

RESIDENTIAL TREATMENT FACILITY PROGRAM REGULATIONS

SCOPE:

This document applies to all facilities reviewed or seeking review by the Department of Public Welfare as a Psychiatric Residential Treatment Facility (PRTF), issued a Certificate of Compliance and enrolled or seeking enrollment in the Office of Medical Assistance Programs (OMAP) as an accredited psychiatric residential treatment facility in both the fee-for-service and behavioral health managed care programs.

In HealthChoices (HC), the PRTF must also be enrolled with the Behavioral Health Managed Care Organization (BH MCO), meet the appropriate credentialing requirements and be approved to participate in the BH MCO provider network.

PURPOSE:

Comments:

- *A welcome addition in that it puts accreditation with JCAHO, COA and CARF on the same playing field.*
- *There must be efforts made to address the relationships across and among all involved entities – Counties, BHMCOs, DPW, Providers, FFS, etc.*
- *....meet the appropriate credentialing requirements and be approved to participate in the BH MCO provider network... does this imply that providers must contract with all the BHMCOs working within HealthChoices? Clearly, the BHMCOs are not required to contract with all interested providers.*

The purpose of this document is to define the minimum program requirements that must be met by any organization approved or seeking approval as meeting the requirements of this chapter. A psychiatric residential treatment facility must meet the requirements in 42 CFR §441.151 through §441.182 of Subpart D of the Federal code as well as other requirements issued by the Centers for Medicare and Medicaid Services (CMS). A Psychiatric Residential Treatment Facility (PRTF) means a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 – Inpatient Psychiatric Services for Individuals Under age 21 in Psychiatric Facilities or Programs. PRTFs must also ensure that they are in compliance with the requirements set forth in §441.151 through §441.182 which pertain to: certification for need of services, the team certifying the need for services, active treatment, individual plan of care and the team developing the individual plan of care.

The facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children Service, Inc. (COA), or by any other accrediting organization with comparable standards that is recognized by the Commonwealth of Pennsylvania.

Comments:

- *Certification of need – does this reference medical necessity of the individual or the state defined parameters for certification of need?*
- *Clarification of terms is needed.*

BACKGROUND:

A psychiatric residential treatment facility for children and adolescents provides comprehensive mental health treatment to children and adolescents who, due to mental illness or severe emotional disturbance, are in need of quality active treatment that can only be provided in a psychiatric residential treatment facility and for whom alternative, less restrictive forms of treatment have been unsuccessful or are not medically indicated. Standards set forth in this document are based on Pennsylvania's Child and Adolescent Service System Program (CASSP) principles and Principles of Cultural Competency as stated in the Cultural Competence Clinical/Rehabilitation Standards of Practice and the Department of Welfare Special Transmittal on Strategies and Practices to Eliminate the Unnecessary Use of Restraint issued on January 30, 2006.

PRTF programs are designed to offer a short term, intense, focused treatment program to promote a successful return by the child or adolescent to the community. Specific outcomes of the mental health services include the resident returning to the family or to another less restrictive community living situation, as soon as clinically possible and when treatment in a PRTF is no longer medically necessary.

Comments:

- *Concerns with this language - "short term, intense, focused treatment".*
- *Who determines that services are no longer medically necessary? Need for determination to be separate and independent – clarification needed;*
- *Certification of Need for services - can the team determine medical necessity if they are not independent, or are they deemed independent?*
- *Need to address circumstances and have allowances for situations where child may no longer meet medical necessity, but have to remain in care because other placement in the community is not available.*
- *Return to the community is not always the most appropriate goal for the youth – C&Y and juvenile justice outcomes, dependency and/or delinquency issues also apply to many children served in PRTFs.*
- *Need to add language of "available".*
- *Need for clarity related to outcomes referenced.*

The residential treatment facility is expected to work actively with the family, other agencies, and the community to offer strengths-based, culturally competent, medically appropriate treatment designed to meet the individual needs of the resident including those residents identified with emotional and behavioral issues including autism and any co-occurring disorder such as developmental delays, substance abuse etc.

Comments:

- *Recommend that sentence end after "to meet the individual needs of the resident". Should add connection to populations/additional issues to be addressed in program descriptions rather than include all these specific issues and behaviors in regulation.*
- *Concern with why this was included in regulation rather than in program descriptions.*

- *Concern that the more medical the process becomes, the greater the chance for confusion and concern among judges and fiscal staff.*
- *Concern as to true impacts of MA realignment.*
- *Need to add special consideration for children and youth and juvenile justice services needs of child – could also be addressed most appropriately in program descriptions.*

DEFINITIONS:

Active treatment means the implementation of services outlined in a plan of care developed by the ISPT that is designed to meet the mental health needs of the resident and is supervised by the psychiatrist who is responsible for the care of the resident and designed to achieve the goal of the resident's appropriate discharge from the PRTF at the earliest possible time.

Comments:

- *Appears to confuse term with treatment planning/plans.*
- *Federal language and legal requirements make provider responsible for decision-making process; plan of care is not being developed by the federally, legally and ethically responsible persons but by a team; need consistency in language, even with ISPT definition.*

Centers for Medicare and Medicaid Services (CMS) is the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program.

Certification of need is documentation that certifies that ambulatory care resources available in the community do not meet the treatment needs of the resident. (See 42 C.F.R. 441.152)

Drug used as a restraint means any drug that—

- (1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;
- (2) Has the temporary effect of restricting the resident's freedom of movement; and
- (3) Is not a standard treatment for the resident's medical or psychiatric condition.

Comments:

- *Concerns noted about this definition, all psychotropic medications fit this description.*
- *Medication generally has an effect of reducing agitation, outbursts and supports greater self control – how does the desired effect fit with #1?*
- *Some medications have a sedating effect when first taken – how does this fit with #2?*

Department refers to the Department of Public Welfare.

Emergency safety intervention means the use of restraint as an immediate response to an emergency safety situation.

Comments:

Suggested change - Emergency Safety Intervention: unclear terminology, it could be a fire/flood, etc... Could be identified as Emergency Behavioral Safety Intervention and adjusted in all following definitions as applicable.

Emergency safety situation means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention (restraint) as defined in this section.

Comments:

- *Significant concerns specific to reference to “unanticipated” resident behavior – emergency safety situations are present in situations where child has history of outbursts/behaviors; repetition of these behaviors is usually anticipated although not desired. This history presents situations that may place others at threat of violence or injury if no intervention occurs.*

Family – birth, adoptive or foster parents, grandparents, siblings and other relatives, legal custodians except child welfare agencies

Comments:

- *Need to address who child identifies as family especially with older youth.*
- *Would encourage consistency in regulatory definitions of this term as children cross systems and program services.*

Hospital leave is an absence from the facility for more than 24 consecutive hours due to the resident receiving inpatient treatment in a hospital, including treatment in a psychiatric unit of a hospital.

Comments:

- *The majority of providers send staff to support youth in physical hospital settings - the provider is not relieved of responsibility even though child is not in RTF programming.*
- *Hospitalization is not always a "leave" - services may even be higher in a medical/surgical hospital setting.*
- *Need to cross reference with language in interim guidelines.*

Individual plan of care is the written plan developed for each resident to improve his condition to the extent that inpatient care is no longer indicated. (See 42 C.F.R. 441.155). The plan must be developed in consultation with the resident and his/her parents, legal guardians, or others in whose care the individual will be released after discharge.

Comments:

- *There appears to be a disconnect with this definition and that offered next for ISPT*
- *The term “consultation” is different than that understood in practice - that those outside of the treatment team are directing the plan (i.e. family, community providers, etc.).*
- *The plan is to be “informed” by the child and consumers.*
- *The ability of the family to “drive” treatment and practice while addressing the role of the treatment team must be clarified.*
- *Providers need to review this section with their medical staff/consultants – also need to look at federal language which says the medical director (psychiatrist) has the final say, that medical director has the federal, legal and ethical responsibility for this.*
- *There appear to be discrepancies in this definition which require clarification.*
- *Time frames for the plan of care are driven by the BHMCO and regulations – there must be consistency in time frames and expectations of duplication of efforts unnecessarily increase costs*
- *What evidence based models are there to be cited as basis for timeframes for development of the plan? Does 14 days work?*

ISPT (Interagency Service Planning Team) – an individualized team established to assist (*assist who? federal language suggests the psychiatrist – need clarification*) in the development and review of the treatment progress and plan of care for every resident who receives PRTF services. The ISPT is comprised of the resident (as appropriate), a responsible family member/guardian, a representative of the county Mental Health/Mental Retardation (MH/MR) Program, the prescribing or treating psychiatrist (*federal requirements identify psychiatrist as the head of the team - who is the designated lead in regulations?*), other clinicians, any representative chosen by the family including an advocate; and, if applicable and with written parental consent if needed, a representative of the responsible school district, the county children and youth agency or juvenile probation office, other agencies which are or should be providing care and services to the resident, and the resident's Behavioral Health Managed Care Organization (BH-MCO).

Comments:

- *Inconsistent with Active Treatment Plan definition.*
- *Additonal inconsistencies identified - different time frame requirements.*
- *Struggles continue with different standards of MCOs including reflection of cost implications as well as with evidence-based practices.*
- *Individual plan of care & ISPT (Interagency Service Planning Team): Intermittent use of the terms care and treatment throughout the document – need consistency.*
- *ISPT (Interagency Service Planning Team): Second sentence: The ISPT is comprised of the resident (as appropriate). When might it be deemed inapproatie for a child/youth in a PRTF to not be included? Need clarification.*

Mechanical restraint means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

Comments:

- *The following staff descriptions are inconsistent with cuurent contract requirements, regulatory language and practice.*
- *Are there national standards to reference re:age requirements?*
- *Have cost implications been projected?*

Mental Health Aide is an individual at least 21 years of age who has a high school diploma or equivalent.

Comments:

- *This eliminates summer employment opportunities (and thereby a recruitment option) for many college students.*

Mental Health Professional is a person trained in a generally recognized clinical, mental health discipline including, but not limited to, psychiatry, social work, psychology, nursing, rehabilitation or activities therapies who has a graduate degree and at least three years of clinical experience working with children or adolescents.

Comments:

- *This position has historically been an entry level one.*
- *Many workers come straight from college, are getting the experience; prerequisite experience level is problematic.*
- *Costs to recruit workers with 3 years of experience will be considerable.*

Mental Health Worker- an individual who is at least 21 years of age and meets at least one of the following requirements:

- A. A bachelor's degree; at least 12 credit hours of education in psychology, sociology, social work, counseling, nursing, education, rehabilitation counseling, or theology; and one year of experience in mental health services in a CASSP system program.
- B. A licensed registered nurse (RN) and one year of experience in mental health services in a CASSP system program.
- C. A high school diploma or equivalent and five years of experience in mental health services in a CASSP system program.

Comments:

- *No inclusion of associates degree level of education.*
- *What are plans for supporting increased rates to adjust wage scales and be able to pay/retain a worker with this level of experience.*
- *No grandfathering inclusion for current employees.*
- *Eliminates ability to hire college juniors and seniors and interns if they are not 21.*
- *Where is the state's data to support these requirements as being legitimate, reasonable and appropriate?*
- *Reality is that RTFs have excellent staff with lower education and less effective staff with higher educational background.*
- *Concern about access, affordability of individuals to meet these requirements.*
- *Qualifier of the CASSP system is problematic and non-inclusive of the rest of the child serving system - it severely limits ability to find and hire staff.*
- *Need to move RN out of this category - they have a totally different role and different requirements, cost factors and utilization, entry salary of an RN vs. entry pay level for other workers is significant; RNs need to be in a separate category.*
- *Need to include the nurse association in this discussion and define nurses as such - not as MH workers.*

Personal restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her, or holding a resident's hand to safely escort a resident from one area to another.

Comments:

- *Definitions as developed by restraint workgroup and as referenced in other applicable and existing regulations need to be coordinated with this section.*
- *Needs to be some consideration for different restraints utilized in different RTF settings/configurations.*
- *Need to have consistency with 3800s in practice and expectations.*
- *Needs consistency in how restraint is viewed – in service systems and within DPW.*
- *Definitional parameters from workgroup, feds, state, medical - all need to be compared and coordinated.*
- *Consistency needed in terminology, references, definition and data gathering efforts.*

- *Also need to incorporate accreditation definitions - need to have clear, universal definitions (but may be different from federal PRTF definitions).*
- *Emphasis must remain on the child - no matter what the setting or service.*
- *Personal restraint: Terminology unclear, previously used terms of chemical, mechanical and manual restraint were very clear.*
- *Manual restraint does not use physical FORCE but TOUCH to limit the movement of a child in crisis.*

PRTF (Psychiatric Residential Treatment Facility) - A facility that provides comprehensive inpatient mental health treatment and/or substance abuse services for residents with severe emotional disturbances, substance abuse or mental illness that meets State and Federal participation requirements and adheres to Child and Adolescent Service System Principles (CASSP). PRTFs are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Council on Accreditation or by any other accrediting organization recognized by DPW.

Comments:

- *Recognize that this is taken from the federal definition for PRTF.*
- *Does not include short-term or brief noted earlier.*
- *Does not include/address CARF as an option.*

Resident receiving PRTF services means an individual under 21 years of age, or if the individual was receiving the services immediately before he or she reached age 21 until the individual reaches 22 years of age. (See 42 C.F.R. 441.151)

Comments:

- *Different age considerations/limitations are used depending on county contracts, MCOs, OCYF/OMHSAS requirements.*
- *Will providers need to change admission criteria to reflect this?*
- *What are the potential liability issues?*
- *Language variations – Resident? Child? Individual? Client? There needs to be consistency in terminology.*
- *Appears as through there are efforts to use federal regulations when convenient and adding additional expectations/qualifiers in an inconsistent manner.*

Restraint means a “personal restraint,” “mechanical restraint,” or “drug used as a restraint” as defined in this section.

Comments:

- *Consistency in terminology referencing restrictive procedures and restraint remains a concern.*

Seclusion - restricting a resident in a locked room, and isolating the person from any personal contact. The term “locked room” includes any type of door locking device such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door closed, preventing the individual from leaving the room. Seclusion does not include the use of a time-out room. Locking an individual in a bedroom during sleeping hours is considered seclusion.

Serious injury means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns,

lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Staff means those individuals with responsibility for managing a resident's health or participating in a restraint and who are employed by the facility on a full-time, part-time, or contract basis.

Comments:

- *Why is restraint in this definition?*
- *Parameters of staff are not reflective of reality.*
- *Why those two areas – “managing a resident's health or participating in a restraint” - appears to be an odd reference.*
- *How does this fit in with expectations identified later? Does this correspond with training and supervision requirements?*

Time out means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

Comments:

- *Concerns noted with this definition.*
- *Need to include that there may be extenuating circumstances that are severe enough to keep the child in a separate safe area.*
- *Need to reference ACT definitions, other regulations and community standards of practice as well as consider specifics of population served.*
- *In addition to the examples mentioned, additional guidance for time out space/location and staff responsibilities is requested. If child chooses to take a time out in their room, may the door be closed without supervision? What if the child needs to be alone for a few minutes to regain their composure, may the child do so in an open room/space as long as she/he is observable when needed for safety?*

Team developing individual plan of care (interdisciplinary team) as described in Federal regulations in 42 C.F.R. 441.156 as responsible for developing the Individual plan of care, is comprised of those employed by, or those who provide services to eligible residents in the PRTF, and is responsible for the review of the treatment needs of a resident receiving mental health services.

Comments:

- *Needs to be consistent with federal specifications as to whom it includes - occupational therapist, psychiatric nurse, licensed social worker, etc.*
- *Needs to be consistency by referencing one team – should be defined in the program description to respond to the needs/issues of youth served in the program.*

(1) PROGRAM DESCRIPTION:

- A. A written program description must guide the agency's operations and delivery of services. Each PRTF is required to develop its own program description to implement the requirements in this document. The program description must be approved by the Office of Mental Health and Substance Abuse Services (OMHSAS) as demonstrating the provider's ability to support, and maximize the quality of life and functional abilities of residents identified with emotional and behavioral issues including autism and any co-occurring disorder such as

developmental delays, substance abuse etc. Any changes to the program description, including changes in capacity, must be submitted to the Department for approval prior to implementation. The Department will review the implementation of the PRTF program description at the annual site visit.

Comments:

- *Same issue as earlier with the D&A inclusion and the specificity outside of the individual program descriptions.*
- *Also covered under the DOH/BDAP requirements.*

- B. The program description will include the facility location, legal ownership, and administration table of organization, the philosophy, vision and mission of the program and explain in detail how the facility will meet the requirements in this document. The description will include detail regarding the population served by the PRTF, including the number of residents served, age groups, and other relevant characteristics of the population.

Comments:

- *Covered in agency policy and procedures manuals, not the program description itself.*
- *These inclusions must match/coordinate with accreditation and other regulatory requirements.*

GENERAL REQUIREMENTS:

- A. Prior to enrollment with the Office of Medical Assistance Programs (OMAP), a PRTF must meet the requirements of this chapter. When a facility provides drug and alcohol treatment, in addition to mental health treatment, the facility must be licensed by The Department of Health. All PRTFs must also adhere to the CASSP Principles and the Principles of Cultural Competency.

Comments:

- *The Bulletin addressing Co-occurring Disorders should be referenced in this section.*

- B. Program staff that have direct contact with residents must have a minimum of three years experience in a CASSSP system and ongoing training relevant to the mental health needs of children, adolescents, and their families.

Comments:

- *The term "Program Staff" is too broad.*
- *Discrete staff categories/titles, consistent with the 3800 regulations, should be used.*
- *There should be consistency in staff categories and titles throughout the document.*
- *Providers do not support the proposed requirement that program staff that have direct contact with clients should have minimum of 3yrs of experience in CASSSP system. There are numerous issues to consider - Where will they get their experience? Where is this work force? Who will pay for this work force? These requirements are too stringent for a direct care position.*

- B. Program staff must maintain information to ensure that arrangements are made with the county of residence to secure and maintain basic entitlements and other benefits, e.g. SSI, Medicaid, insurance coverage, etc.

Comments:

- *Examples of basic entitlements and other benefits should include education and child welfare.*

- C. Each program must have a medical director that oversees the delivery of the treatment interventions to the residents. The medical director must be a board certified psychiatrist. The medical director or clinical director also ensures that all staff receives training and clinical supervision. (42 CFR 441.151) The clinical director must be a mental health professional.

Comments:

- The first lines of this section should be replaced with the following language, “Each program must have a board certified, licensed psychiatrist to oversee treatment of each resident.”*
- The term “medical director” connotes a staff position and could be construed to prohibit the use of a psychiatrist on a contractual basis to fulfill this function.*
- There are serious concerns with requirement that the medical director being a board certified psychiatrist. The psychiatrist can oversee treatment but can also have an attendee model in place.*
- Often the responsibilities of treatment oversight are shared by 2 part-time psychiatrists.*
- Has there been consideration of the financial ramifications if an RTF does not already have a psychiatrist? And where do they get them as they are so limited in numbers?*
- What about programs that contract with Psychiatrists? What about a Corporate Medical Director? There is no need for each program to have this requirement. A recommendation offered is that a board certified psychiatrist, whether it be by contract or staff position, have oversight responsibility of treatment interventions to residents.*
- How would small PRTF's deal with this issue? If the stated desire is to have community based, accessible services which are usually smaller in size, this requirement is in conflict.*

- D. Each resident must have a written individual plan of care, which is outcome oriented and specific, describing the services to be provided. The initial individual plan of care must be developed by an ISPT. The individual plan of care must be developed and implemented no later than 14 days after admission or 24 hours after returning from an inpatient hospitalization or unexcused leave of absence from the facility. (See 42 C.F.R. 441.154.) The plan must address the resident's required education or vocational program. The decision regarding the educational portion of the resident's day is to be made on an individualized basis, with input from all members of the ISPT, by local public education officials. The facility must ensure that they make all efforts to engage parents or legal guardians as applicable and other family members in the development of the treatment interventions, individual plans of care and in the delivery of services. The Parents, legal guardians, or both, if applicable, must be involved in and notified of any significant changes to the plan, including changes in medication (with the exception of emergency life-sustaining services) before they are implemented. Parent and family outreach and engagement efforts must be documented and lack of parent/legal guardian/family member involvement must be explained. A plan to address the lack of parent/legal guardian/family involvement must be included in the

resident's record. Each resident's individual plan of care must be reviewed at least every 30 days by the ISPT.

Comments:

- *The roles and responsibilities of members of the ISPT and Treatment Team should be clearly articulated. As currently drafted, roles and responsibilities appear to overlap.*
- *Language should be added which would require that, "A preliminary plan be completed within 24 hours of admission." RTF providers agree that preliminary treatment plan to be done within 24 hours and more formal plan to be done within 14 days. Federal regs state the plan of care is the treatment plan as we know it and these requirements need to be incorporated as the basis for timeframes. Currently BHMCO's and OMHSAS state that the initial formal plan is to be done within 30-days and done by the MDT.*
- *It is recommended that the sentence, "Parents, legal guardians, or both, if applicable, must be involved in and notified of any significant changes to the plan, including changes in medication (with the exception of emergency life-sustaining services) before they are implemented." be changed, to "The PRTF will make reasonable efforts to notify and involve parents, legal guardians, or both, if applicable, about significant changes to the plan, including changes in medication (with the exception of emergency life-sustaining services.)"*
- *Is the ISPT the same as the MDT? There should be consistency throughout the document.*
- *Suggest change - The facility must ensure that they make all "reasonable" efforts to engage parents or legal guardians.....*
- *Suggested change - Parents, legal guardians, or both, if applicable, must be involved in and notified of "any significant changes (with clarification/definition added)" to the plan, including changes in medication.....*
- *Plan review/updates after return from a hospital/AWOL? Can this be a safety plan which is limited?*

- E. At the time of the resident's admission, the PRTF must designate an individual to be the resident's primary contact and have primary responsibility for case management. The primary contact's responsibilities include liaison activities with the county representative and with other systems involved with the resident, including the resident's family, involved human service systems, and the education system. An onsite meeting with the parents(s) or legal guardians (s) shall occur within the first seven days of the resident's admission. The primary contact is responsible for coordinating the resident's aftercare plan with the involved community agencies, natural supports, and the family when the child will be returning home. The primary contact shall provide all aftercare agencies with a comprehensive written discharge summary, that includes the clinical rationale for each medication, information on treatment rendered during the PRTF stay and the individual plans of care developed by the facility treatment team.

Comments:

- *With regard to the third sentence, options to allow for fuller participation other than just an "onsite meeting" with the resident's parents/ legal guardians should be available.*
- *This directive should state, "The PRTF shall make reasonable efforts to hold a meeting (face to face, by telephone or by other means) with a resident's parents or*

legal guardians within 7 days of the resident's admission." Options for this to be addressed through community visit, on-site, electronically, phone- due to distance and possibility of parents' situation. Parents may be incarcerated or in treatment themselves, limiting access. How will C&Y situations with no family involvement be addressed?

- *With regard to the fourth sentence, PRTF should submit discharge plans to aftercare agencies within 14 days of the discharge.*
- *Suggested change - The primary contact shall provide all aftercare agencies with a comprehensive written discharge summary..... "within 14 days following discharge."*

F. The PRTF shall document its efforts to link the resident and family with community resources, both formal human service systems and informal community supports. Community linkages outside the facility must be based on the planned expectation that the resident will be returning to his/her own community and will include supports to assist the resident in making a smooth transition back home.

Comments:

- *The term "Community Linkages" should be more fully defined to include the county human service system, BHMCO, and community of residence.*
- *A separate heading is warranted to address situations in which the resident is not returning to his or her community of origin. In this event, the "PRTF shall document its efforts to link the resident with community resources in the community where he or she will be living."*
- *Need to clarify roles and responsibility of county and BHMCO's in this process.*
- *Another step needs to be added for children and youth not returning home which is similar to that stated but with greater focus on step-down options and supports. Family, county, BHMCO, referring agency, current provider need to assist with this and collaborate as to what is most appropriate but also what is available.*

TREATMENT REQUIREMENTS:

A. Strengths Based Programming

Active treatment starts with the intake and assessment that forms the basis for treatment and includes a plan for discharge. Active treatment includes ongoing family involvement in the planning for and delivery of services. In active treatment, programming is individualized to the needs of each resident and the family to maximize individual functioning in activities of daily living, education and vocational preparation. The psychiatric residential treatment facility is expected to appropriately treat a resident, document the delivery and response to treatment, and provide or obtain all services the resident needs while a resident of the facility.

Comments:

- *Concerns were identified previously as to definition of active treatment.*
- *Suggested changes - The psychiatric residential treatment facility is expected to appropriately treat and provide or obtain "all" (delete this word) services the resident needs while a resident of the facility (add) "as defined in the program description or within the scope of practice".*

Services provided by the psychiatric residential treatment facility must be built on the competencies of the resident and the family, while addressing specific needs e.g., culture, treatment history, family relationships, etc. Specific expectations include, at a minimum, the following, all of which must be provided as needed and documented in the resident's record, at a minimum, the following:

1. Individual psychotherapy, group psychotherapy, family therapy, and other therapeutic interventions as indicated in the individual plan of care, which address both the residents presenting behaviors and underlying mental health issues and when clinically indicated co-occurring issues to include mental health and substance abuse.

Comments:

- *Add to the end of this sentence, "within the scope of the PRTF program description."*
- *Suggested change - when clinically indicated co-occurring issues to include mental health and substance abuse..... this refernce should beeliminated as it was earlier in the document. As written, it appears as though all PRTF's will have to provide interventions to address D&A issues.*

2. Promotion of social skills consistent with the resident's successful adaptation to both society norms and the resident's individual community.

Comments:

- *This directive is too vague.*
- *Clarification is needed as to what the term "society norms" includes – current presentation leaves it too open to inconsistent interpretation.*

3. Age-appropriate training about maintenance of good physical health including, with the permission of the parents or legal guardians as applicable, the prevention of sexually transmitted diseases including HIV/AIDS.

Comments:

- *Rather than "Age-appropriate", the training should be "treatment indicated."*

4. Special individualized activities, relevant to resident's medical or physical needs.

Comments:

- *Please provide examples of what is expected.*

5. Use of psychotropic medication, when indicated, with clinical rationale for each psychotropic medication.

6. Training in daily living skills and community access skills.

7. Ongoing review of discharge progress by the ISPT with the opportunity to demonstrate that skills have been mastered.

Comments:

- *The words "discharge progress" should be replaced by "treatment progress".*
- *Clarification of "demonstrate the skills have been mastered" is needed.*

8. Prior to discharge the PRTF shall submit documents related to the resident's care in their facility to the ambulatory mental health agencies providing aftercare.
9. Prior to discharge the PRTF shall submit documents related to the resident's care in their facility to the ambulatory mental health agencies providing aftercare. For any resident receiving or who has received psychotropic medication during their PRTF stay the clinical rationale for each medication shall be clearly documented on their psychiatric discharge summary or final evaluation.

Comments:

- *This section should be separated into two sections because it references two discrete tasks.*
- *The original Section 8 should state, "Prior to discharge the PRTF shall submit documents related to the resident's care in its facility to the ambulatory mental health agencies providing aftercare."*
- *The term "documents related to the resident's care" is too broad to provide guidance on what should be included.*
- *The new Section 9 should include the sentence, "For any resident receiving or who has received psychotropic medication during their PRTF stay, the clinical rationale for each medication shall be clearly documented on their psychiatric discharge summary or final evaluation."*
- *A comprehensive explanation regarding the differences in the discharge summary, final evaluation, and documents related to the resident's care is needed.*

- B. PRTFs are responsible for developing supports and skills for children that promote their mentally healthy functioning, in partnership with their families, and the youth themselves. Children need to be involved in services which can provide trauma informed care and utilize positive and proactive approaches. PRTFs that employ trauma informed care make it a priority to listen to children and their families more carefully, so that they can better understand their lives and the challenges they are facing. When children's lives are understood, children can be more successful in overcoming inappropriate behaviors and behavioral health issues.

To achieve trauma informed care, providers and their staff need to:

1. Be respectful of the child and family's perspective and not see themselves as only rule enforcers;
2. Meaningfully partner with families, recognizing their complex needs;
3. Recognize that a child's placement into an out-of-home setting can also be a source of trauma to children and their families;
4. Be educated and committed to providing care sensitive to the child's history of past trauma and current needs;
5. Understand that trauma can be measured through the use of various assessment tools;
6. Recognize that programmatic changes within the organization may be necessary in providing successful trauma informed care; and
7. Understand that staff are the professionals and children who have been exposed to trauma will often provoke staff to get attention.

Comments:

- *While it is acknowledged that providing trauma informed care is an important component of services, regulations should not be used to dictate clinical interventions.*
- *Recommended time frame - “Within 14 days post discharge” PRTFs are responsible for developing supports and skills for children that promote their mentally healthy functioning, in partnership with their families, and the youth themselves.*
- *By including the specifics of trauma informed care within regulation, DPW is prescribing a form of treatment. This appears to be beyond the scope of regulatory authority.*

PLAN OF CARE

B. Individual Plan of Care.

1. “Individual plan of care” means a written plan developed for each resident in accordance with Sec. Sec. 456.180 and 456.181 of the federal requirements, to improve his/her condition to the extent that inpatient care is no longer necessary.
2. The plan of care must—
 - a. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the resident's situation and reflects the need for inpatient psychiatric care;
 - b. Be developed by a team of professionals specified under Sec. 441.156 in consultation with the resident and his parents, legal guardians, or others in whose care he will be released after discharge;
 - c. State treatment objectives;
 - d. Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
 - e. Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the resident's family, school, and community upon discharge.

Comments:

- *Re: section “e”, please clarify what is meant by “partial discharge plans.*
- *What about children and youth with other issues? MH issues are not always the primary consideration/concern - D&A, MR, C&Y/JJ?*
- *Be developed by a team of professionals.....Which professionals are being referred to here? Internal staff? External staff?*

3. The plan must be reviewed every 30 days by the ISP team to:
 - a. Determine that services being provided are or were required on an inpatient basis, and
 - b. Recommend changes in the plan as indicated by the resident's overall adjustment as an inpatient.

Comments:

- *Please clarify the differences in the roles and responsibilities of ISP and Treatment teams.*
- *The plan must be reviewed every 30 days by the “ISP” - again a different team, still not consistent with which team does what or clarity as to scope of responsibilities.*

4. The development and review of the plan of care as specified in this section satisfies the utilization control requirements for—
 - a. Recertification under Sec. Sec. 456.60(b), 456.160(b), and 456.360(b) of the federal requirements; and
 - b. Establishment and periodic review of the plan of care as required in

Comments:

- *Who are external review people? MCO's? County?*
- *Contradicts page 25 with Utilization Review.*
- *What is role and responsibility of treatment teams, internal and external?*
- *....periodic review of the plan of care as required inWhat? Where?*

B. TEAM DEVELOPING INDIVIDUAL PLAN OF CARE

1. The individual plan of care under Sec. 441.155 must be developed by an interdisciplinary team of physicians and other personnel who are employed by the PRTF or provide services to patients in the facility and in coordination with parent(s) or legal guardian(s).

Comments:

- *....interdisciplinary team of physicians and other personnel who are employed... which staff are envisioned as needing to be part of this team? Is this left to the discretion of the PRTF? What efforts are expected to solicit county input? BHMCO input? Referring agency input? Advocate input?*
2. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of—
 - a. Assessing the resident's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
 - b. Assessing the potential resources of the resident's family;
 - c. Setting treatment objectives; and
 - d. Prescribing therapeutic modalities to achieve the plan's objectives.
 2. The team must include, as a minimum, either—
 - a. A Board-eligible or Board-certified psychiatrist;
 - b. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
 - c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

Comments:

- *Why even have a psychologist as part of the team since they are not permitted to do evaluations.*

Note: There are two number 2's here.

3. The team must also include one of the following:
 - a. A psychiatric social worker.
 - b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

- c. An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.
- d. A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

Comments:

- *In light of the critical shortage of RNs, the requirement that a RN have one year of experience working with the mentally ill, will present additional challenges to accessing RN staffing.*
 - *The title “psychiatric social work” is no longer widely used in the profession. What are the qualifications/requirements for this title?*
 - *Is the primary purpose to have a licensed professional involved here? What about a mental health professional as defined earlier?*
 - *The team must ALSO include at a minimum: psychiatric SW, RN with specialized training, OT, or a psychologist. RN's are difficult to recruit and it is an issue that they need to come with 1 year of experience treating mentally ill individuals.*
4. Each PRTF is responsible to assign sufficient staff responsible for the implementation of the Plan of Care as identified in 441.155 and developed by a team as identified in 441.156.

FAMILY PARTICIPATION:

The PRTF shall ensure that the resident's family is given the opportunity to participate as full partners in the planning for delivery of services to the resident. Mutual respect between the facility staff and the family, inclusion of the family in all planning and decision making are critical to successful treatment.

Comments:

- *The expected degree of family involvement in determining a treatment plan appears to conflict with federal regulations relevant to the role of the psychiatrist within the scope of the PRTF. Citing family as “full partners” diffuses/dilutes the role of the psychiatrist in making treatment recommendations. While the need to have purposeful family involvement is supported, this language may create confusion.*
- *How are situations with family member conflicts to be addressed? Custody situations? Again what about children and youth under court supervision/in custody of the county? Children and youth that have no family involvement?*

The facility shall document all efforts to involve the resident's family in service planning and delivery. The facility shall ensure that the family is scheduled for an on-site visit as soon as possible and no later than 7 calendar days of the resident's admission. If a family member accompanies the resident on the day of admission the above requirement is met. The facility must have at least one designated area on-campus for family visits. The facility must assist with the coordination of available transportation for the family's on-site participation and visits when assistance with transportation is needed. The facility's approach to family participation shall be proactive, including active recruitment of family involvement in meetings, evidenced by meetings being held at times convenient to the family and with adequate notice to maximize the possibility of family

involvement. The facility is expected to encourage on-going family participation, as appropriate, through the following methods:

Comments:

- *With regard to the scheduling of visits, a recommended change to this section is that, “The PRTF shall make reasonable efforts to hold a meeting (face to face, by telephone or by other means) with a resident’s parents or legal guardians within 7 calendar days of the resident’s admission.”*
- *PRTFs support their role toassist with the coordination of available transportation for the family’s on-site participation and visits when assistance with transportation is needed. However, most PRTFs are not in a position to offer actual transportation and the costs are not always allowable. If this is required, how will PRTFs pay for it? Staff it? What about costs associated with the on-campus family visit? While some PRTFs are able to offer overnight lodging, most are not. Need greater clarity as to expectations and responsibilities being imposed upon PRTFs.*
- *Costs for these groups/meetings have not been deemed an allowable discrete expense.*

A. Individual plan of care meetings and other formal meetings with the family as active members of the team.

Comment:

- *Prefer reference to family as “active member” of the team rather than “full” member previously referenced.*

B. Frequent and regular family contact including telephone calls and visits with parents or legal guardians and other family members as well as community activities within and outside the facility.

C. Family therapy as well as parent support and education groups involving parents or legal guardians as appropriate shall be provided to all residents as part of the overall treatment offered in the PRTF. Consideration of providing treatment services in the resident’s home or community must be given.

Comments:

- *Concerns were voiced re: Consideration of providing treatment services in the resident’s home or community “must be”..... suggested changes - “attempts” must be made and documented”?*
- *Points A-C are supported as philosophical guidelines but concern was noted as to making them regulatory requirements.*
- *Costs associated with parent support groups were identified as a concern. Will the PRTF have to provide transportation? What about the PRTFs at a distance from the resident’s home? What about children and youth with no families? What about families that are incarcerated? What about families restricted due to their own form of treatment?*

D. Involvement of the family in making appropriate medical and medication decisions.

Comments:

What about children and youth with no legal families? Do county C&Y agencies get involved then?

RESIDENT RECORDS:

Each resident's record shall contain the following:

A. Personal information including:

1. The name, sex, admission date, birth date and Social Security Number.
2. The race, height, weight, color of hair, color of eyes and identifying marks.
3. The dated photograph of the resident taken within the past year.
4. Language or means of communication spoken and understood by the resident and the primary language used by the resident's family, if other than English.
5. Religious affiliation.
6. The name, address and telephone number of the person to be contacted in the event of an emergency.
7. Health records.
8. Dental, vision and hearing records.
9. Health and safety assessments.
10. Current and Past Individual Plans of Care.
11. Restrictive procedure plans.
12. Restrictive procedure records relating to the resident.
13. Reports of reportable incidents.
14. Consent to treatment forms.
15. Court order, if applicable.
16. Admission and placement information.
17. Signed notification of rights, grievance procedures and applicable consent to treatment protections.
18. Education records.
19. Past treatment plans or
20. Current and past PRTF psychiatric evaluations.
21. Special consultations or assessments completed or requested as applicable.

B. Clinical information including

1. Progress notes that document the resident's participation in individual therapy, group therapy, family therapy, and other therapeutic interventions.
2. Progress notes must include summaries of individual plan of care reviews and special consultations regarding all aspects of the resident's complete daily program.
3. Documentation of the resident's progress toward meeting treatment goals.
4. Documentation of the family's participation in the planning and treatment and ongoing efforts of the PRTF to accommodate family schedules and encourage such participation.
5. Current psychotropic medications and regular medication reviews. Clinical rationale shall be clearly documented for each medication. All changes in medication must be documented in the medication orders. Records documenting administration of all prescribed medications indicating dosage, actual administration of the medication, responsible staff administering, and signature of the responsible staff person.
6. Documentation of outcomes and reviews following therapeutic leave.
7. Relevant records from other agencies and systems.

C. Notes must be legible and corrections must be made so as not to alter content.
(A resident's record is a legal document)

Comments:

- *The word “legal document” should be changed to “legal record”.*
- *Where is the connection to “Restrictive procedure plans”? What is the expectation? Restrictive procedures mean something else? Additional clarification and coordination with terminology is needed.*
- *Do all calls to counties need to be documented?*

MEDICATION:

A physician must write all psychotropic medication orders. The rationale for each medication must be clearly documented in the resident's medical record. All changes in medication must be documented in the medical record. The psychiatrist must see each resident on psychotropic medications at least every thirty days, with progress and clinical status documented in writing. All changes in type of medications require written parental or legal guardian approval and changes of dosage require at least verbal parental or legal guardian notification. The clinical rationale for each medication must be clearly documented on the resident's discharge summary or final evaluation.

Comments:

- *Can there be allowance of a verbal permission?*
- *What are the parameters for addressing and recognizing the age of consent of 14?*
- *What are potential responses to county pressure to accept the child's signature if the parent's consent cannot be obtained if the child is over age 14?*
- *What are options for next steps if the PRTF is unable to get consent in writing*
- *Is there consideration of an allowance of two-person approvals?*
- *Clarity of acceptable practice is critical to avoid variations in interpretation of acceptable options for verbal and written consent by DPW licensing representatives.*
- *The time delays involved in obtaining a written consent vs. concerns re: potential allegations of medical neglect, particularly for children over the age of 14 who can sign for themselves to access treatment, is a concern.*
- *Clarification about procedures is needed – in situations where there is no ability to contact the parent and/or the options to document verbal parental consent; county child welfare agency accepting approval of the child over age of 14.*
- *If child comes from another facility or inpatient unit, the prescriptions they come with are not valid. Scheduling an appt. with the new psychiatrist and the need for parental consents present serious challenges as of the point of initial admission.*
- *What are the federal requirements?*
- *How will medical administration training using the OMR curriculum address this issue?*
- *Can there be consideration of use of a faxed form to applicable state offices anytime a change is occurring as notification of the psychiatrist's recommendations. There is concern about a system being reliant upon the prompt response of a legal guardian. What is the course of action when the legal guardian does not approve and goes against the psychiatrist's recommendation?*

STAFFING REQUIREMENTS:

- A. The psychiatric residential treatment facility must ensure there is an adequate number of multidisciplinary staff to carry out the goals and objectives of the facility, and to ensure the delivery on individualized treatment to each resident as detailed in their program description.

Comments:

- *Although broad, this section allows for PRTFs to define staffing patterns within their program description. The flexibility in this section appears to be in conflict with more prescriptive requirements noted in other sections.*

- B. Each prospective employee responsible for providing direct care to residents must have a pre-employment physical, and a drug screening.

Comments:

- *Drug screening requirements are new. There must be recognition of costs involved.*
- *There is no exemption for a pre-employment physical conducted within a certain time frame for other employment.*
- *Requirements for Child Abuse and State Police clearances are not addressed.*

- C. Minimum Staffing Level

Each PRTF shall meet the following minimum staff requirements:

Comments:

- *Does not recognize costs and realities of coverage for weekends and holidays.*
- *Recent wage and hour interpretations as to exempt/non-exempt status may have huge cost implications including overtime costs.*
- *Appropriate staffing patterns need to be addressed in program descriptions, not prescribed in regulations.*
- *Supervisory requirements are not identified/addressed.*
- *Cost implications and annual re-assessment of rates is critical.*
- *Long term lack of ability to adjust wage standards to be competitive from the onset will present significant challenges in recruiting and retaining staff.*

1. The staffing ratio during awake hours must reflect the needs of the population being served. A minimum of one mental health worker shall be assigned to direct care responsibilities for every five residents during all hours they are awake and not in school, unless DPW staff including clinical experts deem these minimum staffing ratios are inadequate to meet the needs of the population being served as described in the program description.

Comments:

- *This section appears to be inconsistent with A, which allows for flexibility.*
- *Concerns were raised that this leaves room for interpretation by licensing reps to come in and in hindsight after an incident say didn't have enough staff.*
- *This requirement mandates more staff without assurances that the fiscal implications will be addressed in an equally direct manner.*
- *The staffing definitions remain a concern.*

- *References to federal requirements support a preference for LSW's to be primary in staffing.*
 - *Providers identify concern in using aides for overnight coverage as immediate interventions are often needed. Flexibility is needed; Staffing patterns are most appropriately reflected in program descriptions*
 - *Variations in program staffing need to be emphasized in program descriptions to support variations in rates costs.*
 - *Is there data/research to support these ratios?*
2. The staffing ratio during sleeping hours must reflect the needs of the population being served as described in the program description. At least one mental health worker or aide who is awake shall be assigned for each eight residents and be available during all hours the residents are sleeping. For 9 or more residents, an additional mental health worker or aide shall be on-site and immediately available to assist with emergencies or problems.

Comments:

- *Realities and costs of salaries and staffing must be interjected into this section.*
 - *Definition of mental health worker reinforced by this section.*
3. Mental health professionals shall be available to ensure that the programs can meet the stated active treatment as described in the PRTF's service description. At least one mental health professional must be on site during all hours that residents are awake and in the facility, and be on-call during all hours the residents are sleeping to assist in emergencies.

Comments:

- *Suggested change to "on-call" rather than "on site".*
- *Differentiation between smaller community-based programs and larger cottage-based programs where professional staff may just be in the next building must be considered in this requirement.*
- *Cost implications are again raised - projected costs for this level of staffing and anticipated outcomes.*

RESPONSIBILITIES OF THE PSYCHIATRIST:

- A. Program staff must include a board eligible or board certified psychiatrist experienced in the delivery of children and adolescent mental health services. The psychiatrist is responsible for the following duties:
1. Regular and ongoing contact with all residents and more frequent contact for those residents on medication. *(Note: this is already included earlier with 30 day med checks)* A psychiatrist must see each resident face to face as deemed clinically appropriate, but not less frequently than every review period.

Comments:

- *Is there a ratio envisioned by DPW for the psychiatrist? How many patients can one psychiatrist see?*
2. Regular and ongoing contact with treatment staff to formulate and monitor the implementation of the resident's individual plan of care.

3. Regular and ongoing face-to-face or phone contact with the resident's family.

Comments:

- *Face-to-face or phone contact as defined in the program description.*
- *How will unavailability of family be addressed - psychiatrists often try to call the family but they are not available; DPW licensing reps have stated that attempts do not count.*
- *What is the time frame viewed as being in compliance with this proposed requirement?*
- *May be most appropriate to have providers address this expectation in their program descriptions and have the description approved holding provider to complying with the process as defined for the program.*
- *Process/timing could be defined/included in the ISP.*
- *What about conflicts within the family? Children and youth that have no family involvement? Families that are in their own treatment or incarcerated?*
- *BPI states contact must occur every 30 days currently. Will this remain the practice?*

4. Regular and ongoing contact as appropriate with external, community agencies and natural supports important to the resident's life including informal networking and face-to-face participation in ISPT Meetings.

Comments:

- *This is an unrealistic expectation - psychiatrists are in short supply and do not have the time to do this.*
- *This is normally a process that is delegated by the psychiatrist to other staff.*
- *Concerns are noted with references and costs associated with "informal networking" expectations.*
- *BPI does require this but such contacts can not always take place. How can efforts be documented to satisfy the intent but address the realities?*
- *This increases demands upon psychiatrist without commensurate increases in funds to support service delivery. What about agencies that have psychiatrists contracted on a part time basis? The contracted hours will need to increase – so will the per diem rates.*

5. Perform and prepare formal, written psychiatric evaluations as required.

Comments:

- *Clarification is requested as to required frequency of such evaluations.*

6. Coordinate and/or advise facility staff on medical matters including the prescription and monitoring of psychotropic and other medication.

GENERAL STAFF TRAINING:

- A. The PRTF shall prepare a training plan for all staff having direct contact with residents including temporary and part-time staff and volunteers which includes specific training for newly hired staff and for the ongoing competence of all staff, including staff with whom the facility contracts for service. A record of all training must be kept for each staff member.

Comments:

- *Definition of volunteers must be revisited.*
- *Unclear as to how much training is needed by volunteers.*
- *How will outside groups coming into volunteer be addressed?*

- *How does this connect with minimum number of hours and related discussion from current 3800 clarifications?*
 - *How does this impact interns as unpaid positions/volunteers?*
 - *Concerns re: implications of definition of staff - roles differ greatly within RTF staffing - from support and non-direct service staff (horticulturalist, kitchen staff, etc.) to direct therapists.*
- B. Prior to working with children, each staff person who will have regular and significant direct contact with children, including part-time and temporary staff persons and volunteers, shall have an orientation to the person's specific duties and responsibilities and the policies and procedures of the facility, including reportable incident reporting, discipline, care and management of children, medication administration and use of restrictive procedures.
1. Prior to working alone with children and within 120 calendar days after the date of hire, the director and each full-time, part-time and temporary staff person who will have regular and significant direct contact with children, shall have at least 30 hours of training to include at least the following areas:
 - a. The requirements of this chapter.
 - b. Training in 23 Pa.C.S. § § 6301—6385 (relating to child protective services law) and Chapter 3490 (relating to protective services).
 - c. Fire safety.
 - d. First aid, Heimlich techniques, cardiopulmonary resuscitation and universal precautions.
 - e. Crisis intervention, behavior management and suicide prevention.
 - f. Health and other special issues affecting the population.
 2. If a staff person has completed the training required in subsection (B) within 12 months prior to the staff person's date of hire, the requirement for training in subsection (B) does not apply.
- C. After initial training, the director and each full-time, part-time and temporary staff person, who will have regular and significant direct contact with children, shall have at least 40 hours of training annually relating to the care and management of children. This requirement for annual training does not apply for the initial year of employment.
- D. Each staff person who will have regular and significant direct contact with children, shall complete training in first aid, Heimlich techniques and cardiopulmonary resuscitation at least every year.

Comments:

- *This clearly exceeds recommended frequency for recertification as prescribed by certification entities.*
- E. Training in first aid, Heimlich techniques and cardiopulmonary resuscitation shall be completed by an individual certified as a trainer by a hospital or other recognized health care organization.
- F. Training in fire safety shall be completed by a fire safety expert or, in facilities serving 20 or fewer children, by a staff person trained by a fire safety expert. Video tapes prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Comments:

- *How often must this training be repeated? How often must medication administrations training be completed? What about crisis intervention re-training?*

CLINICAL TRAINING FOR STAFF

A. In addition to the general training requirements outlined above, all PRTF staff must have an additional fifteen hours of training in the following topics:

Comments:

- *There are huge cost implications and time implications for providing/completing the mandatory training as listed.*
- *The focus on mandated training will deplete efforts to provide program-specific/clinical training.*
- *Suggestion to consider including broader time frames (i.e. 2 years) offered.*
- *Suggestion to consider exempting psychiatrists - they won't come to fire safety training and the cost for them attending other requisites is cost prohibitive.*
- *Latitude within program descriptions is requested – RTFs are already required to develop training plans for staff/agency.*
- *Too many 'have-to's without accommodation of need for other 'want-to' training;*
- *Inconsistency with what is covered in other sections (i.e. CPSL, CASSP principles, etc.); should be a minimal list of 'have-to's, which eliminates the ability to do program-specific trainings.*
- *Much of this should be under the 40 hours, especially if certification periods for CPR, Heimlich & first aid are coordinated.*
- *The proposed training requirements are very prescriptive in telling providers who, what, when, and how they will provide training without guarantee of the funds necessary to support compliance.*

1. Professional ethics and conduct and legal issues including professional boundaries with residents and their families, child and general protective services, mandated reporting and confidentiality.

Comments:

- *Compliance with CPSL requirements is already included under general requirements*

2. Understanding CASSP principles and implementing and supporting those principles in clinical practice.
3. Understanding cultural competency as stated in the Cultural Competence Clinical/Rehabilitation Standards of Practice
4. Understanding and supporting the Department of Welfare Special Transmittal on Strategies and Practices to Eliminate the Unnecessary Use of Restraint issued on January 30, 2006.
5. Staff must be trained on agency policy and should demonstrate the ability to effectively transfer the application of policy and procedure to their direct care work with residents and their families.
6. Characteristics of trauma informed care and attachment issues.
7. Signs and symptoms of abuse and neglect.

Comments:

- *This is normally included with training on CPSL requirements already addressed under general requirements*
8. Mental illness and serious emotional disturbance and other behavioral health needs in children as they relate to the bio-psychosocial needs of the residents being served.
 9. Understanding applicable state laws related to the scope of practice for medication administration.
 10. Understanding psychotropic medications, including types, appropriate uses and possible side effects.
 11. Training appropriate to the age, characteristics, diagnosis, and development needs of the residents served.
 12. Training on the discharge process; and
 13. Cross–system training appropriate to the population the facility serves.
 14. Current clinical practice and methodologies to address the unique characteristics of the residents served.
 15. Documentation skills and requirements.
 16. Understanding the recovery and resiliency model.
- B. A record of training including the person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

STAFF EDUCATION AND TRAINING ON THE USE OF RESTRAINTS*Comments:*

- *There is a general sense that although DPW is proposing training opportunities for staff to work toward the stated goal of restraint elimination, there has been no coordinated plan or commitment of funding to support this.*
 - *Providers are referencing their experiences in being previously promised additional funding to comply with federal requirements which never materialized.*
 - *Cost implications must be addressed, even if best practice; otherwise is an unfunded mandate which cannot be supported.*
 - *These requirements cannot be portrayed as cost-neutral in the fiscal impact analysis. Providers stand ready to develop and share realistic cost projections.*
- A. The facility must require staff to have ongoing education, training, and demonstrated knowledge of –
- Comments:*
- *These items should be included as part of the annual 40 hours of training.*
1. Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
 2. The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and
 3. The safe use of restraint, including the ability to recognize and respond to signs of physical distress in residents who are restrained.
- B. The facility must provide training and education for all staff in the safe application and use of restraint techniques

- C. Identification of signs and symptoms of physical distress in resident's system functions (circulatory, respiratory, skeletal, nervous), skin integrity must be included in the overall assessments during the use of emergency interventions.
- D. Staff responses to the identification of resident distress should include immediate interventions such as first aid, CPR, and removal of physical barriers impacting on the resident's safe care. Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.
- E. Individuals who are qualified by education, training and experience must provide staff training.
 - 1. The facility has the responsibility of establishing and meeting guidelines and criteria of staff training credentials. The training requirements must demonstrate that staff trainers/ instructors are educated, trained and experienced in the areas of expertise in which they teach.
 - 2. Personnel records must clearly reflect current educational training, and necessary recertification requirements. Trained staff may be either employed by the facility in staff positions or services may be on a contractual basis. If the training services are provided under contractual agreements, review the procedure for evaluation of the services provided to the facility.
- F. Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
 - 1. Staff must be trained and demonstrate competency before participating in an emergency safety situation. These competency evaluations must be observed and documented by the trainers.
 - a. The facility must provide documentation records of staff training in emergency safety situations that include: identification techniques to identify staff, resident behaviors and environmental factors that may be triggers, use of nonphysical intervention skills, safe uses of restraint, recognition and responses to signs of physical distress in residents who are restrained or secluded. These training components are required on a semiannual basis. Documentation must include observed competencies in these areas.
 - b. The training documentation must also include records of re-certification in the use of cardiopulmonary resuscitation skills. This training is required on an annual basis.
 - c. The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.
 - d. All training programs and materials used by the facility must be available for review by CMS, the State Medicaid agency, and the State survey agency

RESTRICTIVE PROCEDURES:

A. The facility must establish a policy for the use of any emergency safety intervention, which is defined in this subpart as the use of restraint as an immediate response to an emergency safety situation. Use of seclusion in PRTF programs is prohibited in Pennsylvania.

1. Restraint may only be used for emergency safety situations, which are defined as unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs. The use of restraint should be selected only when other less restrictive measures have been found to be ineffective to protect the resident or others.

Comments:

- *This is unrealistic language - providers cannot guarantee or predict this.*
- *This is a goal, best practice, etc. and should be framed in this manner.*

2. The facility policy should address all requirements set forth by the CMS condition of participation (CoP) to ensure the protection of residents, which includes:
 - a. ensuring safety both during and after restraint.
 - b. specifying the required elements of an order for restraint.
 - c. identifying the staff who are responsible for continual assessment of a resident during restraint as well as defining the minimal physical and psychological elements that must be assessed.
3. The facility shall demonstrate effective treatment approaches and alternatives to the use of restraint or coercion that result in a reduction in the use of restraint.

Comments:

- *This is unrealistic language - providers cannot guarantee or predict this.*
- *This is a goal, best practice, etc. and should be framed in this manner.*

4. A written plan to address the elimination of the use of restraint shall be developed by the PRTF and available for review.

Comments:

- *This expectation is a concern as it may become the basis for penalty/citation/negative response from DPW if a provider is unable to achieve elimination of restraint. What is the expectation and planned use of this plan? What specifics are to be addressed? Is it to include additional resources needed with assurance that DPW will address these needs?*

5. The plan must outline:
 - a. Alternative approaches used by the PRTF based on the *Six Core Strategies for the Reduction of S/R* developed by the National Technical Assistance Center through the National Association of State Mental Health Program Directors and the Department of Welfare Special Transmittal on Strategies and Practices to Eliminate the Unnecessary Use of Restraint issued on January 30, 2006.
 - b. The content and process for the collection of data based on the requirements of the Department.

Comments:

- *Clearly, a written plan exceeds federal requirements.*
- *Providers offer support for compliance with 3, 4. & 5a when the state completes 5b and provides data to support requirements as proposed.*
- *How will all staff be trained in this? Will DPW honor their commitment to provide training? The PRTF training staff will need to be trained as trainers, if they are to be responsible for training others within the PRTF. State does not have one consistent curriculum for training on restraints as safety intervention. Agencies have gone out of state for expertise and come back to train their own staff – significant costs are involved.*

- B. Each resident has the right to be free from restraint, of any form, used as a means of coercion, discipline, convenience, or retaliation. Restraint is not to be used as coercion, discipline, retaliation, and retribution or as compensation for lack of staff presence or competency.
1. An order for restraint must not be written as a standing order or on an as-needed basis.
 2. Restraint must not result in harm or injury to the resident and must be used only—
 - a. To ensure the safety of the resident or others during an emergency safety situation. Emergency safety situation means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for a restraint as defined in this section.
 - b. Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint order has not expired.

Comments:

- *This is unrealistic language - providers cannot guarantee or predict this.*
- *This is a goal, best practice, etc. and should be framed in this manner.*

- C. Emergency safety intervention. An restraint must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
- D. Notification of facility policy. At admission, the facility must—
1. Inform both the incoming resident and the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint during an emergency safety situation that may occur while the resident is in the program;
 2. Communicate its restraint policy that includes the types of interventions and restraints commonly used in a language that the resident, and his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;
 3. Obtain an acknowledgment, in writing, from the resident, and from the parent(s) or legal guardian(s) that he or she has been informed of the

- facility's policy on the use of restraint during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and
4. Provide a copy of the facility policy to the resident and to the resident's parent(s) or legal guardian(s).
- E. Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the Pennsylvania Protection and Advocacy organization. Information must be given to the resident and to the resident's parent(s) or legal guardian(s).
- F. Orders for the use of restraint
1. Orders for restraint must be made by a physician, or if a physician is not available a certified registered nurse practitioner (CRNP) or physician assistant (PA) and permitted by the facility may order a manual restraint. A licensed psychologist or a licensed social worker (LSW) or licensed clinical social worker (LCSW) may also order a personal (manual) restraint if the other practitioners are not available. The resident's treatment team physician must be contacted and informed about the use of restraint, unless the ordering licensed professional is also the resident's treatment team physician.
 2. If the practitioner is not at the facility, a registered nurse (RN) or practical nurse (LPN) obtains the verbal order while the emergency safety intervention is being initiated by staff or immediately after the safety intervention ends. If an RN or LPN is not available, a licensed occupational therapist (OT), or physical therapist (PT) may obtain the verbal order.
 3. If the resident's treatment team physician is available, only he or she can order restraint. The "treating" physician is the physician who is responsible for the management and care of the resident. If the treating physician did not order the emergency intervention, it is important to consult with the treating physician, as soon as possible, because information regarding the resident's history may have a significant impact on selection of a restraint intervention.
 4. A physician or other licensed practitioner permitted in F. 1. and the facility to order restraint must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
 5. If the order for restraint from the physician is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the restraint is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner identified in F. 1. and the facility to order restraint must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner identified in F.1. and the facility to order restraint must be available to staff for consultation, at least by telephone, throughout the period of the restraint.
 6. Each order for restraint must:
 - a. Be limited to no longer than the duration of the emergency safety situation; and
 - b. Under no circumstances exceed 2 hours for residents ages 18 to 21; 1 hour for residents ages 9 to 17; or 30 minutes for residents under age 9.
 - c. The position of the physical restraint or the staff person(s) applying the restraint must change at least every 5-consecutive minutes of applying

the restraint. This means that the hold(s) must be released. Staff must continuously monitor the vital signs of the resident during the time of the restraint.

Comments:

- *This section as proposed changes time limits from those prescribed in the federal requirements – the expectations need to be consistent. While efforts to exceed federal baselines are often supported, given the current environmental challenges and other issues of concern, the rationale for exceeding federal requirements in this area is challenged.*
- *Monitor vital signs – this needs further definition. Medical staff use a blood pressure cuff, thermometer, etc. for specific vital signs. Does expectation of this section reflect need to document that youth is responsive, breathing, etc. that non-medically trained staff can observe? Or does it require true medical level of monitoring vital signs?*

7. The use of restraint must be limited to the duration of the emergency safety situation regardless of the length of the order. The time frames specified in these requirements are maximums per age group. The ordering practitioner has the discretion to decide that the order should be written for a shorter period of time; and in the meantime, staff should be assessing, monitoring, and re-evaluating the resident so that he or she is released from the restraint at the earliest possible time.
 8. If restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying the restraint. At the point in which a new order for restraint has been obtained, all requirements for monitoring and documentation begin as with all new orders. Specifically, after a resident has been removed from restraint for any amount of time, the next incident of restraint may not be considered a continuation of the previous restraint order.
- G. Face to Face Assessment. Within 1 hour of the initiation of the restraint a physician, CRNP, RN or PA trained in the use of emergency safety interventions permitted by the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to—
1. The resident's physical and psychological status;
 2. The resident's behavior;
 3. The appropriateness of the intervention measures; and
 4. Any complications resulting from the intervention.
- H. Documentation of Order for Restraint.
1. Each order for restraint must include—
 - a. The name of the ordering physician or other licensed practitioner identified in F.1. permitted by the facility to order restraint;
 - b. The date and time the order was obtained; and
 - c. The specific type of restraint ordered, including the length of time for which the physician or other licensed practitioner identified in F.1. and permitted by the facility to order restraint or authorize its use.
 2. Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends

3. Documentation must include all of the following:

Comments:

- *These items need additional clarification.*
 - *Recommend documentation should be as stated in the program description/prescribed by consistent DPW generated format.*
- a. Each order for restraint as required above.
 - b. The time the restraint actually began and ended.
 - c. The time and results of the 1-hour assessment required in H of this section.
 - d. The emergency safety situation that required the resident to be restrained.
 - e. The name and job title of staff involved in the restraint.
 - f. The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.
 - g. The physician or other licensed practitioner permitted in F. 1. and by the facility to order restraint must sign the restraint order in the resident's record as soon as possible.
 - h. Consultation with treatment team physician
- I. If a physician or other licensed practitioner permitted in F.1. and by the facility to order restraint orders the use of restraint, that person must contact the resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician.
1. The person ordering the use of restraint must—
 - a. consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained; and
 - b. document in the resident's record the date and time the team physician was consulted.
- J. Monitoring of the resident in and immediately after restraint
1. Clinical staff trained in the use of emergency safety interventions must be
 - a. physically present,
 - b. continually assessing and monitoring the physical and psychological well-being of the resident and
 - c. ensuring the safe use of restraint throughout the duration of the emergency safety intervention.
 2. Clinical staff monitoring a resident in restraints should take into account the individualized assessment including both physical and psychological factors of the resident. Facility policies and procedures should specify who is clinically trained and appropriate to monitor residents in restraint. Those policies should also include clearly specified criteria for the use and discontinuance of restraints. Continual assessment of the resident should also result in release from restraint as soon as possible.
 3. If the restraint continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint to receive further instructions.

4. A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well being immediately after the restraint is removed.

Comment:

- *Nothing noted about if the child/youth is off-grounds on an outing?*

K. Notification of parent(s) or legal guardian(s).

1. The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained as soon as possible after the initiation of restraint.

Comments:

- *Can the family define/express their desires to be contacted? Next phone call? Next family session?*
- *What if there are no legal "parents" involved? References are made to family throughout document and but now notification of "parents" is made.*

2. The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

L. Application of time out.

Comments:

- *This section appears to be misplaced in the middle of this section on restraint.*
- *Location of this section confuses the issue, as time-out is not restraint.*

1. A resident in time out must never be physically prevented from leaving the time out area.
 - a. Time out may take place away from the area of activity or from other residents, such as in the resident's room or in the area of activity of other residents.
2. Staff must monitor the resident while he or she is in time out.

M. Post intervention debriefings.

1. Within 24 hours after the use of the restraint, staff involved in a restraint and the resident must have a face-to-face discussion.
 - a. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well being of the resident.
 - b. Other facility staff, ISPT members and the resident's parent(s) or legal guardian(s) shall be given the opportunity to participate in the discussion.
 - c. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s).
 - d. The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint.

2. Within 24 hours after the use of restraint, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of :
 - a. The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention;
 - b. Alternative techniques that might have prevented the use of the restraint;
 - c. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint; and
 - d. The outcome of the intervention, including any injuries that may have resulted from the use of restraint.
3. Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation:
 - a. The names of staff who were present for the debriefing,
 - b. The names of staff who were excused from the debriefing, and
 - c. Any changes to the resident's individual plan of care that result from the debriefings.

N. Medical Treatment for injuries resulting from the use of restraint.

Comments:

- *Conflicts with guarantee of Section A - "no injury" although this is an unrealistic expectation.*
1. Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of a restraint. It is the responsibility of the facility to assess the resident to determine the extent of any injuries and implement plans to administer appropriate medical care. It is also the responsibility of the facility to attain medical care immediately if the resident requires it. Staff that is medically trained to provide emergency first aid care and CPR should be available to provide the emergency medical interventions until further follow up emergency care can be provided.
 2. The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that—
 - a. A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;
 - b. Medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and
 - c. Services are available to each resident 24 hours a day, 7 days a week.
 3. The facility must be responsible for assuring that one or more hospitals are available to receive residents in the case of an emergency.

Comments:

- *While an agreement can be in place, how can this be enforced?*
- *If the hospital does not have a bed, they simply do not have a bed.*

4. Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.
 - a. Complete documentation of any injury that resulted in the use of emergency medical care must be located in the resident's record.
 - b. A facility must have written policy and procedures that include all elements that must be included in this documentation.
 - c. Staff injuries resulting from restraint must be documented. Additional staff injury documentation may be kept in other facility documents.
5. Staff involved in a restraint that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.
6. As part of the staff debriefing following the use of an emergency safety intervention, supervisory staff should process details of the incident including:
 - a. events leading up to the use of the intervention,
 - b. description of the implementation of the intervention,
 - c. any resident or staff injuries sustained during the altercation,
 - d. and the resident's response to the intervention.

O. Facility reporting: Attestation

1. Each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21 must attest, in writing, that the facility is in compliance with CMS' standards governing the use of restraint.
2. This attestation must be signed by the facility director.
3. The minimal elements of an attestation include:
 - a. The facility name and location
 - b. Total number of facility beds
 - c. Number of Medicaid residents in the facility
 - d. Number of residents for whom the Psych under 21 is paid for by another state
 - e. A list of all states from whom the facility has ever received Medicaid payment for the provision of the Psych under 21 benefit
 - f. A statement certifying that the facility currently meets all of the requirements of Part 483, Subpart G governing the use of restraint
 - g. A statement acknowledging the right of the State Survey Agency (or its agents) and if necessary, CMS to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences
 - h. A statement that the facility will submit a new attestation of compliance in the event that the facility director is no longer in such position
 - i. Name of individual and position of individual signing the attestation
 - j. The date that the attestation was signed

4. A facility with a current provider agreement with the Office of Medical Assistance Programs (OMAP) within DPW must provide its attestation to the appropriate Bureau within OMAP annually by July 21 of each year.
5. A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.
6. In order to be eligible to provide a Medicaid covered benefit and receive federal financial participation (FFP) for the provision of those covered services, a facility must have a provider agreement with any Medicaid Agency for which it provides services. For example, if a PRTF accepts residents from other states, then the PRTF is expected to have provider agreements with those other states.

Comments:

- *What if have youth with private insurers or private contracts outside of MA?*
- *The regulations should address the treatment and practice issues, not the payor issues.*

7. Psychiatric residential treatment facilities must attest to being in compliance with CMS' requirements regarding the use of restraint. In the event of change of ownership or a new director, the facility is expected to re-attest.

P. REPORTING OF SERIOUS OCCURANCES

Comments:

- *Consistency is important, including with the various BHMCOs*

1. The facility must report each serious occurrence to both the State Medicaid agency and to PA Protection and Advocacy system.
2. Serious occurrences that must be reported include;
 - a. a resident's death;
 - b. a serious injury to a resident ; and
 - c. a resident's suicide attempt.
3. Staff must report any serious occurrence involving a resident to both the State Medicaid agency and to PA Protection and Advocacy system by no later than close of business the next business day after a serious occurrence.
4. The report must include the name of the resident involved in the serious occurrence,
 - a. A description of the occurrence and,
 - b. The name, street address, and telephone number of the facility.
5. Serious injury means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else. All serious injuries that require medical intervention are to be reported, regardless of whether it was associated with the use of restraint. It is the

- responsibility of the facility to ensure that it reports serious occurrences appropriately.
6. The facility need not report every injury that a resident experiences, but only those that are substantial in nature. For instance, a small bruise on a thigh, which occurred as a result of running into a table, or abrasions as a result of a fall, may not be appropriate to report. It is the expectation that a facility investigate any injuries of unknown origin to ensure that a resident is not being harmed. In addition, if a resident has repeated injuries that are indicative of a pattern the facility should investigate to ensure that the resident is not subjected to a hostile environment and also to take steps to minimize the risk of more injuries.
 7. The facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.
 8. Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and to PA Protection and Advocacy, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

Q. REPORTING OF DEATHS

1. In addition to the reporting requirements contained in paragraph Q. of this section, facilities must report the death of any resident to the Centers for Medicare and Medicaid Services (CMS) regional office.
 - a. Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death.
 - b. Staff must document in the resident's record that the death was reported to the CMS regional office.

QUALITY MANAGEMENT:

- A. The psychiatric residential treatment facility must have a documented quality management program which demonstrates quantitative data, and includes a written plan and policy for clinical case reviews, periodic staff conferences, and written utilization review documentation.
- B. Each PRTF quality management program must include the following:
 1. The facility must assign staff responsibility for quality improvement activities. Identification of areas in need of improvement should be identified in a systematic manner through routine scheduled Quality management/Quality Improvement (QM/QI) committee meetings.
 2. The facility must identify important aspects of care and services and identify appropriate clinical and organizational indicators of quality. The

aspects must include at least the following minimum core issues which must be addressed in the subsequent evaluation process:

- a. Strengths-based planning and delivery of services.
- b. Use of community resources and natural supports to promote community re-entry.
- c. Active resident participation in the planning for treatment.
- d. Expression of cultural competency of staff in all planning for treatment and delivery, with an emphasis on the cultural and ethnic values of the resident and family.
- e. Use of the least restrictive settings necessary for service delivery.
- f. Promotion of real world competence.

Comment:

- *As defined by whom? What?*

- g. Documentation of the resident and family's satisfaction with the delivery of services and outcome of services delivered.

3. The facility must establish thresholds for evaluation and reevaluation of services, (e.g. patterns, trends or incidents that automatically trigger the need for evaluation). A clinical audit by an external professional should be performed when an alarming trend is identified by the above tracking system.

Comments:

- *Clinical audits are expensive – how will costs be covered? Who would pay for this? When would it have to occur – clearer definition is needed to support consistency?*

4. A separate section entitled "Risk Management" should be included in the QM/QI Plan. Incidents including any use of restraint to maintain safety should be recorded and tracked in order to collect aggregate data to show improvement.

Comments:

- *Aggregate data cannot reflect the special circumstances of unique situations.*

- a. The facility must collect and organize data relevant to the above.

Comments:

- *Consistency needed in data collection - of looking at/setting definitional parameters that are the same thing.*
- *Cost implications are significant.*

- b. The facility must initiate evaluation of above data.

- c. The facility must take corrective action, as necessary.

- d. The facility must assess effectiveness of actions taken and maintain a level of improvement.
- e. The facility must communicate the results to affected persons or groups such as consumers, families, advocates, county MH/MR programs, OMHSAS, BHMCOs.

Comments:

- *What are the expectations for “communication” to satisfy this requirement?*
- *What information should be shared with the families, consumers and advocates?*
- *Is an invitation to the annual report sufficient?*
- *Assurances of confidentiality of the data and use of this information is needed.*
- *Could this be incorporated as part of a report from the state? If so, this would give credence to value of a statewide outcomes reporting system.*

REPORTABLE INCIDENTS:

- A. In addition to the reportable incidents requirements in PA Code Title 55 § 3800.16 – 3800.17 an PRTF must orally notify the county mental health program in which the facility is located, the county mental health program of the resident’s residence, the funding agency and the appropriate regional OMHSAS field office where located within 24 hours after a reportable incident occurs at the facility. (Cross reference with serious occurrence bulletin)

Comments:

- *What are acceptable procedures with non-residents? Providers often receive inconsistent answers when regional offices, counties are asked.*
- *“Funding” agencies have different expectations – have they been involved in the discussions regarding reporting procedures?*

- B. Incident reports should be logged in the risk management section of the quality management plan to identify trends and identify areas in need of improvement.

Comment:

There appears to be a ‘disconnect’ in this area, especially with HIPAA requirements and provider liability.

UTILIZATION REVIEW (UR)

In accordance with 42 C.F.R. 456 Subpart D relating to Utilization Control of Mental Hospitals, all Medicaid PRTF services shall have procedures that provide for review of each resident's need for the services. For the Utilization Review (UR), each PRTF shall perform on-going evaluations of the necessity and appropriateness of PRTF services for each resident. The UR shall include a review of the appropriateness of the admission, individual plan of care, length of stay and discharge plan.