HOFFMAN HOMES

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TO WHOM IT MAY CONCERN:

I have been the medical director of Hoffman Homes Psychiatric Residential Treatment Facility for 30 years. I am board certified in adult psychiatry and also board certified in child and adolescent psychiatry. I am a fellow of the American Academy of Child & Adolescent Psychiatry. In addition to my work at Hoffman Homes, I see outpatients and have worked extensively in the Juvenile Justice System. I was the psychiatric consultant of a federally funded gender specific grant to address trauma in females in the juvenile justice system. Also, during my time at Hoffman Homes, I have authored chapters on ADHD and nutrients, neurotransmitters, and brain dysfunction in a textbook on developmental disorders and nutrition published by Oxford Press. More recently, I presented data regarding vitamin D levels in children and adolescents in our residential treatment facility at an international meeting of child psychiatrists in Toronto, Canada; and we are in the midst of a research project looking at grip strength, diagnoses, and inflammatory markers in children and adolescents admitted to Hoffman Homes. I recently read with great interest proposed statewide regulations regarding residential treatment facilities in Pennsylvania and felt compelled to respond to several of them.

5330.145 Treatment Services – As medical director of a psychiatric residential treatment facility, I am responsible for the care of each of our youth at the facility. This involves, but is not limited to the following:

1) Initial comprehensive psychiatric evaluations on every youth admitted to this facility.
2) Quarterly comprehensive psychiatric re-evaluations of every youth admitted to the facility.
3) Meeting with each patient approximately weekly in my office for the first month they are in care.
4) Meeting with any patient on an as-needed basis in my office while they are in care.
5) Parent contacts.
6) Notification and review of all self-injurious acts, elopements, restraints, ChildLine calls, medication refusals, day passes, therapeutic leaves, and any other significant incidents.

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7) Twenty-Four-hour availability to speak with nursing staff, therapists, education team members, other mental health professionals, and patients/parents regarding any urgent concerns.
8) Availability to all external team members to include managed care organizations, Children & Youth caseworkers, the patient's home school district personnel, and multiple other external team members (GAL, SAM, CASSP, MH-IDD, etc.).
9) Review of all laboratory data, EKG's, medical diagnostic tests, and medical appointments (neurology, endocrinology, cardiology, ophthalmology, gynecology, occupational therapy, physical therapy, ENT, dental, etc.) for every child in care. This includes consultation as needed with outside physicians.
10) Monthly structured interdisciplinary treatment planning meetings for every patient.
11) Weekly structured meetings with the clinical supervisor, the therapist.
12) Monthly structured meetings with all of the therapists.
13) Doctor-to-doctor reviews with physicians for managed care organizations. The need for which is determined by the MCO.
14) Development of all medication protocols.
15) Review of all intensive supervision protocols and safety transition plans, and any other specific behavioral protocols to be implemented in the care of a patient.

All of this is done to provide the best quality of care to each of our patients. Please note that this is <u>not</u> a comprehensive list of all duties but rather a summary of some of them.

I am unaware of any evidence-based literature to support that a board-certified child and adolescent psychiatrist seeing a child for 1 hour per month in a psychiatric residential treatment facility is of any superior benefit in terms of treatment outcome as compared to meeting for 15 minutes, 30 minutes, 45 minutes . . . 2 hours, etc. The arbitrary selection of some particular frequency and duration of time is actually an affront to a board-certified medical doctor who is more than capable of determining which child requires how much time and how frequently they should be seen. With the thrust in all of medical care being individualizing treatment, a cookie-cutter approach is completely inappropriate.

In a recent work force Pennsylvania State Review, completed by the American Academy of Child & Adolescent Psychiatry, it was noted:

1) There are greater than 2.6 million youth in Pennsylvania under the age of 18.
2) There are less than 500 Child & Adolescent Psychiatrists.
3) That yields approximately 18 child psychiatrists for 100,000 youth, which is considered a high shortage.

4) The percentage of counties in Pennsylvania with **0** child psychiatrists is 45% and all but a single county has severe or high shortages of child psychiatrists.

To make an arbitrary mandate of a certain amount of time and frequency that a youth must be seen, with no evidence-based clinical rationale in the face of the already extremely high time demands on child psychiatrists is going to contribute ultimately to poor care for youth in need.

Proposed solution: Trust the judgment of a Board-Certified Child & Adolescent Psychiatrist to determine the duration and frequency that a child needs to be seen to provide the best clinical care for that particular child. The requirement for frequency and duration in meeting with youth should be removed from the regulations.

5330.41 Supervision of Staff – As medical director at a psychiatric residential treatment facility, I work intimately with nursing staff on a daily basis to include 24 hours, 7 day a week availability. We collaborate closely to provide the best care for our youth. I am a trained physician and I am **not** trained in nursing care. To require me to supervise the team of nurses at our facility does not make sense, as I am not trained in their job. What is feasible and would be indicated would be a structured meeting with the Director of Nursing who oversees the department to discuss any pertinent issues. The direct supervision of nursing staff should then be the job of that Director of Nursing.

Proposed solution: The medical director would meet with the director of nursing for 30 minutes weekly and the Director of Nursing would then oversee the nursing staff.

5330.34 Searches – Children placed in a psychiatric residential treatment facility are at extremely high risk for severe self-injury, suicide attempts, and sadly completed suicides. The ability to search these children for objects that they may use to harm themselves or others is an absolutely necessary part of keeping them (and others) safe. At our facility, a doctor's order is required to search a child, two staff are present, and the patient would never be completely unclothed. They are searched one body area at a time and are not asked to remove undergarments. We are well aware of our patients' frequent history of trauma and utilize these searches only when they are absolutely necessary to prevent harm to self or others.

Proposed solution: Continue to have the ability to allow a physician to order the search of a patient to prevent harm to self or others. The search would be implemented by 2 gender appropriate staff. The child may be required to remove clothing, but never completely unclothed.

Regards,

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