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To: Internal Regulation Review Committee
From: Perseus House, Inc.
Dr. Nick Viglione, CEO
Re: Proposed 1330 and 5330 Regulations
November 27, 2024

To the members of the Internal Regulation Review Committee:

Perseus House, Inc. (PHI) in Erie, Pennsylvania specializes in mental and behavioral health care for children, teens, families and individuals. We specialize in trauma-informed care by providing innovative evidence-based treatment and services through research, clinical practice and professional training. We provide congregate care including RTF and non-RTF programming.

PHI is providing comments on the proposed §1330 and §5330 regarding the payment of the psychiatric residential treatment facilities and the minimum licensing requirements, respectively. Our organization believes in policies, best practices, and informed decision making. The proposed regulations were developed without adequate provider input to inform the decision. The last provider consultation occurred in June 2020, and this draft includes items that were not shared with providers to solicit input. We are hopeful that our voice, along with other providers, is heard as we are concerned that the promulgation of these regulations would not be in the best interest of clients or staff.

PHI Comments Regarding the Proposed §1300 and §5330 Regulations

A. <u>Four Overarching Primary Concerns</u>

The four primary overarching concerns include:

1. The increase in staff is unrealistic and there is no evidence presented as to what research says about the increased expectations.
    a. Psychiatric time increases and role expectations does not support the current shortage in the Northwestern Region of PA, and across the U.S. Additionally, the expectations exceed what the standards are within an in-patient setting.
    b. Mental Health professionals are a limited pool of professionals, which is also an issue in the Northwestern Region of PA, and across the U.S.
        i. The failure to permit telehealth in protocols does not support the trend in healthcare, nor support providers in offering a work schedule that meets the needs of this limited population.
    c. The funding does not provide the level needed to secure and sustain mental health professionals.

2. The proposed regulations significantly increase administrative and training expectations without supporting evidence that it shall improve client care. The amount of documentation and training to meet the existing parameters is excessive.
    a. A major error in thinking is that due to technology time to complete a task is minimal. The details of floor coverage, staffing demands, etc. appear not to be considered in the thought process.
    b. The required documentation following manual restraints increases exponentially while the available reporting window, in some cases, drops from 24 hours to one.

The equity on realistic expectations is skewed at best, leaving the provider to address an item that is unrealistic from its design.

3. OMHSAS's estimated fiscal impact on providers makes two unrealistic assumptions:
    a. 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.
    b. 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.

4. The true Fiscal Impact the proposed regulations incur is likely beyond what payors may find acceptable, then what?

B. Response to the various sub-sections:

§1330.30 Nonallowable Costs (a)(7): Costs for a service if payment is available from another public agency, insurance or health program or any other source.
Separating program expenses by clients who are MA versus those covered by other payors creates an administrative burden.

§1330.30 Nonallowable Costs (a)(9)(xviii) and (xxiv): Client hygiene items and clothing are nonallowable costs.
When parents and guardians are unable to adequately clothe our clients, PHI absorbs the cost of clothing without reimbursement. Under the new proposed regulations (§5330.31) clean and seasonal clothing are not categorized as a client right, placing the burden of purchasing these items on the PRTFs without providing appropriate reimbursement.

§1330.30 Nonallowable Costs (a)(9)(xxiv) Transportation and living costs associated with onsite visits by parents, legal guardians or caregivers.
The agency currently provides parents with gas cards and hotel rooms to help economically challenged parents who live a distance from the PRTF visit their children. There is an obvious benefit to the client through the strengthening of the parent-child bond. Disallowing this expense will make it difficult for the agency to continue this practice.
Alternate Rule: Establish MATP reimbursement for parents traveling to medically necessary visitation and therapy in a PRTF. Or allow providers to account for this cost.

§1330.31 General Payment (b) The MA Program will pay for medically necessary services provided to a child, youth or young adult who is an MA recipient by a residential treatment facility licensed under Chapter 3800 and certified by the Department as of [*effective date of final-form rulemaking*] for 12 months after [*the effective date of this final-form rulemaking*].
This proposed rule starts the countdown to an inevitable licensing crisis among providers. Requiring PRTFS to acquire extra psychiatric, clinical, and nursing hours against the setting of a well-documented national shortage of these providers while providing no realistic assurance of adequate remuneration is confrontational and endangering to behavioral health providers.
This agency fails to appreciate the urgency to promulgate and enforce these regulations without OMSHAS consulting with PRTFs and the Behavioral Health Managed Care Organizations to ensure the financial viability of the proposed regulations.

§1330.32 (a)3 MA will pay a PRTF if the following conditions are met: The independent team is independent of the psychiatrist who completed the psychiatric evaluation and the PRTF that is being recommended.
This agency cautions that the demand Minimum Treatment Standards Section of the 5300s places on PRTFs for increased psychiatric hours will potentially make it difficult to acquire an independent evaluation for the client due to many psychiatrists in rural areas serving dual roles.

§ 1330.33. Limitations on payment. (a) MA will pay for hospital-reserved bed days for a PRTF that is currently participating in MA as follows: (2) Payment for hospital-reserved bed days is limited to 15 cumulative days per calendar year, for each child, youth or young adult, regardless of whether the child, youth or young adult was in continuous or intermittent treatment at one or more PRTFs during the calendar year.
The significant error in this regulation is the failure to support providers who are being asked to take more complex clients with hospital bed days as warranted. Asking providers to take more complex clients and limiting a support that may be critical to safety and treatment is not in the best interest of clients. Furthermore, providers will be less open to taking complex clients when the regulation limits the support that may be warranted. While many of the regulations are about staffing and spending, this regulation says that Providers and clients may not be supported at their most stressing times.

§ 1330.33. Limitations on payment. (d) MA will not pay a PRTF for the following: (1) A day of care during which a child, youth or young adult was absent from the PRTF for one of the following reasons: (iv) Visits, unless the visit meets the criteria in subsection (c).
The visitation piece of this regulation needs clarified. Additionally, the 2 days of elopement in a calendar year has the same negative carry-over impact as the 15-day hospital stay when a provider takes a client who has used the days in a previous setting. Some children run, and PHI provides unsecure setting. While our system attempts to mitigate the issue, it does happen. Providers will be left to consider discharge if maintaining the bed will be unfunded. More parameters and details need to be identified.

§ 1330.39. Annual cost reporting and independent audit. (a) Residential treatment facilities that are licensed under Chapter 3800 and certified by the Department [*as of the publication date of the final-form rulemaking]* shall provide a projected cost report to the Department within 3 months of [*the publication date of the final-form rulemaking*].
Asking the PRTFs for cost reports three months after the promulgation of these regulations is akin to beginning construction on a mansion before setting a budget for the project. Again, the agency requests that the IRRC require a collaborative exploration of the financial implications of regulations between OMHSAS, the PRTFs and the MCOs prior to considering the passage of these regulations.

§ 1330.40. Rate setting.
BHMCO and MA rate setting are not applied together or regulated together. The rule needs to account for how PRTFs will be reimbursed when there is a difference in rate.

§ 5330.13 (c) Abuse. A PRTF shall comply with the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704).
This requirement creates an extra administrative and training burden, equaling more cost put on the provider to meet the expectations.

§1330.14 reportable Incidents:
Having a provider understand the various stakeholders reporting standards and procedures is failing in application. Once facility may need to understand more than 40 versions of how to report the same issue. It is recommended that all reports use HCSIS and stakeholders need to utilize that methodology in their own systems, including DHS departments from various counties, and MCO's (CCBH has different standards within their counties).

§ 5330.14 (c) Reportable incidents. A PRTF shall complete an incident report through the Department's information management system within 12 hours after the following reportable incidents are known to a PRTF:
Reducing the window from completing reportable incidents from 24 hours to 12 hours creates an unreasonable burden on the residential staff who often complete multiple reportable incidents throughout a single shift. In addition to completing the incident reports in the Department's information system, staff must also complete serious incident reports regarding the same events for the clients' Behavioral Health Managed Care Organizations (BH-MCOs), as well as notifications to parents and referring agencies.
The condensed deadline creates the potential for the reduced quality of documentation as staff strain to submit their documentation within the twelve-hour window. PRTFs would need to consider hiring administrative staff to ensure compliance.
It is also unclear how this requirement improves client care as there is no indication that the Department will be offering support to the provider or client in a more expedited manner.
Alternative rule: This agency proposes the §3800 regulation allowance of 24 hours to inform the Department of a reportable be maintained in the §5300 regulations.

§ 5330.14 (c)(5) Incidents of physical assault involving a child, youth, or young adult or PRTF staff.
The agency appreciates OMHSAS' intention to protect clients with this rule. However, we serve a young and impulsive clientele who often get into minor physical altercations that do not result in injury and that, at times, are developmentally normal for their age. Reporting each of these childhood skirmishes represents an unproductive administrative burden for the front-line staff.
The agency requests that the Department provide a definition of assault that would instruct the PRTFs to report only significant acts of aggression.

§ 5330.14 (e) A PRTF shall report the following reportable incidents to the State-designated Protection and Advocacy system no later than close of business the next business day after the reportable incident is known to a PRTF.
This agency seeks clarification regarding the "State designated Protection and Advocacy system." If this is a new State Department, then providers will be duplicating the amount of required documentation after a reportable incident occurs.
PHI requests the department information management system (HCSIS) be configured in such a way that reportable incidents filed by providers are automatically forwarded to the information system of the State-designated Protection and Advocacy system.

§ 5330.31 (5) Rights. To clean and seasonal clothing that is age and gender appropriate.
The proposed regulation elevates the clients' need for clean and appropriate clothing to that of a right without providing reimbursement to the PRTF. §1300.38 (a)(9)(xviii) categorizes client clothing as nonallowable when preparing the cost report.
The Agency also requests that this regulation be reworded to "clean and seasonal clothing that is appropriate according to the client's age and gender identity" to better reinforce the spirit of §5330.33 (Nondiscrimination).

§ 5330.31 Rights (b)(25) To be discharged from the PRTF as soon as the child, youth, or young adult no longer needs services.
The agency agrees that clients should not be made to stay on placement longer than it is medically necessary. However, the PRTF has no control of whether a child has an appropriate discharge resource and is often dependent on outside agencies for that resource to be developed. This rule should be omitted from the client rights since PRTF should not be held accountable for the lack of resources. Or, indicate a planned regulation as to where clients go from PRTF when no discharge resource exists?

§ 5330.41. Supervision of staff.
Throughout this section of the proposed rules, it is unclear whether OMHSAS is prescribing solid or dotted lines on each PRTFs organizational charts. The agency seeks clarity on this issue.
The agency notes that this section of the rules does not support the role of the advanced practice professional in role clarity of inclusiveness. There is an opportunity for the APP to provide clinical supervision and reduce the burden of the treatment team leader.

§ 5330.41 (1) A medical director shall provide the following supervision to an RN, clinical director, or an APP.
This regulation pushes the medical director to operate outside of their scope of work. The additional time required by the Medical Director to provide supervision and observation detracts from the available time the Medical Director must serve as treatment team leader and to provide medication management.

§ 5330.41 (a)(3) A clinical director, medical director or mental health professional shall provide the following supervision to a mental health worker supervisor:
(i) Two hours of supervision each month. Of the 2 hours of supervision, 1 hour shall be face-to-face.
(ii) One hour of direct observation of the provision of services every 6 months. Each occurrence of direct observation of services shall be for at least 30 minutes.
At this agency, the mental health worker supervisors are directly supervised by the program director. The proposed regulations would consume 38 hours a month of our Clinical Director's time to provide supervision and an additional 38 hours annually of providing direct observation. This time demand detracts from the Clinical Director's proper role of establishing and training the clinical best practices of program and the supervision of the mental health professionals and case managers.

§ 5330.42 (a) Staff working in a PRTF shall be 21 years of age or older.
This rule will have a negative impact on PRTFs being able to develop an employee pipeline by providing clinical field experiences (practicums and internships) to students at local colleges and universities.
Alternate Rule: This agency suggests that OMSHAS allows an exception for students enrolled in clinical field work and in process of earning a degree and/or 2 years of previous experience.

§ 5330.42 (c) During the PRTF's awake hours, the following requirements must be met: (2) PRTF staff providing supervision shall always be within auditory and visual range of children, youth or young adults.
This regulation is inherently unworkable. Clients have the right to privacy while changing their clothing, showering, or toileting. It is also not possible to maintain visual contact with all clients while they are in their rooms enjoying their time alone. The requirement will limit or stop activities that promote normalizing behaviors in the community due to staff on duty and would significantly increase costs.

§ 5330.42 During the PRTF's awake hours, the following requirements must be met: (3) A mental health professional shall be present at the PRTF.
As noted in the comment to § 5330.48 (d), requiring non-traditional hours for MPHs will make the PRTFs' recruiting and retention of MPHs more difficult. There must be acknowledgement of the staffing concerns and availability of competent and credentialed applicants. On-call access and telehealth is much more reasonable.

§ 5330.44 Treatment Team Leader
Psychiatric Evals completed in 7 days is unreasonable, due to the timeline and staffing complexities/ shortages with a psychiatrist. It is requested to maintain it for 14 days.

§ 5330.47(c) The RN shall have at least 1 year of experience in treating children, youth or young adults with behavioral health needs.
According to The Hospital-Health System Association of Pennsylvania, the nursing shortage in the Commonwealth is among the starkest in the nation due to an aging workforce, burnout, and a shortage of

nursing programs.[i] This additional requirement will only further increase the difficulty of hiring nurses in the PRTF setting.
It is already difficult hiring RN's due to PRTFs' inability to offer competitive pay due to the current MA fee structure, and the need for staff RNs on second shifts and weekends. This additional requirement will further challenge the PRTFs' ability to be appropriately staffed. RNs are already trained to work with individuals across the entire human life span. They also work in the context of a milieu and team who also possess this knowledge.

§ 5330.48 (d) The mental health professional's assigned caseload may not exceed eight children, youth or young adults.
MHPs have been increasingly difficult for PRTFs to recruit due to the highly regulated environment of the PRTFs compared to the flexibility and competitive salaries offered in private practices. The proposed regulations will require MHPs to work non-traditional hours, making the position much more difficult to recruit. This agency already schedules evening and weekend hours for the therapists as best practice. However, due to instances of staff turnover, there are occasionally uncovered shifts. In those circumstances, we would be out of compliance instead of being out of best practice. Turnover in this position is common and the likelihood of occasionally being out of compliance is significant, placing PRTFs at risk of receiving citations for being unable to overcome labor trends beyond their control.
The regulation does not account for the need for clinicians to cover each other when team members are on vacation. The act of picking up clients while a peer was on vacation would put that therapist out of compliance with the proposed rule.

§ 5330.48 (e)(2)(4)(4) Completed a clinical or mental health direct service practicum and have a graduate degree with a least nine credits specific to clinical practice in psychology, sociology, social work, education, counseling or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or have an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.
The agency requests that consideration be given to internships as well as practicums to fulfill the educational requirements of this rule. Without this revision, the proposed rule unnecessarily limits qualified applicants from consideration.

§ 5330.49. Mental health worker. (c) The mental health worker shall have a high school diploma or the equivalent of a high school diploma and at least 1 year of experience working with children, youth or young adults.
The agency agrees that it would be ideal to only hire candidates with one year of experience, this is not realistic. Under the current funding model, PRTFs are hard-pressed to compete with wages in the fast food or retail industries. It is already difficult to attract potential mental health workers into a high-stress field with inconvenient work schedules when they can find better-paying jobs with preferable hours. Adding this additional requirement is a further barrier to hiring that will result in increased PRTF rates and diminished bed capacity.

§ 5330.50. Additional staff positions (5) The LPN shall have 1 year of experience working with children, youth, or young adults.
This proposed regulation will make it more challenging for PRTFs to staff appropriate nursing rosters. According to the National Center for Health Workforce Analysis, the number of licensed practical nurses declined by over 9% in 2022.[ii] Again, the requirement of the LPNs to have prior experience working with this population will only make hiring more difficult.
LPNs are already trained to work with individuals across the entire human life span. They also work in the context of a milieu and team who also possess this knowledge.

§ 5330.51. Initial staff training. (c) Except as required by subsection (d), PRTF staff shall complete at least 30 hours of training in the following areas within 120 days of their date of hire:
and *Staff* – Individuals employed by a PRTF on a full-time or part-time basis. Staff includes contracted staff, temporary staff, volunteers and interns.
Applying the staffing requirements to all PRTF volunteers, regardless of how often they directly work with clients, will result in individuals becoming dissuaded from working with clients due to the requirement to complete 30 hours of annual training.
More clarity is need in general for this proposed regulation.

§ 5330.52. Annual staff training. (b) PRTF staff shall have at least 30 hours of annual training in the areas specified in §5330.51(c) (relating to initial staff training).
Currently PRTF staff who are not working with clients are not regulated by any annual training requirements in the 3800s. PRTFs are responsible for establishing their own training standards based on their policies and any professional standard accompanying each staff role. However, 5330s prescribes 30 hours of annual training, with many of the topics having no relevance to the staff's role. For example, billing agents do not need to be trained in the use of manual restraints, verbal de-escalation, mental health diagnoses, or principles of child development.

§ 5330.77. First aid supplies. (a) A PRTF shall have a first aid kit available to PRTF staff on every floor of the PRTF.
Requiring first aid kits to contain opioid reversal medication and be located on every floor of a PRTF is excessive. This will create more undue costs for providers and require more monitoring.

§ 5330.112. Initial medical assessment. (e) If a physician did not complete the initial medical assessment, a physician shall review and sign the initial medical assessment within 3 days from the date the initial medical assessment was completed.
This proposed regulation will have unintended consequences regarding the PRTFs capacity to admit clients. For example, if a client were admitted on a Thursday or a Friday and a physician was not present on either of those days, a physician's signature would not be able to be secure over the weekend, playing the PRTF in a state of noncompliance.
PRTFs will be required to increase the number of contracted hours with PCPs, an expense that is not accounted for in OMSHAS' estimated fiscal impact statements. PRTFs are dependent on the available of contracted PCPs who are willing to accept MA rates and will find it difficult to find enough doctor's time to meet the demands of this regulation, which will result in needless delays in admissions.
Alternate Rule: If a physician did not complete the initial medical assessment, a physician shall review and sign the initial medical assessment within 15 days from the date the initial medical assessment was completed.

§ 5330.142 Treatment Planning
This simply is not realistic nor makes operational sense. 48 hrs. for a Mult. Disc. Team assessment is an insufficient timeframe to apply. This ask is not very Trauma Informed friendly for the client. This requirement should be equal to the Psychiatric Evaluation, which should be 14 days.
Clarity as to the intention and evidence for purpose needs clarified.

§ 5330.145. Treatment services. (c) The following must be provided in accordance with the child's, youth's or young adult's treatment objectives:
(1) Individual therapy with the child's, youth's or young adult's treatment team leader must be provided for at least 1 hour each month.
This regulation is problematic for two reasons. Since the 1990s, there has been a steady decline in the amount of psychotherapy provided by psychiatrists. The percentage of psychiatric visits which involve psychotherapy

dropped to 21.6% of patient visits between 1996 and 2016.[iii] There is no data to suggest a reversal in this trend. This data suggests PRTFs will have difficulty hiring psychiatrists proficient in providing psychotherapy.
Against this backdrop, there is a well-documented shortage of psychiatrists in Pennsylvania. According to the American Academy of Child and Adolescent Psychiatrists, Pennsylvania has 18 child and adolescent psychiatrists per 100,000 children, placing the state in the "High Shortage" category (18-46%). 45% of Pennsylvania counties do not have a single psychiatrist with a specialty in children and adolescents. The average child and adolescent psychiatrist is age 54 which indicates that the workforce may continue to contract due to retirement. A 2018 article published in the National Library of Medicine stated that it was unclear if the current psychiatric shortage would be resolved by 2050.[iv] It should be noted that those projections were made before the pandemic and the subsequent increased demands for behavioral health and substance services. The Kaiser Foundation estimated that as of April 1, 2024, Pennsylvania would require an additional 59 psychiatrists to remove the 118 Health Professional Shortage Areas that have been identified in the Commonwealth. The additional cost is unclear as is the understanding that payors will accept and absorb this regulation caused cost increase.

§ 5330.145. Treatment services. (c) The following must be provided in accordance with the child's, youth's or young adult's treatment objectives:
(1) Individual therapy with the child's, youth's or young adult's treatment team leader must be provided for at least 1 hour each month.
(2) Individual therapy with the child's, youth's or young adult's mental health professional must be provided for at least 2 hours each week.
(3) Group therapy must be provided for at least 3 hours each week. PRTF staff that meet the qualifications of a mental health professional, clinical director or treatment team leader shall facilitate group therapy.
(4) Family therapy as follows:
(iii) Family therapy must be provided for at least 1 hour each week.
(5) Psychoeducation group therapy must be provided at least 3 hours each week.
The agency points out that the Department has provided no evidence-based research to support these arbitrary standards for treatment. Furthermore, these standards violate the Pennsylvania-mandated CASSP Principle of "Child Centered Treatment" which states that services are planned to meet the individual needs of the child, rather than to fit the child into an existing service.
These standards do not account for a constellation of factors including client's age, diagnoses, developmental delay, cognitive level, or family system.

§5330.141. Treatment planning requirements. (d) PRTF staff shall maintain a communication log for each child, youth or young adult that includes daily notes about the child's, youth's or young adult's behaviors and observations about the child, youth or young adult that can be used by the treatment team in the treatment planning process.
This proposed rule is asking for a duplication of the electronic medical record. Each day floor staff enter narratives summarizing each client's behavior, three times a day into the EHR. In addition to the narratives, they use the D.A.P. (Description, Assessment, Plan) format to describe the therapeutic groups that were led and each client's response to them. These daily progress notes currently provide data used by the treatment planning team. Staff use alerts with in the electronic medical record to notify clinicians and coworkers about significant behaviors which occur on the shift.
This rule calls for a duplication of service entry which already occurs daily and would create an administrative burden that would detract from the client care and increase costs at the same time.

§ 5330.147. Discharge.
The proposed regulations do not account for discharges that occur against medical advice. The agency requests that this contingency be addressed to prevent PRTFs being held accountable for situations over which they have no control.

5330.151. Transportation.
Most PRTFs are currently not operating at their licensed capacity due to chronic staffing shortages. The proposed transportation ratios will make it difficult for the agency to assist in the transportation of clients on family visits, especially around the holidays when client visits increase. Providing transportation to court hearings and required health care appointments could become increasingly difficult.
Many RTF's use van transports to school, how has this been relayed to the Department of Education, and would they then need to transport? In our case, PHI operates a school that normalized school behaviors. However, this rule may cause us to shut down the school and educate clients in the facilities. This is a major step backwards in thinking about the realities of transportation in a PRTF.

(e) A manual restraint may not be utilized on a child, youth or young adult during transport.
The agency seeks clearer language. Does transport mean "while the vehicle is in motion" or the entire trip including stops and time spent at the destination?

§ 5330.166(c). Medication refusal. A PRTF shall inform the child's, youth's or young adult's treatment team leader of the refusal to take prescription medication as soon as possible, but no later than 1 hour after the refusal.
This time window is excessively restrictive as it does not account for the potential of the nursing staff being pulled away to observe a restraint or other crisis.

§ 5330.170 Self-administration of medication
The proposed regulation shall cause more interaction with the Dr.'s that seems a bit unneeded. This will also add a cost for staff time.

§ 5330.182 (i) An order for a manual restraint and the application of a manual restraint may not exceed 30 minutes.
This proposed rule is far more stringent than what is required by the Federal regulations (see 42 CFR 483(e)(2)), which permits a manual restraint for no more than 4 hours if the individual being restraint is between 18-21 years old; no more than 2 hours of the individual being restrained is 9-18 years old; and for no more than 1 hour if the individual is under the age of 9.
Alternate Rule: § 5330.182 (i) An order for a manual restraint and the application of a manual restraint may not exceed one hour. When the restraint exceeds 30 minutes, the attending psychiatrist must be updated.

§ 5330.184. Restrictive procedure plan (a) A restrictive procedure plan must be written within 24 hours of a child's, youth's or young adult's admission to a PRTF and prior to the use of a manual restraint.
Requiring restrictive procedure plans to be written at the time of admission will result in a lack of individualization of the plan as the facility will have no time to observe the client.
Agency Recommendation: That 3800.24 Unanticipated Use be continued in the 5300 regulations, which calls for the creation of a restrictive procedure plan after any type of restrictive procedure is used four times for the same child in any 3-month period.

§ 5330.185 (a) A PRTF shall have at least two PRTF staff present during the application of a manual restraint.
This agency agrees that having two staff present during the application of a restraint is ideal. However, there are circumstances where this is not possible. For example, if a client who has expressed suicidal intention attempts to elope, a staff person would pursue the client, and if necessary, restrain the client for their safety. At the start of the restraint, it is possible that a second staff person may not be available. Other circumstances include when a staff person transitions the client from one building to another. It is highly unlikely that a second staff person would be physically present to assist with restraint in those circumstances. However, to ensure client staff, our agency has video surveillance cameras monitoring the campus grounds as well as inside the buildings.

§ 5330.185 (i) Within 30 minutes of initiation of a manual restraint or immediately after a manual restraint is removed, a treatment team leader, physician, APP or RN, who is certified in the use of manual restraints, shall conduct a face-to-face assessment...

This proposed rule halves the Federal standard of a 1-hour window for the face-to-face assessment to occur. It is likely that clients may not be sufficiently deescalated after the restraint to cooperate with the face-to-face assessment. This standard could be impossible to meet if multiple restraints occur simultaneously on campus.

§ 5330.185 (k) A PRTF shall notify the child's, youth's or young adult's parent, legal guardian or caregiver of the manual restraint within 1 hour after the manual restraint has ended.

At times this proposed rule will create an unrealistic burden on the PRTF staff as on occasion multiple clients can be dysregulated at once. The CFR states that the parent /legal guardian contact happens "as soon as possible" but not place a specific period in which the contact must take place. Our agency policy requires the contact to occur within the 24-hour window. The proposed 1-hour window for parent contact is excessively short by comparison and creates unnecessary potential for regulatory non-compliance on the part of the PRTFs. These regulations do not account for the staff sometimes having to attend to multiple crises on campus and the subsequent administrative tasks that follow. The rules do not account for barriers parents encounter such as location, work, and responsibilities with other family members.

Alternate Rule: A PRTF shall notify the child's, youth's or young adult's parent, legal guardian or caregiver of the manual restraint as soon as possible, but not longer than within 24 hours after the manual restraint has ended.

§ 5330.187 (b)(10) Written statements from PRTF staff describing the events prior to, during and following the manual restraint from each PRTF staff person who was directly involved or who observed the manual restraint.

Federal regulations (§483.358(h)(4) require the documentation of the emergency safe situation that necessitated the restraint. The agency satisfies those requirements by having the restraint team leader document the narrative in the restraint form that includes the client's antecedent behaviors, using the Behavior, Intervention, Response (B.I.R.) format.

It should be noted that Federal regulations already require the presence of an observer during restraint and that many PRTFs, including this agency, also utilize recorded video surveillance.

Requiring each participant in the restraint to submit their own written statements is an excessive administrative burden that exceeds Federal regulation.

Alternate Rule: § 5330.187 (b)(10) In the event that the restraint results in a client injury, written statements from PRTF staff describing the events prior to, during and following the manual restraint from each PRTF staff person who was directly involved or who observed the manual restraint.

§ 5330.188 (b) Within 24 hours after the use of a manual restraint, a face-to-face discussion with the child, youth or young adult must occur and include the following: (2) Representatives from the child's, youth's or young adult's treatment team.

Requiring representatives of the treatment team, in addition to the PRTF staff involved in the restraint creates a scheduling and administrative burden and reduces the likelihood that the debrief can occur within the CFR-mandated 24-hour window for the debrief to occur. Representatives of the treatment team after frequently not scheduled to work in the evenings or weekends. Moreover, there is no corresponding Federal regulation.

Alternate Rule: § 5330.188 (b) Within 24 hours after the use of a manual restraint, a face-to-face discussion with the child, youth or young adult must occur and include the following: (2) Representatives from the child's, youth's or young adult's treatment team, if available.

§ 5330.188 (b) Within 24 hours after the use of a manual restraint, a face-to-face discussion with the child, youth or young adult must occur and include the following: (3) The child's, youth's or young adult's parent, legal guardian or caregiver, if available.

This proposed rule exceeds Federal regulations regarding child debriefing following a restraint. A client's Mental Health Professional already has the discretion of discussing the events leading up to a manual restraint in family therapy with the client and parent or guardian. Requiring parent or guardian participation in each child debrief, when possible, combined with the requirement of having a representative of the client's treatment team in the debrief, will necessarily make the increasingly difficult to schedule these debriefs within the required 24-hour window.

The regulation does not account for the fact that state workers assigned to adjudicated youth will not be available during the evenings and weekends to participate in the debrief.

The agency recommends that this rule be omitted.

§ 5330.188(d) Within 24 hours after the use of a manual restraint, the PRTF staff involved in the manual restraint, supervisory and administrative staff, shall conduct a debriefing that includes, at a minimum, a review and discussion of the following:

This proposed rule requires the presence of both a mental health worker supervisor and a PRTF administrator in the staff debrief. We ask for clarification as to who is administrative staff are as defined by the regulations. Our concern is that, depending on their definition, administrative staff may not be available to participate in the debriefs due to their schedules.

§ 5330.221. Quality assurance requirements.

The §5330 regulations do not have quality assurance requirements. This agency already has a quality assurance program which already accomplishes several of the requirements of the proposed annual report including a restraint reduction analysis, program review, and staff, client, and parent satisfaction surveys. This adds an unnecessary layer

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Should you have questions contact me directly.

Thank you,

Nick

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