Received 11/27/2024
#14-555-11

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November 27, 2024

Re: Proposed PRTF Regulations Community Care Comments

Community Care Behavioral appreciates the opportunity to comment on the proposed PRTF regulations. We have used this opportunity to provide feedback, request clarification, and share our concerns.

Accreditation requirements

All RTFs must become PRTFs and expected to comply with requirements. Should RTF providers elect not to comply with the requirements to become PRTFs, for example specialized programs serving those with neurodevelopmental disorders, what is the Department 's plan for continuity of care for those HealthChoices members with complex needs who are currently being served ?

Will the 6 providers who are currently nonaccredited remain program options under CYF/JPO funding should they choose not to proceed with requirements to become PRTF? The potential loss of those RTF programs could have significant impact on access.

Financial Assumptions , Unintended Consequences of Increased Staffing, Supervision, and Access

The proposed regulations note that currently there are 22 providers that are licensed and accredited with 6 providers who are not accredited and that during CY 2019 2,564 youth were treated in an RTF certified by the Department. It was not clear if these numbers reflect the multiple closures, consolidations, and downsizing in the past few years of multiple RTFs across the Commonwealth reflecting diminished capacity.

The proposed regulations impact staffing ratios, supervision, and require new positions including a medical director, treatment team leader, mental health professional and RN.

RTF providers are already struggling to recruit and retain staff. While the intent of the proposed regulations is admirable, to improve the quality of services provided to children, youth, and young adults, there is real concern that the cost of increased staffing and supervision and inability to meet the new requirements due to staffing challenges will result in PRTFs closing or reducing their capacity to serve children and youth. Such a scenario would significantly reduce access to needed behavioral health services for vulnerable children, youth, and young adults in the Commonwealth.

Furthermore, the assumptions regarding the financial impact associated with meeting the proposed requirements of increased staffing and supervision may be too low given the workforce challenges. The statement "The Department's BHMCOs' capitation rates and MA provider rates are anticipated to be adjusted to reflect the increased PRTF costs" forecasts an unknown outcome that can create uncertainty in providers.

Advanced Practice Professional (Physician Assistant or Certified Registered Nurse Practitioner) The proposed regulations state if within the scope of the APP's practice, they may :

"Evaluate the physical or psychological condition of a child, youth or young adult who takes a prescribed medication. Review, update, sign and date the child's, youth's or young adult's treatment plan. Perform initial or routine specific screenings and assessments to assess the physical or psychological condition of a child, youth or young adult."

The requirement is for the APP to be licensed and have had a least 1 year of experience working with children, youth, or young adults. There is no requirement to have psychiatric training or behavioral health experience.

APPs are providing behavioral health services in a number of treatment settings. Please clarify if an APP is permitted to conduct the psychiatric evaluation recommending the initial treatment in PRTF or recommending continued stay in PRTF or if such evaluation must be carried out face-to- face by the psychiatrist ? If the APP conducts such an evaluation would there be a requirement that the initial PRTF or continued stay evaluation to be reviewed and signed by the psychiatrist ?

If a Nurse Practitioner obtained the *Psychiatric Mental Health Nurse Practitioner Certificate* please clarify what the scope of their activities in PRTF would include.

Treatment Requirements

The proposed regulations requiring staff training in trauma informed care, child development, cultural competency, diversity, equity and inclusion elevates the core knowledge base of staff relative to current regulations. Expanding beyond the required training we feel the need for receipt of evidence based treatment should be recognized and strategies developed to ensure such treatment is delivered in PRTF.

Psychiatrists must provide at least 1 hour each month of individual therapy with the child, youth or young adult. This will extend the amount of psychiatric time needed while there is a known shortage of psychiatrists/child psychiatrists. Other clinical staff have the expertise to conduct therapy. The psychiatrist time could be better spent attending monthly treatment team meetings, reviewing the case formulation and over all treatment plan, observing youth in the milieu, providing clinical guidance to the treatment team, seeing youth for a shorter time more frequently, monitoring and reassessing medications, consulting with staff engaging with the child/youth, and communicating with parents and guardians. We recommend that psychiatrist be utilized to help develop and promote quality improvement initiatives that are population based such as adopting best practices in pharmacotherapy including the practice of deprescribing.

Family Therapy is a proposed requirement to be provided at least one hour per week. Has there been consideration given to programs that serve youth diagnosed with ASD and or IDD that provide ABA and skill building programming ? Most of the work with families in more specialized programs is teaching implementation of the behavioral strategies and skill building techniques so that there is transfer of successful interventions to home. Some providers go to the home to work with families during a therapeutic leave and at other times to support the proper use of behavioral interventions. Will these therapeutic activities be credited as family therapy ?

Staffing requirements and availability

Mental Health professionals (therapists) are required available during awake hours each day, to ensure a clinician is available to respond to treatment needs and to allow for more frequent family therapy. Awake hours may range from 7 am to 9 pm. Do awake hours pertain to weekend days as well as weekdays? The extended coverage requirement may create a barrier to recruiting, hiring, and retaining therapists.

The presence of a mental health professional does not necessarily translate into more opportunities for family therapy as the therapist on shift will not likely be the youth's therapist. It is unlikely that youth and their family would feel comfortable with a therapist with whom no prior therapeutic relationship exists and so having such coverage is not likely to increase the frequency of family therapy sessions. Presently we expect PRTFs to be flexible in accommodating parents' availability for family therapy and our experience is most often that providers do make that extra effort to ensure family participation in therapy.

Restraint not to exceed 30 minutes and documentation While seeking to limit the use of restraint is applauded, having the standard for time in restraint that is more stringent than federal regulations may be problematic. If youth has not de-escalated within 30 minutes it may lead to resorting to STAT IM medications or sending youth to emergency departments and potential admission to IPMH. Is there data on the frequency or proportion of restraints that exceed 30 minutes ? If the restraint ends at 20 or 25 minutes and then the youth needs to be restrained again for safety, will another restraint be permissible or considered to be part of the same restraint episode and be forced to end?

Restraint 5330.190 Attestation Within 5 days of receiving notification from the Pennsylvania Department of Health that it has determined that the PRTF **is out of compliance with 42 CFR Part 483, Subpart G (relating to condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under age 21) and must close,** the PRTF shall provide the Department with the PRTF's plans for the orderly transfer of children, youth or young adults.

Are there any exceptions to closure, such as the staff involved in improper restraint is on administrative leave or is no longer permitted to carry out restraints or has been terminated ? Does closure apply to the entire facility, or only the unit where the restraint occurred ? How will the BH-MCOs be notified of necessary closure and what is the timeframe for transfer of youth ?

Notifications of incidents

Incidents involving a fire, disruption of water, heat or cooling be reported to parents, caregivers and the Department within 12 hours. If all youth were safely moved to another building with minimal disruption in programming, could there be consideration of 24 hour rather than 12 hour notifications.

Guardian notified within one hour of restraint- Appreciate the intent to keep guardians informed in timely manner, however in practice one hour may not be feasible.

Medication

Medication Errors- How will these be tracked and monitored ? What are the expectations if providers have such errors in terms of interventions to enhance prevention of medication errors and engage in quality improvement activities.

Prohibit PRNs Will STAT medications be permitted that require a specific order by a provider and include rationale ? While the literature does not find PRNs to be effective, the use of PRNs is prevalent in inpatient settings. Doing away with PRNs completely will require a culture shift for physicians and staff who are accustomed to using PRNs. Many youth in PRTF are coming directly from hospital settings that permit the administration of PRNs. Youth who are in IPMH facilities and seeking admission to PRTFs will continue to be denied access to PRTFs because of their IPMH history of PRN use.

A PRN may be viewed as preferable to a restraint or sending a youth from the PRTF to an Emergency Department. A process for monitoring, tracking, and reporting PRN use could be developed that reviews the rationale, frequency, dosing parameters (age, weight) of PRNs within the context of standing orders for psychotropic medications. Threshold requirements to trigger the assessment of the use of PRNs could be created. The use of alternative strategies to de-escalate, and promote self-regulation such as Trauma Informed Care, Collaborative Problem Solving , Collaborative Proactive Solutions, behavioral modification, use of a sensory room, helping staff with their own stress, facilitating positive staff patient interactions should be facilitated to mitigate the use of PRNs and restraints. .

Use of a level system- Level systems have been debated and criticized. How will the expectation of having P/Ps that utilize trauma informed care principles to provide incentives, structure, limit setting and encouragement and support to a child be reviewed and monitored ?

Visit or Therapeutic Leave ? The proposed regulations use the term visit not therapeutic leave. Is a visit different than Therapeutic Leave (TL) ? Having TL is important to help children, youth, young adults, and families practice the skills learned in the home and community and prepare for discharge. A visit is defined as when the child, youth or young adult is under the approved temporary supervision of an individual at the individual's residence or in the community and not under the supervision of PRTF staff. MA will pay for a day of care if the child's, youth's or young adult's bed is reserved while the child, youth or young adult is on a visit. How will reimbursement or allowable days be defined for therapeutic leave ? Previously there had been a cap on the number of days paid.

Quality Assurance Requirements § 5330.221. The required written quality assurance plan must provide an analysis of manual restraint usage. Could there be consideration of requirement of reporting on findings, recommendations, and implementation of restraint reduction activities, use of alternatives to restraint, review of prescribing practices including concomitant pharmacotherapy, and the practice of deprescribing, implementation and use of evidence based practices, implementation of trauma informed practices, and evidence of work to promote culturally responsive care is delivered ?

Has there been consideration of requiring random and planned video review by PRTFs to assess safety, quality of care, critical incidents and how tasks and responsibilities of staff are executed ?

Are there required quality assurance activities for any of the reportable incidents ?

Secure PRTF- other than the § 5330.201 requirements listed, are there any service description requirements around programming or therapeutic interventions offered ? The proposed regulations reference admission of youth to secure PRTF will depend on medically recommended treatment needs rather than delinquency status. Will there be guidance around "medically recommended treatment needs" for secure PRTF ?

If a child or youth is in Secure PRTF would they be permitted to attend the local school if their educational needs were best met by that school ?

Respectfully submitted on behalf of Community Care,

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