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RTF Regulation Comments
11.18.2010

We appreciate having the opportunity to review the RTF Regulations. We anticipate that there will be more discussion during the Healthchoices Webinar on December 14. These comments are sent on behalf of the Philadelphia Department of Behavioral Health/ Mental Retardation Services and Community Behavioral Health.

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23.24 Maximum capacity-
What is the plan to accommodate all the youth if the programs over the 48 bed capacity must reduce size? Where will these additional youth go? Is there a plan for the reduction is size something that would be phased in over time?

Given the reduction in size will there be increased funding to allow for the loss of economies of scale? (for example a building that will now be half empty still has the same fixed operating costs with fewer opportunities for revenue)

23.20 Consent to treatment
No reference to Act 147
No mention of obtaining assent for youth under age 14
Consent for medication should be cross referenced with 23.183 Use of prescription medication.
Would recommend separate consent for each psychotropic medication (will detail more under 23.183) not just overall consent

23.202, 23.303, 23.04, 23.206 – Restrictive procedure policy, restraint free, time, out, restrictive procedures records.
These sections are much more detailed than current regulations and leave little room for interpretation, nice improvement.

23.17 Reportable incidents
These regulations only require chemical restraints to be reported. Would recommend that the State require passive physical restraints/manual restraints to be reported as well.

Staffing
23.53 RTF Director- the credentials do not require any course work or administrative experience in fields that are relevant to mental health, Masters and BA could be in anything, human services administration may not relate to mental health

23.54 Medical Director

Qualifications- clarify assume board certified in psychiatry, not board certified in child and adolescent psychiatry. The ABPN no longer uses the designation board eligible. Suggest board certified in psychiatry or has completed training in general psychiatry from an ACGME credentialed psychiatry program AND has at least 2 years experiencing in delivery of services /programs to children and ***adolescents.*** AACAP Principals of Care for Treatment of Children in Residential Treatment Centers June 2010, recommends for RTF serving children ages 13 and younger, that the medical director be board certified in child and adolescent psychiatry; if over age 13 yrs, that the medical director be boarded in general psychiatry with extensive experience treating adolescents or be boarded in child and adolescent psychiatry,

The role of Medical Director as written is too diffused and combines direct delivery of clinical care with oversight. Should spell out overall responsibility for clinical leadership, quality of clinical services, including policies and procedures related to clinical care and oversight of quality of improvement, credentialing, and other management functions related to the delivery of care. Should specify a minimum number of hours/week dedicated to oversight responsibilities, not just for clinical care. Also the regulations state the Medical Director could serve as the Clinical Director—so without some designation of hours, how would the Medical Director oversight responsibilities be met, the clinical services delivered and the role of training and supervision which is under the Clinical director be ensured?

Attending psychiatrist time is not spelled out, but included with the medical director. How is the psychiatrist integrated with the treatment team? How is the psychiatrist utilized in managing the milieu which had implications for safety as well as the clinical care? The disconnect of the psychiatrist from evaluation, treatment, team meetings, and milieu has only resulted in poor quality care and serious incidents in my opinion.

23.57 Mental Health Worker and Mental Health Aide

Mental Health worker includes an option for high school diploma or equivalency and 4 years experience. Recommend minimal educational requirement should be bachelors' degree.

The mental health aide is not counted in the minimal staffing ratios- need to clarify. Mental health worker is 1:4 children while awake and 1:6 when asleep. How is the supervision of the mental health aide and worker provided?

Nursing- nursing is included under the Mental Health Worker, but there is no separate staffing role described. There is no requirement for an onsite registered nurse who would manage medication and other medical treatment.

23.60 Family advocacy

The position is described as full time equivalent, yet also under 5) Ensuring availability to families and children as requested. Is the expectation that the advocate be available

24/7 or be on call? No description of background and training of individuals who could serve as family advocates.

23.62 Staff training

b (5) "... proper safe use of restraint..." Recommend it specify in the use of non-prone restraint and reference the Ongoing Annual Training c 5 (iv) that refers to Dept Strategies and Practices to Eliminate the Unnecessary use of Restraint". The concern is new staff can show they had 30 hours of training in a number of areas, but the safe use of restraint may not be consistent with DPW policy and the new staff would not get training again until a year later.

23.96 First aid supplies

Recommend inclusion of AED (automated external defibrillator) and training on the use of this device. AEDs are common place in many public places. RTFs may be at some distance from an hospital and delay in emergency care can result in morbidity and mortality.

23.143 Child Health Examination

Child health exam in 3 days is too long a time frame. AACAP Principals of Care for Treatment of Children in Residential Treatment Centers June 2010, recommends "medical assessment and physical examination within the first 24 hours of admission, unless a physician determine that an examination within the week prior to transfer to the facility is sufficient ".

The health examination section should include a comprehensive biopsychosocial evaluation by a psychiatrist with expertise in child and adolescent treatment, or in adolescents only facility as appropriate to the facility.

23.141Child Health and Safety assessment occurs in 24 hours but is signed and dated by medical staff or staff trained by medical personnel as specified in RTF training. It is not clear when a physician would review and sign off. As the nursing staff role is not specified, it leaves the oversight of medical staff unclear.

23.183 Prescription Medication

c- reads like a typo ... "prescribing physician shall obtain and document consent ***form*** the responsible party". Probably means ***from***, although it would be highly recommended to have a specific consent form as well as documenting the discussion. The consent process should include an interactive discussion about the purpose, risks, and benefits between the prescriber the parent/guardian and the youth. There should be a mechanism to obtain assent from minors. In addition to the elements listed of rationale, side effects, and expected effects of withholding medication, the following elements are recommended: the rationale should include the condition or targeted symptoms, if the selected medication is off label, the nature of the off label use and reasons for choosing a non FDA approved medication, if the medication has a black box warning the physician should discuss the nature of the warning, the regulatory requirements and monitoring schedules set forth by the FDA, proposed strategy for tapering and or discontinuing the prescribed medication.

Under j (pg 74) it is recommended to give examples of psycho educational materials and medication information sheets.

There should be a section on Monitoring of medication and with the expectation that evidence- based strategies would be used to screen and monitor adverse effects. Providers should have a policy outlining how psychotropic meds are monitored. Specific monitoring and management of Metabolic Syndrome should be outlined. There are a several evidence based references; one is from the Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes, Diabetes Care, Vol 27, no 2, February 2004.

23.190 Medication performance monitoring
Quality and outcomes are require a 6 month reporting on number and per cent of youth receiving 3 or more psychotropics and number and per cent who are receiving 1 or more antipsychotic medications. Recommend that there be an age breakdown on youth receiving 3 or more psychotropics, not just under age 21, such as 6-12 years, youth over 13 years. Recommend requirement of a policy on regarding screening and treatment of medical syndrome and requirement of policy on the use of psychotropic medication in children and adolescents (FDA and off label use) that contains elements of informed consent and plan for monitoring adverse events.

23.223 Development of ISP
Under d (2), the psychiatrist description should include expertise in child and adolescent mental health, not just board or board eligible.