OhioRISE Psychiatric Residential Treatment Facility (PRTF) Workgroup

May 6, 2021
10-11:30 AM
All participants can mute and unmute their own lines, so please be sure to mute your line when you’re not talking. If you are muted during the meeting and called in, you must press *6 to unmute.

Please introduce yourself by entering your name, title, and organization in the chat feature.

We hope to have robust oral discussion among workgroup members. All other attendees may enter comments or questions using the chat feature in Teams.

The slides from this meeting will be available following the meeting on the OhioRISE Website.
Agenda

1. Welcome and Introductions
2. PRTF Overview
   - QRTP vs. PRTF
   - Building Bridges Initiative (BBI) Overview
3. Federal Regulations
4. Recap of Small Group Discussion
5. Next Steps
PRTF Workgroup

Psychiatric Residential Treatment Facility (PRTF) Workgroup Role

» Contribute personal experience from providing / participating in use of residential and psychiatric residential treatment
» Provide expert clinical and programmatic feedback on development of serving children and youth in these settings
» Review and provide feedback on regulatory concepts and rules
» Provide critical feedback regarding PRTF implementation

PRTF WORKGROUP MEMBERS:
OhioRISE Advisory Council members and others they suggested for workgroup participation

- Diverse range of expertise and experience
- Local system partners
- Associations and providers of services
- Youth and Families with lived experience
- Ohio’s geography
OhioRISE PRTF Timeline

OhioRISE Advisory Council Meetings

January 2021 - TBD 2022

- PRTF Workgroups
- Initial Rule Filings
- Implementation and Operations Workgroup
- Final Rule Filings

March-Fall 2021

Fall 2021

Spring 2022

Summer 2022

PRTF Go-Live 7/1/22
PRTF Overview
Making the Case for a Comprehensive Children's Crisis Continuum of Care

Psychiatric Residential Treatment Facilities

Presented by:

Elizabeth Manley
Clinical Instructor for Health and Behavioral Health Policy
What works best is anything that increases the quality and number of relationships in a child’s life. People, not programs, change people.

Dr. Bruce Perry, Mind and Heart Foundation
Language is Important:

The Language of System of Care
• Children, youth, young adults
• Parents, caregivers
• Treatment
• Engagement
• Transition
• Missing
• Family time

Not the Language of System of Care
• Clients, cases, consumers
• Mom and Dad
• Placement
• Not motivated
• Close, terminate
• Run away
• Home Visits
Implications for Residential Interventions Best Practice

Movement away from “placement” orientation and long lengths of stay

Residential as part of an integrated continuum, connected to community

Shared decision making with families/youth and other providers and agencies

Individualized treatment approaches through a child and family team process

Trauma-informed care

For more information, go to Building Bridges Initiative:

www.buildingbridges4youth.org
Psychiatric Residential Treatment Facility

PRTF provides an inpatient equivalent of care for youth with complex needs.

Trauma Informed

The intervention is necessary due to youth’s complex needs

May include youth with child welfare involvement, but it is not required

All youth referred with the clinical need are accepted if a bed is available. Rejection due to the client mix in milieu is antithetical to the work of a PRTF

Engagement in the treatment process is a driving value. The team focuses on transition as part of the admission process.

Youth return to community at the completion of treatment. Move away from step downs.
“No Eject, No Reject”

• No reject philosophy allows residential teams to focus on engagement strategies to meet the needs of youth that the PRTF is designed to serve.

• No eject philosophy allows teams to focus on the necessary clinical interventions to meet the youth’s needs. Recognizes the crisis points within the treatment experience and works to prevent the escalation of behaviors. Moves away from coercive interventions.
Qualified Residential Treatment Program (QRTP)

- Child welfare involvement
- Focuses on improving the quality of care for youth in group care
- Assessment within 30 days
- Trauma Informed
- Court Oversight
• Funding is IV-E
• Purpose is to increase the quality of care for children for children within a residential intervention.
• Nursing
• Required to provide family-based aftercare supports for at least 6 months post-discharge

• Limits IV-E within residential to:
  • QRTP
  • Pre-natal & Post-partum or parenting supports for youth
  • Supervised settings for youth over 18 who are living independently
  • High-quality residential care for youth who are at risk or have experienced sex trafficking.

• Foster Care
Residential Interventions within a System of Care

- Home Like Environment
- Trauma Informed
- Goal is for the child to feel better

No breaks for the team when the youth is in an out of treatment intervention

There are diminishing returns on long lengths of stay
Residential Best Practices:

- Connection to Home and Community Based Services and Supports
- Strength Based
- Moving toward “No Eject, No Reject”
- Match youth to best residential intervention to meet their needs
- Individualized Planning
- Coordination across Programs and Systems
- Committed to Health Equity
- Commitment to Natural Helping Networks
- Resiliency Oriented
Residential Best Practices: Continued

• Trauma Informed Lens:
  • Leadership
  • Workforce
  • Environment
  • Programming
  • No Point Systems
Residential Best Practices Continued:

- Family Driven:
  - Family Choice
  - Family Engagement Strategies
  - Family Time
  - Maintaining and Supporting Family Connections
Residential Best Practices:

Youth Guided: Goal is for the Youth to Feel Better

- Engagement
- Individualized Planning
- Community Strategies and Connections
- Youth Advisory and Feedback Strategies
Residential Best Practices Continued:

Trauma Informed Environments: Observe from a Self-Regulation Lens

- Creating environments that focus on dysregulation
  - Use sensory rooms
  - Use weighted blankets and other sensory sensitive tools
  - Attentive to the physical needs of youth, eating, sleeping, moving

- Shifting language and understanding of the child behavior and the function of the behavior
  - Move away for the use of the diagnosis as the descriptor for children
  - Identify the behavior and the concern around the behavior is relation to safety
  - Give evidence of the youth’s success

- Identify strategies around safety for youth as part of engagement
  - Soothing Plans developed with each youth
  - Sensory box for each youth
Residential Best Practices Continued:

Regulation and Sensory Tools for all Senses: Understand the sensory diet of each youth

- Sight
- Sound
- Smell
- Touch
- Taste
- Proprioception
- Vestibular input

Tools such as Yoga, chalkboard paint, weighted blankets, rocking chairs
Residential Best Practices Continued:

• The Role of Restraint

• The Role of Seclusion

• The Role of Coercion
Data and Outcomes Driven:

- Length of Stay
- Return to Care
- Community Connections
- Permanency
- School Attendance and Performance
- Juvenile Justice Involvement
- Rigorous Debrief
References:

- Making the Case for a Comprehensive Children’s Crisis Continuum of Care; NASMHPD 2018; https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf
- Pires, Sheila; Building Systems of Care: A Primer; 2002; https://gucchd.georgetown.edu/products/PRIMER_CompleteBook.pdf
- Pires, Sheila; Customizing Health Homes for Children with Serious Behavioral Health Challenges; 2013; https://nwi.pdx.edu/pdf/CustomizingHealthHomes.pdf
References Continued


• Berrick, Ken and Sprinson, John S. *Unconditional Care; Relationship-Based, Behavioral Intervention with Vulnerable Children and Families*. Seneca Center. Oxford University Press, NY 2010


Questions???
Thank you
Thank you!

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Federal Regulations
Inpatient psychiatric services for individuals under age 21 must be:

- Provided under the direction of a physician
- Provided by:
  - A psychiatric hospital; or
  - A psychiatric facility that is not a hospital that:
    - Is accredited by The Joint Commission, CARF, COA, or any other state-approved accrediting organization; and
    - Meets requirements in 42 CFR 441.151 to 441.184, and 483.350 to 483.376
- Provided before the individual reaches age 21, or if receiving the services upon turning age 21, until the earlier of:
  - Discharge; or
  - Reaches age 22
- Certified in writing to be necessary in the setting in which the services are provided
42 CFR Part 441, Subpart D Review: Certification of Need for Services

441.152 - A team must certify:

- Ambulatory care resources available in the community do not meet the treatment plan needs of the recipient
- Proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can reasonably be expected to improve the recipient’s condition to prevent further regression so that the services will no longer be needed.

441.153 – Certification of the need for services must be made by an independent team that:

- Includes a physician;
- Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
- Has knowledge of the individual’s situation
42 CFR Part 441, Subpart D Review: Active Treatment and Individual Plan of Care

441.154 – Active Treatment – Requires a professionally developed and supervised individual plan of care that is:
• Developed and implemented no later than 14 days after admission and designed to achieve the beneficiary’s discharge from inpatient status at the earliest possible time

441.155 – Individual Plan of Care – A written plan developed for each beneficiary in accordance with regulations, to improve the patient’s condition to the extent that inpatient care is no longer necessary
• The plan of care must:
  • Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the beneficiary's situation and reflects the need for inpatient psychiatric care;
  • Be developed by a team of professionals specified under §441.156 in consultation with the beneficiary; and parents, legal guardians, or others in whose care the youth will be released after discharge;
  • State treatment objectives;
  • Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
  • 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 beneficiary's family, school, and community upon discharge.
• The plan must be reviewed every 30 days by the interdisciplinary teams to:
  • Determine that services being provided are or were required on an inpatient basis, and
  • Recommend changes in the plan as indicated by the recipient’s overall adjustment as an inpatient.
The individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:

- Assessing the beneficiary’s immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- Assessing the potential resources of the beneficiary’s family;
- Setting treatment objectives; and
- Prescribing therapeutic modalities to achieve the plan’s objectives.

The team must include at a minimum, either:

- A board-eligible or board-certified psychiatrist;
- A clinical psychologist who has a doctoral degree and or a physician licensed to practice medicine or osteopathy; or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, 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.

The team must also include one of the following:

- A psychiatric social worker;
- A registered nurse with specialized training (in mental health) or one year’s experience in treating mentally ill individuals;
- 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; or
- 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.
PRTF must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years, that must:

- Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
- Include strategies for addressing emergency events identified by the risk assessment.
- Address resident population, including, but not limited to, persons at-risk; the type of services the PRTF has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
- Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.

The emergency preparedness plan must include:

- Implementation of emergency preparedness policies and procedures re: subsistence needs; a system to track the location of staff and residents; safe evacuation from the PRTF; a means to shelter in place; a system of medical documentation the preserves and protects the confidentiality of resident information; emergency staffing strategies; arrangements with other providers to receive residents; and the role of the PRTF in the provision of care and treatment at an alternate care site; and
- Development and maintenance of a communication plan; and
- Development and maintenance of an emergency preparedness training program
Restraint or seclusion must only be used for the protection of residents in an emergency safety situation

• Each resident has the right to be free from restraint or seclusion of any form used as a means of coercion, discipline, convenience, or retaliation

• An order for restraint or seclusion must not be written as a standing order or on an as-needed basis

• Restraint or seclusion must not result in harm or injury to the resident and must be used only:
  • To ensure the safety of the resident or others during an emergency safety situation (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); and
  • Until the emergency safety situation has ceased and the resident’s safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired

• Restraint and seclusion must not be used simultaneously

• An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, 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)
PRTF Regulations – 42 CFR Part 443 Subpart G - Restraint and Seclusion

Restraint or seclusion must only be used in an emergency safety situation:

- If resident’s treatment team physician is available only, he/she can order restraint or seclusion
- Physician must order least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
- The physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention
- Each order for restraint or seclusion must:
  - Be limited to no longer than the duration of the emergency situation
  - Under no circumstances exceed 4 hours for residents 18-21, 2 hours for residents 9-17, or 1 hour for residents under 9
  - Be documented in the resident’s record by the end of the shift in which the intervention occurred
- Face to face assessment must be completed by a physician or licensed practitioner within 1 hour of initiation
- Notification, reporting and staff training requirements
- Postintervention debriefings within 24 hours
- The facility must notify the parent or legal guardian of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention
HIGHEST LEVEL OF CARE

- Intermediate Care Facilities (ICF)
- Inpatient Hospital / Psych Hospital
- Nursing Facility

IFC/IDD-IBSS

Psychiatric Residential Treatment Facility (PRTF)

RESIDENTIAL LEVELS OF CARE

- Residential facility
- Group Home
- Tiers 1-3

LOWER LEVELS OF CARE

- Congregate Care
- Treatment Foster Care
- Family Foster Care

+ Family-Based Residential for SUD
PRTF Alignment with Other Types of Facilities

- PRTF
- ICF with behavioral rate add-on
- QRTP
Summary of Small Group Discussion
Discussion with Ohio Facilities Recognized as PRTFs by Other States

Current state
- PRTFs for Pennsylvania Medicaid only
- Serve some kids from other states, but don’t act as PRTFs for those states
- No identified issues with family engagement
- No “no reject no eject” policies in place

Challenges to serving Ohio youth
- Difficulty finding partners for youth with higher needs
- Units/groups are larger size
- Workforce challenges

Future
- Need enough PRTFs in OH to meet the need
- OhioRISE will bring consistency and involvement with MCO
PRTF Workgroup

• Continue working with Ohio-based PRTFs
• Gather data from different sources to determine the needs of children and youth who need PRTF services
• Identify similarities and differences of children and youth in residential treatment in Ohio vs. out-of-state
• Explore policies and best practices from other states that have PRTFs
  • Consideration of BBI principles
Next Steps
Next Steps

• Next Meeting June 2, 9AM – 11AM
  » Discuss draft rule concepts
  » Breakout rooms

• Consider breakout room feedback
• Share draft rule for stakeholder comments
OhioRISE Website

On the OhioRISE website we post the dates and times of future meetings, links to join the meetings, and presentation materials.

Select ‘Advisory Council and Workgroup Meetings’ dropdown tab

Access meeting presentations by clicking on the ‘Meeting Name (Link to Materials)’

Join meetings by clicking on the meeting links in the ‘Registration Link’
Thank you for participating!