floor depends upon the number of youth sleeping on those floors. **This should not be the case.**
- Suggestion: "If the bedrooms where youth sleep are located anywhere other than on the first floor, at ground level, that level will have a minimum of one interior and one exterior exit from the building. If four or more youth sleep on any floor other than the ground-level floor, then there will be a minimum of two interior *and* two exterior exits from each floor.
- Request: Review the minimum safety standards with licensing to determine the minimum interior/exterior exits, based on increased numbers of youth with bedrooms on the upper levels. (Will a unit of 12 youth have access to the same number of exits as youth who sleep in one of two bedrooms located on the upper level?)

Smoke Detectors and Fire Alarms, page 57

- Note: Establishing minimum standards for operating smoke detectors, fire alarms, and alternatives for individuals who are unable to hear the alarm is important.
- Request: CO2 detectors should also be required for each floor of the RTF.

Child's Health Examination, page 63-68

- Note: Outlining minimum expectations pertaining to the youth's physical health, which can impact the youth's behavioral presentation, as well as expose others, is welcomed.
- Question: Who is responsible for expenses associated with the various physical examinations, lab work, dental and vision care? Not all insurances cover dental/vision, and there are limitations as to how often a physical can be reimbursed.
- Request: These expectations are a potential barrier to families, as they might be reluctant to accept this level of care for their child if there are additional health care expenses associated with the level of care.
- Request: Is there an option for the RTF's to accept youth who have religious beliefs that hold contrary to the these regulations?

Use of tobacco, page 68

- "Use or possession of tobacco products by a child is prohibited".
- Note: This regulation does not address youth receiving treatment at an RTF who are 18, 19, 20, 21 years old.
- Request: Is this a violation of civil rights?
- Request: What type of cessation programs will be mandatory to treat withdraw associated with youth who are dependent on tobacco?

Storage of Medications, page 72

- (f) **"... shall be disposed of in a safe manner."**
- Request: This statement is vague. Minimum standards for disposal of discontinued, expired, or abandoned medication should follow the disposal standards outlined in the certification for medication administration.

Restrictive Procedures, page 78-86

- Note: Outlining a formal de-briefing session with the youth, family, RTF staff, and inter-agency team is appreciated. This is critical to determining causes for the behavior and decreasing the physical interactions by developing an thoughtful, individualized plan that includes the voice of the youth and family.
- Request: It should be noted in this area that a youth and their family has the right to exclude physical/chemical restraint from the youth's treatment plan. In such instances, the crisis safety plan will outline alternative responses to the at-risk behavior. All inter-agency team members will sign acknowledgement of the plan, and the family will sign off liability due to exclusion of this intervention.
- Note: Regulations pertaining to restrictive procedures reflects an awareness of trauma informed care, and the Commonwealth's commitment to interaction with all youth in a safe, respectful manner.
- Note: Given the research in this area, one can expect youth who are subjected to treatment that falls outside of these regulations are potentially re-traumatized by those who are assigned to assist them in their recovery. They will be unprepared for the transition back to the Commonwealth, and this transition will be less successful than if they had received the same level of respect as youth who received treatment within PA.
- Request: How will the Commonwealth ensure that youth who are receiving treatment at RTF's physically located outside of PA will also receive trauma informed care?
- Language clarification: (page 86, g2)
- "During a restraint the these trained staff will..."
- **This statement should read, "During a restraint *the* trained staff will..."**
- Note: A face-to-face assessment of the youth by a medical professional is welcomed.

Notification:

- Request: How is it that the time frame of "no later than 5 hours after the initiation of the restraint" was determined?

Documentation:

- Request: Incident Reports which are forwarded to the county of origin, MCO, DPW should be outlined in these regulations to include the minimum standards.
- Note: Often the incident report does not adequately reflect the preceding events, type/duration of restraint, de-briefing, notification, or plan to prevent similar interactions in the future.

Admission Process, page 96

- Note: The draft regulations state that if a youth is readmitted within 5 days to the same facility, it will be considered a continuation, NOT a new admission.
- Request: This is concerning. If a youth was successfully discharged after participating in the ongoing discharge planning meetings, but was then re-admitted, then this needs to be viewed as a new admission in order to be accurately tracked for quality purposes.
- Request: If a youth was discharged AMA, then the RTF should determine P&Ps for accepting that youth back if transition home is unsuccessful.
- Request: If a youth is transferred to acute care (inpatient), for stabilization, and then returned to RTF, then this can be considered a continuation, rather than a new admission.
- Request: Once a youth is discharged from a facility, and has access to the community, all regulations pertaining to safety planning and medical assessments should be instituted.

ISP

- Content of the ISP, page 99
- Note: The expectation that the ISP documentation, including verbal discussions during meetings, should be presented to the youth and family using their primary mode of communication is appropriate.
- This might increase the costs associated with interpreters and printed materials.

Records, page 107

- Clarification of language.
- 23.243. Contend of child records
- This should read, **"*Content* of child records".**
- Record retention, page 109, outlines an expectation of *6 years*.
- **Federal standards for record retention is 7 (seven) years. These regulations must meet the minimum federal standards.**

Payment Limitations, page 143

- (c) Payment is not made to an RTF for… (v) Therapeutic Leave.
- Note: Therapeutic Leave is a vital part of treatment. It requires a prescription from the psychiatrist, safety planning, medication education, transportation, and overlying supervision and responsibility of the youth during that Therapeutic Leave. Crisis prevention/intervention occur while the youth is on leave with family. Generalizing skills to the community occurs through this process.
- Discontinuing payment for Therapeutic Leaves might encourage RTF providers to implement one of two unfortunate practice.
- 1) Discontinue Therapeutic Leaves. The youth will spend each night at the RTF. Only daylight passes will be permitted, as the RTF cannot/will not take on the responsibilities associated with overnight Therapeutic Leaves unless compensated.
- 2) All youth will take Therapeutic leaves each weekend, on a scheduled basis, regardless of the safety concerns, hesitation of the family, or stability of the youth. This is planned into the management of the RTF, and weekend supports are downsized, reflecting the minimal census during those days. This results in failure to provide individualized

treatment to each youth, and scheduling Therapeutic leaves based on the routine and availability of family, rather than the convenience of the RTF.

- Request: It is suggested that RTF's be compensated for appropriately prescribing Therapeutic Leaves. It is suggested that the regulations reflect the planning process and crisis response during Therapeutic Leaves, including expectation that RTF staff support youth and family in the home, if necessary, during the therapeutic leaves.

Admission Criteria, page 153

- Note: It is stated in the regulations that the interagency service planning team must be independent from the RTF.
- Request: Is the intent of the regulation that the prescribing psychiatrist also be independent from the RTF?

Recertification for continued stay, page 156

- Request: Is it the intent of the regulations that recommendations for continued treatment at RTF level of care is prescribed by a psychiatrist who is independent from the RTF?