RECEIVED
Nov 25 2024
Independent Regulatory Review Commission

Date: 11/25/24

To: Mr. David Sumner and Members of the Independent Regulatory Review Committee

Subject: Proposed 5330 Psychiatric Residential Treatment Facility (PRTF) regulations as developed by the Office of Mental Health & Substance Abuse Services (OMHSAS)

Dear Mr. Sumner and Members of the IRRC:

Hoffman Homes was founded in 1910, and for more than 114 years, we have been providing services to youth and young adults (i.e. clients as referenced throughout this document) throughout the state of Pennsylvania. For more than sixty years, we have provided behavioral health and mental health services to our community through contracts with county agencies and managed care organizations (MCOs). Hoffman Homes was one of the first to become accredited through the Joint Commission, and since the early 1990's, we have operated as a Psychiatric Residential Treatment Facility (PRTF) to support the growing needs of our communities to address the safety and well-being of those struggling with mental disorders. We feel that we are a highly regarded organization by our families, stakeholders and regulatory bodies. We strive to provide exemplary care to those who seek our services.

We value our relationships within the Department of Human Services. We believe that we are all working towards the common goal of creating a delivery system focused on trauma-focused/healing-centered initiatives to improve the lives of those we serve. In reviewing the proposed PRTF regulations developed by OMHSAS, we can appreciate the goal of creating a more clinically driven program. We understand the value in having leaders with clinical expertise to guide the treatment and care of those we serve. However, most, if not all of us, are already doing this, and there are several concerns within this document that we fear will negatively impact the services being provided. At a time where there are significantly less PRTF beds available than those who need it, and providers are already struggling to recruit and retain employees, several requirements within this document will likely cause providers to further decrease bed capacity, find other service delivery channels through OCYF, or potentially close their programs all-together. It seems that there is a significant disconnect between the expectations from the department and the reality for providers that will only hurt those we are trying to serve. We appreciate your willingness to review our comments related to the Regulatory Analysis Form and the Chapter 5330 Psychiatric Residential Treatment Facility proposed regulations. **You will find our comments in the following pages.**

Sincerely,

Rebecca Van der Groef, LSW
CEO Hoffman Homes

815 Orphanage Rd. Littlestown, PA 17340 | 717-359-7148 | 717-359-2600 Fax | hoffmanhomes1910.org

Regulatory Analysis Form Comments

On Page 6 of this document, the Department indicates that they consulted the Mental Health Planning Council on the development of the proposed regulations. As a member of this council, I would be interested in knowing the date(s) that the council was consulted. I attend these meetings, and while the PRTF regulations were a standing agenda item during the Children's committee meetings, the information shared was only an update on the status of these regulations. I do not recall a time where the details of these regulations were discussed with the council or feedback was solicited from council members on specific areas of the regulations.

On Page 7 of this document, the Department states that it provided updates on the proposed rulemaking. We are unclear on what this means. We will agree that OMHSAS provided regular updates at various meetings on the status of the regulations; however, if they are implying that providers were provided updates on the content of these regulations, we would disagree. When initial conversations occurred about OMHSAS creating these regulations to oversee the license of PRTFs, providers, stakeholders, advocates, etc. were brought together to discuss this. We were included in initial drafts of the regulations until COVID. At this time, these meetings ceased. Since that time, there was, I believe, one other meeting that providers were brought in on to do a walk beside of our current 3800 regulations and the Federal guidelines by CMS as the draft was being developed. We felt the meetings were collaborative. However, upon reviewing these regulations, there are several areas where there are significant changes that were never discussed during these meetings as providers would have expressed significant concern on these issues. We were never told of these changes until a webinar was held in July 2024, where we were not permitted to ask any questions or engage in discussion. Some of the significant changes, such as the requirements for a Mental Health Worker were not even address then, and were not known until the regulations were posted.

On Page 10, we disagree with the statement that the requirements are "minimum standards". We have always been told that regulations are to be minimum standards and contracts with MCOs, or counties or accreditation bodies would increase standards as they felt appropriate. What is being required in the regulations related to clinical treatment, training, and job qualification requirements is above what we are doing now and beyond what MCOs and accrediting bodies are currently requiring. If the MCOs/accrediting bodies are to define a "higher standard" and these regulations require above that, how can they be considered "minimum standards". As a PRTF who has provided clinical services for more than thirty years, we have never been told by a MCO or Joint Commission that we were not providing enough clinical treatment or training, or that the qualifications of our staff were not good enough to meet the needs of our clients. We have also been accredited for over 30 years.

Also on Page 10, it discusses that additional costs incurred by the provider are to be submitted in the cost reporting process. It later states that the cost report is to be submitted within three months of when the regulations are promulgated. It seems that a review of potential costs should be a primary factor when deciding whether these regulations, in part or whole, should pass yet we are not submitting cost impact until after the regulations would be passed. While the MCOs are within the department of OMHSAS, OMHSAS has not committed to making the MCOs pay for these additional costs, nor have the MCOs discussed rate increases because of these regulations. As providers, we are facing significant cost implications from these regulations, and there is no commitment from the Department to support this.

On Page 12, the Department provided what they feel would be cost implications for a provider to come into compliance with positions noted within the regulation. We are unclear where they got these numbers, but they are not in line with current salary requirements. For example, they indicate that a medical director would cost $289,000. Most providers have psychiatrists as their medical director. We pay our psychiatrists, who are contracted part-time professionals, over $450,000/year. Psychiatrists are extremely difficult to find, especially ones that are Board Certified Child and Adolescent Psychiatrists. The other positions listed are anywhere from $10,000-$20,000 under the actual cost for a new employee in those positions. That is also without consideration for the changes to work schedule proposed for the Mental Health Professional, which would require us to significant increase this salary.

On Page 15, it states that the Department would be paying $782,000/year for six additional human services program representative staff. That comes to $130,000/year per staff. We would be remiss if we did not say that this seems excessive when daily per diem rates continue to fall under the rates providers are requesting to provide these services. Perhaps there are other expenses in here outside of salaries that are not being noted.

Chapter 5330: PRTF Regulations

5330.14 Reportable Incidents:
(b) We question the necessity to both call and complete an incident report to the same agency. This is duplicative work where the information is going to the same place. If there is a concern that the information is going to be missed by OMHSAS staff, that appears to be an internal issue within the Department that needs to be addressed. This requires additional time of our staff that is then taking away from the care and treatment of those we serve. Those completing these documents, or making these calls, are Supervisors within the program that would have better use of their time supporting the staff and clients.
(c) We question the rationale for decreasing the time of reporting from 24 hours/end of next business day to 12 hours. Twenty-four (24) hours/end of next business day is the current requirement for both OCYF and the Federal regulations under Department of Health. What

data shows that this decrease in reporting has been beneficial? If staff are rushing to complete reports to meet a deadline, this could increase the chance of mistakes and force providers to submit documents that have incomplete information. Often times, we need time to follow up with staff, which includes calling them outside of work. If the timeline is decreased, it is likely going to increase the amount of additional information that will have to be submitted or clarified once all the information is gathered. Provided the necessary steps were taken to ensure client safety, there should not be an urgency to get a report submitted.

(d) This section notes that the provider shall call the parent, legal guardian or caregiver regarding the incident. We feel that other means of contact should be permitted, such as email. Depending on the time of the incident, the guardian, parent, or caregiver may prefer to be emailed rather than called, especially if it is at night and they have other children in the home. We feel the method of contact should be something the guardian decides on.

(3) What is the State-designated Protection and Advocacy System? Based on this requirement, it sounds like there are two different reporting systems. If so, we question why two different reporting systems are required. This is duplicative work and seems unnecessary and unreasonable. As noted above, this is going to take away from the care and treatment of the individuals we serve if we are spending our time documenting.

Proposed Solution: We request that current requirements of 3800s and Department of Health remain in place with regards to reporting of incidents. We request that language be changed to match other areas in the regulations to state that the guardian be "notified".

5330.20 Visits

(g) While there may be some cases where it would be beneficial for the provider to contact the family to ensure the client is safe, most families will find this intrusive of their time. We feel that contact during leaves is something that should be discussed between the Mental Health Professional (MHP) and the family to determine if/when this would be appropriate. Some families could see this as the provider not trusting them with their child or not trusting their ability to maintain their child's safety and well-being if we are calling to check on them, regardless the reason we are giving for the call. Families are provided with a safety plan and phone numbers to call if there are concerns during a visit. They also know they can call the facility to speak with staff (which they have done). This should be initiated by the family, not the provider. This also takes away from the direct supervision and care of those that are at the facility because it will be the Mental Health Workers or Supervisors that will be making these calls. In addition, the calls may end up being made by an individual the family does not have a relationship with which can make them uncomfortable. Ultimately, if the family and MHP feel a "check in" is appropriate, we support this, but this should not be required of all clients for every visit that lasts more than 24 hours.

Proposed Solution: We request that contact with families during visits be a decision made between the family and the MHP and the MHP will document this discussion for the client's file.

5330.34 Searches

(c) We are unsure if this regulation just needs some clarification. It indicates that unclothed body searches cannot be done. Does this reference an individual being completely unclothed or is partial unclothing not permitted? If any/all unclothed body searches are not appropriate, what is a provider to do when they have concerns that a client may be hiding an object on their person that they could use, or are using to harm themselves or others? We have clients that, having the opportunity, can cause significant injury to themselves, or maybe even others, and it is imperative that staff be able to ensure their safety. They will often hide these items in their bra or underwear. Our current policy is to have two staff present for the search, and it is only under the psychiatrist's order to do so, and the client is never completely unclothed. We focus on one body area at a time. While these searches are relatively rare, to take this away put both the provider and the client at risk. We do not take these decisions lightly and while we realize this may create additional trauma for the individual, the safety of the client and others is paramount.

Proposed Solution: We request that a provider reserve the right to conduct a body search on a client provided it is ordered by the psychiatrist, medical director or other physician, occurs with two staff present who are the same identified gender as the client, and where there may be removal of clothing, but the client is not completely unclothed.

5330.41 Supervision of staff

(a)(1) Due to the size of our program, we have several RNs; specifically, four that are considered part of the clients' treatment team. Based on feedback from other providers, our programs are set up similarly in that we have a Vice President/Director of Medical Services, which is a RN, who then oversees all the nursing staff within the department. Our Medical Director is contracted to provide psychiatric care and oversight to our program. They are not a full-time employee, and they are not a supervisor within the program. It is not realistic to expect the medical director, who is there to provide psychiatric services to our clients and clinical guidance to our MHPs, to spend hours each week providing supervision to individuals they do not directly supervise. We request that there be the option within 5330.41 for the Medical Director to only provide supervision/observation to the RN who oversees the department (if there is a VP or Director), who can then, in turn, provide supervision to everyone else.

Proposed Solution: We request that the Medical Director provide 2 hours of supervision each month and 30 minutes of observation every six months to the RN who oversees the medical department, with the understanding that the RN will then provide supervision to their staff. All supervision will be documented.

(a)(3) While we appreciate that OMHSAS is taking a more clinical approach to training and supervision, their chain of command appears to be very linear, and this does not support the current structure of providers. Providers have two separate tracks when it comes to their chain of command within the residential and clinical realm of the program. The direct care staff (MHWs) are supervised by MHW Supervisors, who are then supervised by a

Director within that Department that is not the Clinical Director. This regulation has the MHW Supervisors being supervised by someone within the clinical track of the chain of command. While we agree it is important for MHWs and MHW Supervisors to have clinical knowledge, we feel this can be obtained through current structure and training. The mental health professionals and MHW Supervisors work together as leaders of the facility to ensure that the staff are providing safe and clinical treatment to the youth. The MHP is not in a supervisor role, nor do they want to be. Our facility attempted to do this in the past, and it was unsuccessful because the MHPs did not want to be supervisors. In addition, this would add additional work to their already over-flowing job responsibilities (not counting the additional responsibilities these regulations are wanting to impose). The Director that oversees the MHW Supervisors has significant knowledge and experience, even if they do not meet the educational requirements of a Clinical Director. The Clinical Director supervises the MHPs. Given the size of our facility, they cannot supervise both MHPs and MHW Supervisors and be able to complete their other job responsibilities.

Proposed Solution: We support that MHW Supervisors should have the hours of supervision and observation noted within this regulation however, we request that the Department allow the provider to determine who that individual should be, with the understanding that providers are working to meet the State's requirement of being Healing Centered and training, education and support should be supportive of that.

5330.42 Staff Requirements

Under this regulation, the Department is requiring a MHP to be on site during waking hours. The purpose for this is to provide additional clinical support to the facility when the clients are awake. While we understand the rationale, there are two major issues with this regulation. First and foremost, providers are already finding it extremely difficult to find MHPs who want to work in this setting. Currently, our MHPs work a regular schedule of Monday-Friday, 8/8:30am-4/4:30pm with the understanding that they may have to work hours outside of this schedule to meet the needs of the client or their family. They also get notified outside of this schedule for pertinent issues related to their clients. The work they do is challenging and it is very important for MHPs to be able to engage in self-care and have time in their personal life apart from work. Many of them have families and young children where it is difficult for them to work evenings and weekends without sacrificing time with these individuals, and most MHPs are not willing to sacrifice this for work. If this schedule requires them to work evenings and weekends, they will likely leave employment for a job where they can work regular week-day hours. We have Supervisors on site 24/7. We also have clinical support via phone through the Director of Clinical Programs, Vice President of Programs for Healing, the Psychiatrist, and the CEO, who are experienced clinicians to provide support at any time. Some of these individuals have come on site after hours when needed and would be willing to continue doing so. There has not been a situation on this campus that has not been able to be managed safely with our current structure. This allows for the MHPs to engage in self-care and have time with their families

while others provide support to campus. There has never been a time when a supervisor has attempted to contact someone and has not been able to do so.
The second major concern with this, is that it is set up to operate under the assumption that having a MHP on site will improve the quality of care for all clients. If a MHP's schedule requires them to work evenings or weekends, they will be spending this time doing their own work. They will be holding their own sessions with clients and families, as this will be part of their work week. Their availability to the rest of the facility will be minimal, and it would likely be more difficult to reach them during this time than someone who is on call and readily available. Additionally, the MHP will be familiar with their clients, not other clients. Clients unfamiliar with the MHP will likely respond to them in the same way they would respond to any other staff they do not know. The interaction would be uncomfortable and could lead to the client further escalating as they have someone, they do not know trying to work with them and counsel them. Our Supervisors and Mental Health Workers, who are on site 24/7, knows the clients on campus and would have more success managing a situation than an MHP.
Proposed Solution: We request that this expectation be removed from the regulations. We do not feel that this would provide any additional benefit to the care and treatment of our clients beyond what is already being provided through phone calls to individuals outside business hours. Providers should have a plan on how clinical matters are addressed when MHPs are not on site, which should include having someone on call.

5330.45 Clinical Director

(c) We have serious concerns about requiring a clinical director to be licensed. There needs to be consideration for experience in lieu of a license as some clinicians may not have been able to obtain their license for several reasons that have no reflection on their ability to provide clinical leadership. Some examples include: they may not do well on tests and have had difficulty passing the licensing exam, they cannot afford the test, they may have a degree that does not provide licensure (e.g. psychology), or they may have direct care/clinical experience but moved into a non-direct care position (e.g. supervisor role) before they met the licensing requirements. Currently, our VP of Clinical and Residential Programs, who oversees the Director of Clinical Programs and our entire clinical/residential program, has over twenty years of experience with the facility and has a master's degree in counseling however, they are not licensed. They are far more qualified to provide clinical leadership than someone who has only two years of experience but happens to be licensed. Putting this stipulation in the regulations will significantly limit the applicants and put programs at risk of being out of compliance. Currently, we only have two MHPs out of ten that would qualify to be a clinical director even though many of them have five or more years of experience. We request that within this requirement, there be consideration for years' experience in lieu of a license. Generally, it takes an individual two years to receive the necessary clinical hours and supervision to qualify for a clinical license and so it would be appropriate to say an individual without a license needs two or more years of clinical experience.

Proposed Solution: We request that two year's clinical experience qualify an individual for this position in lieu of a license.

5330.48 Mental Health Professional

(d) We agree with the caseload limit within this regulation however, the Department needs to be understanding of situations where there are staff out on vacation or there are vacancies that need to be filled as this would increase an individual's caseload until the staff returns from leave or the position is filled. We would like to see something; either in the regulation or in the regulatory compliance guide that notes this exception so long as the provider is able to show that they are working to fill the position or there is a timeframe for which coverage must occur due to staff leave.

Proposed Solution: We request that either the regulation or the regulatory compliance guide allow for higher caseloads when there is a MHP vacancy of a MHP is out on leave, provided the provider can show they are attempting to fill the vacancy or provide a tentative timeline of when coverage will end.

5330.49 Mental Health Worker

(c) We have serious concerns about requiring a mental health worker to have 1 year experience working with children, youth, and/or young adults. While we appreciate the desire to increase the qualifications for positions, there needs to be a balance of expectation within the regulation to what is realistic; both today and in the future since we can expect these regulations to last at least twenty years. We do not want to make decisions that will create significant strain on an already fragile system. There is no empirical data that shows 1 year of experience with children, youth or young adults makes for a better mental health worker. We have had staff that have come in without any experience and have proven themselves to be a better staff and leader than ones with experience. Currently, 50% of our Mental Health Workers are hired with less than 1 year experience. If we were required to follow these regulations today, we would need to close ½ of our facilities, which would decrease our bed capacity by at least 30 beds. This also does not factor in the layoffs that would occur. We are not sure we could sustain such a loss as a program. Smaller programs are at an even greater risk for shutting down. The Department is certainly aware of the staffing challenges that providers are facing, and this is not improving. We have discussed this with them at every meeting. To place higher qualifications on positions will most assuredly cause a decline in applicants that are already difficult to find. Since the pandemic, we have increased the starting salary for this position by almost 20% for some of our residential programs and this has not increased the qualifications of those who apply for the position. We provide a two-week orientation training and go above and beyond the yearly requirement for training hours for our Mental Health Workers to ensure they receive the appropriate training, guidance and education they need. In speaking with other providers, if this requirement goes through, on top of reducing the staff to child ratios (which is also noted in the regulations), it will force

providers to decrease bed capacity, face citations and be at risk for provisional licenses because they would be unable to meet these regulations consistently. Given the state of the system and the need to secure PRTF beds for these individuals, we feel the Department should ensure that decisions they are making help to maintain, or even increase, service delivery, not cripple it. Ultimately, it is the Department's responsibility to find care for these individuals, and this is going to make it more difficult for services to be available when there are less beds and less providers.

In addition, if this specific regulation goes through, providers will most assuredly have to increase wages to have the possibility of hiring individuals that meet this requirement. At a minimum, we would likely have to increase wages by $2.00/hour per staff. Given the size of our organization, this would likely cost approximately $300,000 just for the Mental Health Workers. You then must consider the compression wage scale and the requirement to increase the salaries of those who supervise them, which would cost an additional approximate $50,000.

Proposed Solution: We request that current requirements of 3800 regulations remain in place. If there is additional training the Department would like these specific individuals to receive prior to working with the clients, we would also support that. If there is any experience required, we also ask that lived experience be permitted, to include the individual having experience as a parent/guardian of a child, youth, or young adult. The Department puts a lot of emphasis on the value of individuals with lived experience being an effective part of someone's recovery, so it is felt that this should apply here as well.

5330.50 Additional staff Positions

(4) In regard to requiring an LPN to be on site when a RN is not, we have attempted to hire an overnight LPN or RN for years and have been unsuccessful. The closest we have come are individuals that are willing to work until midnight, which is what we have now. We currently have a 5-6.5 hour gap in nurse coverage, which occurs during the overnight hours (anywhere from 10:30pm-5am). There have been very few incidents that have occurred when a RN or LPN has not been on-site, and even when this has occurred, a RN has been available and has been able to report to our site within the necessary time frame when needed. We have RNs on call to respond to any situation that may occur. We also have Supervisors on site 24/7 who are trained in CPR/First Aid and equipped to handle situations that may arise who would then call the RN, or the VP of Medical Services for direction as needed. We also have a Medical Emergency policy that would be followed and includes calling 911 in certain circumstances. We feel our current process is efficient and has proven to work effectively when needed. To fill this position would likely be very costly to an organization due to the schedule, if we could even find someone to fill it. Based on the lack of incidents that have occurred and the need for someone during these times, we also feel this would be a waste of resources, as the cost for this position would take away from other personnel or programming opportunities that could be used to better serve the clients. We request that providers be exempt from this regulation if they can provide a detailed plan of how medical issues will be addressed when a RN is not present.

(5) Because a LPN is not a required member of the treatment team, we also disagree with requiring them to have one year experience. Medical personnel are very difficult to find, especially with hospital, urgent care centers, etc. surrounding our communities. These for-profit entities can provide a much higher salary than what we are able to provide. Since a LPN is not required to be part of the treatment team, if hired, they likely are doing non-clinical tasks and their license limits them from doing most medical tasks as well. The LPNs we currently have on staff handle medication prepping and administration and other administrative duties. We are requesting that this stipulation be removed.
Proposed Solution: We request that providers be required to have medical personnel available on site or by phone at all times and establish a plan for medical care in lieu of requiring them to have medical staff onsite. We also request that if a LPN is required, that there not be a minimum requirement for experience.

5330.51 & 5330.52 Initial staff training and Annual staff training
5330.51(c) and 5330.52 (b) We are combining these specific sections because our response applies to both. We fully support that staff who work within our organization and who will have direct contact with the clients should have the hours of training and topics of training listed within this regulation. However, we employee staff that do not have contact with clients based on their job responsibilities (e.g. secretaries, Development/Fundraising staff, Business office/Financial staff, Technology staff, etc.). While they should have an orientation to our organization and the clients we serve, we disagree that they should be required to have 30-40 hours of training a year and be required to be trained on topics that are not relevant to their specific job duties. We feel this is a waste of time and resources for both the company and the Department (because the Department will then be reviewing these records), and doing so does not benefit the purpose of these regulations or the clients we serve. **Proposed Solution**: We agree that all employees should be required to complete the necessary documentation for employment, which includes a physical screening and obtaining all three clearances. We agree that all employees should be trained in the Child Protective Service Law (CPSL) training as required by law. We agree that all employees should have an orientation to the organization and the clients it serves, but those that are not directly working with clients should have an orientation that is at the discretion of the provider based on what they feel the employee needs trained on.

In addition, our medical director (psychiatrist), psychiatrist (we have a second one that is not the Medical Director), and somatic physician are medical doctors who has been practicing in their field for over thirty years. They are also contracted individuals and not employees of the organization. They do not work full-time schedules at our organization. To require them to get 40 hours of training a year in the areas identified in this regulation is unnecessary, unrealistic and not possible. As doctors, they are already required to maintain up to date information on their specialty/license. No other regulatory body has required this of them. We do not keep training records on them, and no agency has requested this. I am confident that all providers will agree that these individuals are not

going to have the time to complete this requirement with their other duties of providing psychiatric and medical care to their patients and consultation to the clinical teams. This is also going to cause them to reconsider the work they are doing for us, and it is already extremely difficult to find individuals with these qualifications that are going to want to do this work.

Proposed Solution: We request that the Department respect the qualifications, knowledge and skills of these individuals and exclude contracted individuals from this section of the regulations.

5330.145 Treatment services

(c:1-4) We find it clinically inappropriate to prescribe the quantity of services an individual/family receives from the Psychiatrist or MHP. The Department should evaluate successful treatment based on the quality of care given, not the quantity. There are several ways to evaluate quality of care (some of which is already being completed by MCOs as part of their review of a facility): client file reviews, a client successfully meeting treatment goals, a decrease in behaviors/clinical symptoms, satisfaction surveys, successful discharges and transitions, etc. The Medical Director (i.e. treatment team leader) is present for every client's monthly treatment team meeting, completes evaluations, and assesses medication management. They also meet with clients as needed based on current symptoms and behaviors. They are regularly informed of incidents occurring with the clients and are consultants to the Mental Health Professionals. They are available 24/7 and are often contacted after hours. They are notified for every self-injurious statement/act or serious incident, as well as every restraint. They are often asked to participate in doctor-to-doctor reviews with MCOs and will speak with guardians when needed. They are very knowledgeable of their cases and should not be required to put in a specific number of hours per individual. Doing this, takes time away from seeing clients who may require more time for assessments and evaluations. The Department should base their view of quality treatment on documentation and in-person conversations with the psychiatrists during licensing to determine quality of care. This is what the Department of Health does during their surveys.

The same concern applies to the MHPs. The Department does not seem to know the amount of work that MHPs are required to do to meet regulatory and contracting requirements. There was a time when care was far more important than compliance. That has changed. Documentation and regulatory requirements are extensive and take up more time than any other part of a MHP's job. Each week, at a minimum they are: meeting with clients at least twice weekly for individual and/or family therapy and completing documentation of these sessions, completing assessments (sometimes daily on a client) and completing documentation, creating/updating treatment plans, updating safety plans, updating restrictive procedure plans, communicating with external teams (which can take up hours each week, especially for clients who have multiple agencies involved or as discharge approaches and there may be discharge issues) and documenting these interactions, managing Childline calls/documentation, attending treatment team

meetings, facilitating group therapy, and consulting with the internal team for treatment needs. This job is extremely challenging and demanding. The risk of burnout is high. When there are vacancies, we rarely get applicants for therapist position (maybe 2-3, and most end up not responding, not showing up for interviews, or not being interested after the interview). There are less students coming out of colleges with these degrees. We have had vacancies for up to six months before we could hire someone. Therapists that want to do this work are extremely hard to find. They could work remotely or in settings that are not near as challenging, can create their own schedules, and get paid more. If the Department wants to increase work, the overall quality of both documentation and care will decrease and we will likely see more turnover with this position, leaving other MHPs to fill in for those vacancies, which will decrease the quality of care that is provided due to the impossibility of them managing their own caseloads in addition to others. This may also force providers to hold admissions, decrease bed availability or close entirely if they are not able to maintain these staff.

The frequency/duration of sessions should be discussed and agreed upon by the MHP, the individual, and their family. Certainly, if the client or their family are not satisfied with the amount of time a client receives therapy, they can express that through grievance and complaint procedures-both internal and external. Many clients cannot sit for long periods of time. Most of them have experienced various and multiple levels of trauma that make it difficult to process their emotions or incidents. It can take weeks, and sometimes, months, for a client to open up and begin to work with their MHP. Progress can be very slow for some. The Department places a significant focus on trauma and requires providers to be trauma-informed/healing-centered. Forcing frequency and duration of sessions is the exact opposite of this. Forcing a client to sit in a MHP's office is not therapeutic and can damage the relationship the MHP is trying to build. It removes the empowerment the client must guide their own treatment and can lead to feelings of mistrust.
If the department prescribes the frequency and duration of sessions, it hinders the collaboration and client-centered approach that is an important aspect of trauma informed care. Setting expectations on the frequency and duration of sessions, eliminates the ability for the client, as the treatment team leader, to have choice in the frequency and duration of services needed. This violates two principles of trauma informed care, which is collaboration and mutuality and empowerment, voice and choice.
This length of time and frequency also sets an unrealistic expectation in terms of the level of care they would receive outside of a PRTF. Our hope is that clients will transition from our program to the community where the frequency of therapy is going to be significantly less. There is a concern that clients will struggle with the sudden change in the level of support they are receiving. Our goal is to help clients learn how to manage their emotions and behaviors independently. When they are receiving six hours of therapy a week between individual, group and family therapy, it can deter them from developing these skills and cause them to rely on the support of their MHP more than they should. MHPs are professionals and should be given the respect and independence to determine the frequency and duration of therapy sessions with the understanding that they should be

seeing their clients at least twice a week (once for individual and once for family or twice for individual if there is no family involvement). We are certain that placing more expectations on their already overloaded job responsibilities is going to cause them to leave for other opportunities. As noted earlier, this will only force providers to put holds on admissions, decrease bed capacity or potentially even close programs if they can't find staff willing to do this work. This regulation also fails to acknowledge all other levels of support a client receives in our program. PRTF is truly a 24/7 support system for clients. The staff who work alongside them day after day are a significant source of support. They are the ones assisting the client in implementing treatment strategies and coping skills and keeping the client safe. They are role models of courage and strength. While therapy is extremely important, the real work is happening outside these sessions.

Proposed Solution: The Psychiatrist is a medical doctor with years of experience. The Department should respect their ability to determine the frequency and duration of client meetings and assessments. We request that any requirement placed on them related to the frequency/duration of client meetings be removed from the regulations. If there is a specific concern with a specific provider/Psychiatrist over their involvement with clients, that should be addressed individually.

Proposed Solution: With regards to the frequency/duration placed on MHPs to meet with clients and families, we request that the frequency/duration of sessions be agreed upon by the MHP, the individual, and their family. We agree that MHPs should meet with clients at least twice a week; whether this is twice in individual therapy **or** once for individual and once for family therapy and would support this being the regulation instead.

5330.151 Transportation

(b) We would like to know what the rationale is for requiring two staff on a transport. If this is going to be required, this is going to limit the number of transports a provider can provide. Providers who are currently transporting client's home for visits will likely have to stop doing this due to staffing constraints, which is going to upset families and significantly decrease the opportunity for clients to be able to go home. Medical transports may be delayed because there are not enough staff to transport clients to appointments on any given day, which puts providers at risk of citations and/or provisional licenses due to clients being out of compliance for medical appointments set forth in the regulations. Currently, we average 15-20 transports a week. Many of these are one staff with 1-2 clients, which is our current ratio. If we would have to have another staff accompany them, this would put a significant strain on our program. It would cost overtime to schedule additional staff or potentially put facilities out of ratio if the transport is urgent and we need the staff to go but don't have the staffing patterns to do both the transport and maintain regulatory ratios (which are also increasing in these regulations). If this is for safety reasons, are there other options, such as putting cameras in vehicles? To note, we have never had a concern reported during a transport. We utilize vans so when a staff is taking two clients, they can sit in separate rows and not next to each other. We also have cameras in our vehicles.

Proposed Solution: We request that the ratios stated in the 3800s be maintained or that a provider can provide a plan for safety and supervision that allows for different ratios than what the regulations state.

(e) We are unclear on exactly what this means, and in consulting other providers it seems some, like us, are reading this to mean that a restraint is not permitted any time a client is off site, but others think it may mean a restraint cannot be done when the vehicle is in motion (during the actual transporting of a client). If the intention of this regulation is to state that a restraint cannot be used at any time during an off-site transport, providers are going to significantly reduce transports to only what is required under regulation because we cannot be put in a position to have a client put themselves, or someone else, at risk and not be able to intervene. What would happen if a client attempted to flee the vehicle and run into traffic? What if the client begins to assault individuals in the community? We must be able to maintain the safety of the client and the community when they are off site, and providers will not put the client or the community at risk. This also creates a significant liability risk for providers if we are expected to stand by and not do anything when a client poses a risk to themselves or others. Therefore, if there is even the slightest concern the client may escalate when off site, the transport will be canceled, causing medical appointments to be canceled and possibly putting the provider out of compliance with medical treatment requirements, or it may prevent clients from getting to court or going home for visits.

Proposed Solution: We agree that restraints should not occur during the physical transportation of a client. We request that this be clarified as to the intent of this regulation. If the intent is that no restraints can occur off site, then we request this expectation be removed from regulation.

5330.182 Ordering a Manual Restraint

(i) This part of the regulation limits a restraint order to only 30 minutes. Current Federal guidelines provide varying time limits on restraint orders depending on age: under 9 (one hour), 9-17 (two hours), 18+ (four hours). The requirement of staff to initiate and maintain a restraint is that the client poses and continues to pose a risk to themselves or others that cannot be safely managed utilizing other non-physical de-escalation strategies. A restraint is to be released as soon as the client no longer poses this risk. While we understand that the initiation of a restraint can be a traumatic event for anyone, including staff, we also recognize the risk of trauma and injury when releasing a restraint on a client while they are still escalated and posing a risk to themselves or others. To release a restraint before it is safe to do so, increases the risk of harm and injury. In addition, this creates an unnecessary duplication of work on many levels. This requires an additional order and therefore an additional contact to the psychiatrist to order this restraint. This also requires an entirely new set of restraint documents to be completed which are very time consuming and include: documentation of the restraint, medical assessment post-restraint from the RN, an administrative debriefing by a Supervisor, a Life Space Interview with the client, and a restraint review meeting with the treatment team. Staff receive significant amounts of

training on both non-physical and physical de-escalation strategies. They must show competency in this area to perform these interventions. The Department should trust that staff are making the appropriate decisions of when to intervene, how to intervene, and how long any particular intervention (including physical restraints) should last.
Proposed Solution: We request that the Department maintains the current Federal guidelines in this area regarding the length of a restraint order.

5330.185 Application of a manual restraint
(a) This regulation states that two staff must be present when a restraint is initiated. While we try to have two staff, this is not always possible. A client can escalate at any time, and there is no requirement (nor should there be) that a staff member cannot be alone with a client. The safety of the client is paramount and if they pose a risk to themselves or the staff member, the staff member must have the right to manage them safely, so they do not further harm themselves or the staff. To require a staff member to wait until another staff can arrive to initiate puts great liability on the provider and poses significant safety concerns for both the client and the staff. There are multiple situations that can occur where this would be very unsafe. For example, we have clients that leave the facility without permission (e.g. run out of area) and staff must run after them. We have a road that runs alongside our campus. If the client approaches that road and there are vehicles approaching, staff will not allow the client to run into the road because another staff is not present for the staff to initiate a restraint to maintain their safety. So, according to this regulation, the provider will end up with a citation for violating this regulation to save a client's life. Another example is the proposed regulatory staff to client ratio is 1:5. We have 192 acres on our campus and could have a staff with three clients at the pond or equine area when one client starts to violently attack another. The staff is not going to wait for another staff to arrive before they physically intervene for the safety of both clients. Again, to wait for another staff would put the victim at significant risk for further injury and puts the provider at risk for negligence. Staff are not going to allow one client to continue assaulting another because a second staff is not present. This regulation sets providers up for non-compliance and citations. In addition, most providers have cameras throughout various areas on campus to monitor incidents that occur.
Proposed Solution: We understand the importance of having more than one staff present when a restraint is occurring and would agree that a second staff should be present as soon as possible, but it is not realistic to put a time frame on when that staff is to arrive. We would support noting that a second staff should be present as soon as possible, but if a staff member is not able to be present, the restraint documentation needs to clearly indicate the reason.

(i) This part of the regulation requires that a RN complete an assessment within 30 minutes. Current Federal guidelines require an assessment be done within one hour of the initiation of the restraint. In previous conversations providers had with the Department related to restraints as part of these regulations, we felt the Department supported keeping to current

Federal guidelines regarding restraints however, this does not appear to have happened in several areas. While we support assessments being completed as soon as possible; there are times when we have multiple restraints occurring with different clients in different facilities within a short period of time. It is not possible for the RN to be present for each of these at the same time, and it is not possible for them to be able to do their assessment in such a short amount of time. We have been able to comply with the hour assessment, and there have not been any negative outcomes with allowing this timeline. However, we will have difficulty meeting the 30-minute requirement. In addition, RNs are the only ones that can do the assessment, and so if they are not on site when a restraint occurs, most of them can be present within the hour, but will not be able to be on site within 30 minutes. This is setting the provider up for non-compliance and citations.
Proposed Solution: We request that the Department maintains the current Federal guidelines.

(k) This part of the regulation is requiring providers to notify guardians within one hour of a restraint. Current Federal guidelines require notification within 24 hours. It is not reasonable to expect the provider to notify the legal guardian within one hour of a restraint. There are many situations that could prevent this from happening. There are certain staff that are identified to make these notifications who can answer questions, or address concerns a guardian may have. However, those individuals may be involved in other situations at the facility, especially if there are several behavioral concerns occurring at one time, and this is setting the provider up for being out of compliance. There could be several restraints in one evening and one phone call to a parent/guardian could last up to 45 minutes depending on the guardian, and so the provider would either disrespectfully end phone calls to make them all on time or be late calling another guardian due to the calls they are already making. There has not been any negative outcomes at our facility in allowing a provider to contact the guardian within 24 hours. While I agree that the guardian should be notified as soon as possible, this regulation goes far beyond the Federal requirement of 24 hours.
Proposed Solution: We request that the Department maintains the current Federal guidelines.

5330.187 Documentation of a manual restraint
(b-10) This part of the regulation requires written statements from each staff who were in the restraint. This is not required by any other regulatory body, including Federal guidelines and current 3800 regulations. To require this of a provider creates duplicative and unnecessary work on the part of staff, and also takes time away from the supervision, care and treatment of our clients. The current requirement is for the staff, who initiated the restraint, to document the incident. However, there are opportunities within this process to obtain the feedback of other staff. The administrative debriefing requires all staff within the restraint to be debriefed and to sign off that they received a debriefing. The debriefing is a time where staff are to share their perceptions. From there, if there are concerns,

Supervisors can, and will, meet with individual staff to document their reports as needed. Staff are also mandated reporters and required to report any suspected abuse or the use of untrained techniques. They can report these concerns anonymously if needed. There are cameras in common areas throughout our program and in most other provider programs. All of this allows for a thorough review of an incident without requiring each staff to physically document their perception of the incident. We are unclear how this additional work and time away from direct care promotes more effective care and treatment to our clients.

Proposed Solution: We request that the Department maintains the current Federal and 3800 guidelines related to the documentation of restraints.