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Independent Regulatory Review Commission

SARAH A. REED
Children's Center
For a brighter tomorrow

11/24/24

Dear members of the Internal Regulation Review Committee,

I am writing to address concerns on the recently issued Draft Psychiatric Residential Treatment Regulations. Sarah A. Reed Children's Center (SARCC) is a mental health facility in Erie, PA that specializes in mental and behavioral health care for children, teens, families and individuals. We embrace a trauma-informed care model by providing innovative evidence-based treatment and services through research, clinical practice and professional training. We offer a full continuum of care including Psychiatric Residential Treatment, Partial Hospitalization, Outpatient, and Intensive Behavioral Health Services to 1,700 individuals annually from 46 counties throughout Pennsylvania.

The proposed regulations contain well intentioned strategies and processes designed to deliver high-quality trauma-informed care. The concept of the draft regulations is client-centered and focuses on standards, practices, and operational tenants that seem to align with a trauma-informed care model. However, they are not fully congruent with federal regulations, at times exceeding those standards. Further, the proposed regulations come at a time when the workforce is exceptionally strained, and providers are experiencing significant challenges to recruit and retain high-quality staff due to the emotional and physical demands of the work which are further complicated by poor competitive wages.

While I appreciate the spirit of the regulations, which provide additional clinical support to families, the regulations have unintended consequences. First, the regulations require providers to engage in several increased administrative and financial burdens regarding training and documentation with accelerated time frames. These requirements multiply administrative and training burdens such as decreasing time allowed to complete reportables. Additionally, the required documentation following manual restraints increases exponentially while the available reporting window, in some cases, drops from twenty-four hours to one.

The expressed standardization of training practices is commendable, however SARCC currently offers extensive training and orientation to residential employees. It is unclear

how this additional training may further benefit the treatment implementation with the expected indirect staff, such as billers or maintenance staff, who will be assigned an additional 30 hours of annual training including topics irrelevant to their work. These are just a sample of the additional requirements that will add further stress to already over-taxed systems without providing discernable benefit to the clients.

The newly proposed regulations require additional roles and responsibilities of the residential director, treatment team leader (psychiatrist), and clinical director. Currently, SARCC employs all these positions; however, their allocated time is programmatically defined by the need of the team and the new proposed focus can be a restrictive imposition based on the narrow criteria including limited scope for the program director, and increased roles for the clinical director and treatment team leader (psychiatrist). This can produce confusion among the families about the interface of clinical and administrative staff and the roles they play in the treatment planning process.

The minimum treatment standards in the regulations require a dramatic increase in the amount of psychiatric and clinical time that the PRTFs would need to supply. PRTFs would face two onerous barriers: The national shortage of psychiatrists, mental health professionals, and nurses and inadequate MA funding. The additional clinicians needed to satisfy these proposed rules are not available and, even if they were, PRTFs are not adequately funded to hire them. Currently, a full-time psychiatrist would cost upward of $320,000 not including malpractice insurance premiums, professional continuing education (outlined by discipline) as well as expected sign on bonus.

The staffing ratios identified in the proposed regulations that one Mental Health Professional be present for every 6 patients during waking hours. A Mental Health Professional as defined possesses a graduate degree. The implementation of this regulation would have PRTF's supervised both at a higher staffing level than many acute units in the state and with a master's degree individual for all waking hours. Additionally, the ability to attract and retain this level of staffing will further strain operations, as providers are already struggling to recruit and retain staff with advanced qualifications. If implemented, based on our current capacity, SARCC would need to add a full-time psychiatrist (37.5hrs), approximately 15 full-time undergraduate-degreed employees (an additional $760,094 total package) and 3 full-time graduate-degree individuals ($202,800 total package). These staffing changes will financially impact the organization by an estimated additional $1million plus, which does not include the recruiting, orientation/training, and benefit expenditures. Operationally, the proposed regulations will limit the overall capacity and unit size. The proposed comprehensive changes will conservatively increase our per-diem rate by 20%. The language in the draft regulations

does not ensure that providers will be reimbursed congruently or to any specified increased level for the large number of increased operational practices ascribed in the newly proposed regulations. Though the state has some influence over the Health Choices payers, the changes do not take into consideration 3rd party commercial insurance payer rates and processes.

Additionally, OMHSAS's estimated fiscal impact on providers makes two unrealistic assumptions:

1. Full Staffing: OMHSAS assumes that PRTFs are fully staffed, despite ongoing workforce shortages. This assumption is untenable and disregards the significant challenges providers face in recruiting and retaining qualified personnel.

2. MA Enrollment: The agency's report to the IRRC assumes that Medicaid Advantage (MA) plans will absorb additional regulatory costs, even though MA enrollment in Pennsylvania has declined. This projection is unfounded and fails to consider the current landscape of MA coverage.

As a result, I am concerned that the full implementation of the proposed draft regulations without amended changes will a) jeopardize bed capacity and limit the accessibility of treatment, b) change staffing/operational practices to levels exceeding inpatient hospital standards, c) establish unrealistic staffing expectations for graduate degree staff that are a challenge to recruit as the result of the limited applicant pool, d) demand operational enhancements that are not evidenced-based practices with an unrealistic expectation that payors will provide commensurate reimbursement, and e) financially compromise many providers attempting accreditation, consequently forcing many programs to eliminate this level of care.

Respectfully,

Adrienne Dixon

CEO/President