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Other Local News Stories

U.S. fails to reduce misuse of restraint

Wednesday, March 22, 2000

By PETER URBAN
nabrup@aol.com

WASHINGTON +IBQ- The Clinton administration has failed to follow through on initiatives it announced last July +IBQ- with much fanfare +IBQ- to reduce the misuse of restraints and seclusion techniques at mental health facilities.

At least 142 Americans +IBQ- including Andrew McClain, 11, of Bridgeport, Conn. +IBQ- have been killed in the past decade by the misuse of restraints in mental hospitals.

Since August, mental health facilities have been required to report to the Health Care Financing Administration any patient deaths stemming from restraints.

McClain+IBk-s death prompted the regulation and also spurred Connecticut+IBk-s congressional delegation to introduce legislation last year calling for a national ban on the inappropriate use of restraints. The bill is still pending. McClain was suffocated to death two years ago today after two mental health workers wrestled the child to the floor and restrained him.

The required reports were meant to be shared with state protection and advocacy agencies that would investigate what went wrong and what could be done to prevent other incidents. But six months later, no agencies have been notified by HCFA of any restraint-related deaths.

James McGaughey, executive director of Connecticut+IBk-s Office of Protection and Advocacy for Persons with Disabilities, said Tuesday he has not received any reports from HCFA.

"If we got a report of a death caused by restraint or seclusion we would investigate it," McGaughey said. "We would want to know exactly what happened and to see if it could have been handled differently."

To: Devorah

From: Patti Unruh
Ph: 690-6726
2 pages

25
deaths
since
Aug.

**DAIRIE NEWS-
FAIRFIELD CITY
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WESTPORT NEW**

"Our goal is to learn from what has happened, but so far we haven't received any reports," Curtis Decker, executive director of the National Association of Protection & Advocacy Systems, said Tuesday.

Decker said he has been told by HCFA that the agency has received about eight death reports and is "working on" releasing them to state advocates.

Not satisfied with the slow response, Decker said he contacted Tipper Gore, as well as a few House members who worked on the issue, including U.S. Rep. Rosa DeLauro, D-3.

DeLauro sent a letter Tuesday to HCFA Administrator Nancy-Ann DeParle expressing her "serious concern" for the apparent failure of HCFA to "abide by its commitment.

"This lack of reporting prevents critically needed independent investigations by [advocates] and other outside watchdog agencies," DeLauro wrote.

DeLauro said Tuesday she intends to follow up with HCFA to ensure that it releases the reports to protection and advocacy groups as planned.

A HCFA spokesman said Tuesday that the agency is committed to giving hospital death reports to advocacy groups but has had to work out technical and legal issues to make that possible.

"It is in progress and we are committed to doing it," said a spokesman, who asked not to be identified.

In October, Deputy Administrator Michael Hash told members of the Senate Finance Committee that HCFA was requiring all hospitals that provide services to Medicare and Medicaid beneficiaries to report any death that occurs while a patient is restrained or in seclusion.

"We in turn will report it to the state protection and advocacy agencies," Hash said.

Hash made no mention of any "issues" that had arisen to hamper a prompt turnaround. But, Hash did point out the positive results New York has experienced from a state requirement that all deaths of mental health consumers be investigated.

"Recommendations based on these investigations have significantly reduced use of seclusion and restraints and brought about other substantial improvements in care," Hash said

Other Local News Stories:

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of preventive services

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TRANSMITTAL

To: Audrey Tayse Haynes
Of: Mrs. Gore's Office
Fax: 202-456-7044
Pages: 5
Date: 2/28/00

*Melissa - ~~to~~ set up a
meeting with Zorger/Sarah B.
and me to discuss
this issue
early next wk*

Here is a letter from the Advocates Coalition for Appropriate Use of Restraints regarding the Health Care Financing Administration's regulations concerning restraint and seclusion. This will be mailed as well. Thanks for your office's assistance.

From the desk of
Gary Gross
Senior Public Policy Counsel
National Association of Protection and Advocacy Systems
202-408-9514 (voice), 202-408-9520 (fax), 202-408-9521 (TDD)
Gary@NAPAS.org

ADVOCATES COALITION FOR APPROPRIATE USE OF RESTRAINTS

February 28, 2000

Mrs. Tipper Gore
Office of the Vice President
Old Executive Office Bldg
Washington, D.C. 20501

Attn: Mrs. Audrey Tayse Haynes, Chief of Staff to Mrs. Gore

Dear Mrs. Gore:

We are the Advocates Coalition for Appropriate Use of Restraints – eight national organizations¹ concerned with preventing death and serious injury resulting from restraint and seclusion use. The Coalition is dedicated to improving the quality and appropriateness of treatment for persons with mental illness, children with serious emotional disturbance, and persons with developmental disabilities.

We are writing to express our serious concern regarding the failure of the Health Care Financing Administration (HCFA) to abide by its commitment to share with protection and advocacy (P&A) agencies hospital reports of deaths that occur as a result of restraint and seclusion. HCFA clearly spelled out this commitment in its July 2, 1999 interim final regulations on Hospital Patients' Rights. As you know, the regulations, which became effective on August 2, 1999, establish six sets of standards that ensure minimum protections for patients' physical and emotional health; hospitals are required to meet these standards as "conditions of participation" in the Medicare and Medicaid Programs.

The rules' standards relating to restraint and seclusion set out detailed requirements on the practice, addressing time limits, personnel qualified to order restraint and seclusion, monitoring and training. Further, the regulations specify that hospitals must report to HCFA any death that occurs while a patient is in restraint and seclusion, or where it is reasonable to conclude that the death was related to restraint or seclusion. In the guidance issued with the regulations, HCFA stated that it will share these reports with P&As.

As explained below, this is critically important, as the P&A System – whose fundamental mandate is to investigate and remedy abuse and neglect of persons with disabilities – needs these reports to carry out that mandate, for instance, by seeking appropriate reforms in hospital restraint practices.

¹ The ARC, Bazelon Center for Mental Health Law, Federation of Families for Children's Mental Health, International Association of Psychosocial Rehabilitation, National Alliance for the Mentally Ill, National Association of Protection and Advocacy Systems, National Council for Community Behavioral Health, and National Mental Health Association.

However, to date, HCFA has apparently failed to provide a single report of a restraint-related death to a P&A – despite the fact that the agency has indicated that it has indeed received such reports from hospitals.

The Advocates Coalition requests that you intervene with HCFA to ensure that the agency makes good on its commitment to report these deaths to P&As across the country. A representative of our Coalition has repeatedly discussed this issue with HCFA, but the agency has failed to act.

In addition, we have very considerable concerns regarding the nature and quality of the reporting to both HCFA and to P&As required by the interim final regulations (the Coalition expressed these concerns in its comments previously submitted to HCFA on the regulations). Specifically, the interim regulations do not ensure that timely, accurate and detailed reporting will occur; further, the reporting should be expanded to cover a broader universe of deaths, as well as serious injuries. We ask your help in encouraging HCFA to address as well these concerns in its final regulations (which we understand will be issued in the near future). Set out below is an outline which provides background information on this issue and addresses the need for prompt and accurate reporting to P&As on restraint-related deaths.

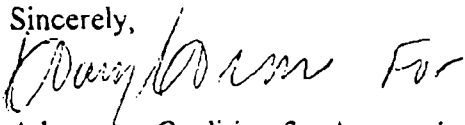
- Abusive Restraint and Seclusion Practices are Widespread and Deadly – As chronicled in the *Hartford Courant* and other newspapers, the misuse of restraints and seclusion (R/S) for people with mental illness and mental retardation – for reasons of staff convenience, discipline and punishment, rather than as an emergency safety measure – continues to be prevalent. These practices result in perhaps 100 or more needless patient deaths each year and thousands more serious injuries. This amounts to a national crisis in our system of care for these vulnerable individuals, especially children, who suffer the brunt of these abuses.
- GAO Report Affirms Compelling Need for Reporting – An October 1999 GAO report confirmed that there is no adequate system of reporting deaths and injuries related to R/S, making it impossible to determine the true level of these incidents nationally and preventing independent investigations. The report found that only 15 states have any systematic reporting on any deaths that occur in residential treatment settings, that most reporting covers only state facilities, and that in any event, this reporting is so fragmentary that investigations are impossible.
- GAO Recommends Death and Injury Reporting to P&As – To facilitate investigation, GAO recommended that HCFA mandate that any hospital or residential facility that treats individuals with mental illness or mental retardation promptly report to the appropriate P&A all deaths and serious injuries among persons in that population. It was stated that these facilities should make their reports using a uniform protocol, and should indicate whether R/S was used during or prior to death or injury.

- P&As are Uniquely Able to Address this Issue But Must Receive Reports to Act – P&As nationwide are the most appropriate agencies to act on these death reports, given that they have a unique federal mandate to investigate and remedy abuse and neglect of persons with disabilities, including the misuse of R/S. In fiscal year 1998 alone, P&As responded to about 34,450 reports of abuse and neglect. However, under current federal law, P&As are authorized to investigate only when they receive a report of abuse or neglect or have a probable cause suspicion. A mandatory federal reporting requirement is imperative – because, given the lack of state requirements, a large number of restraint-related deaths never come to the attention of P&As, and may not be investigated.
- Reporting Should Cover A Broad Universe of Deaths – To ensure effective review and follow up by P&As, hospitals should be required to report all deaths of patients with mental illness or mental retardation, or, at the very least, deaths of such individuals who have died within a specified time frame after having been placed in restraints and/or seclusion. (Ideally, such reporting should also cover serious injuries.) Such reporting is necessary to ensure that P&As (as well as HCFA) can make unbiased determinations as to whether a death was indeed precipitated by the misuse of R/S.
- Reports Must be Submitted Promptly and Provide Detailed Written Information – In order to ensure that follow up is thorough and prompt, reports of R/S-related deaths must be provided (to both HCFA and P&As) within a short period after death (e.g., within seven days), and they must provide standardized written information. For instance, such a report must provide, in addition to information on the cause of death, standardized documentation on clinical issues such as the patient's underlying condition, and medications taken and other treatment provided.
- P&As Can Achieve Effective Individual and System Reforms with Such Reporting – Once the P&A receives such reports, their trained investigators and legal staff can determine which deaths may be due to the misuse of R/S, and can take appropriate corrective actions to ensure that these abuses do not occur in the future. For example, through negotiation or litigation, if necessary, corrective actions could be imposed to reform facility practices or statewide policies, appropriate compensation for family members of the deceased can be obtained, and staff involved in the death can be subjected to termination and/or criminal prosecution.
- A Mandatory P&A Reporting System Clearly Would Be Effective – A parallel state reporting system, involving the New York Protection and Advocacy System, has worked with great success in that state for more than 20 years. New York State law requires detailed, standardized reporting of all deaths of mental health consumers (within 72 hours) to the P&A, and authorizes the New York P&A to investigate. Over the past 20 years, using this authority, the agency has conducted over 5,000 death investigations, resulting in hundreds of recommendations on a facility- or system-wide basis to improve the care for those in treatment. Its recommendations also have resulted in significant reductions in the

use of restraint and seclusion, as well as related benefits – improved emergency medical care and a reduction in suicide rates.

Thank you very much for your assistance.

Sincerely,

A handwritten signature in cursive script, appearing to read "Gary Gross For".

Advocates Coalition for Appropriate Use of Restraints

NAMI: Clarke Ross, 703-312-7894

ARC: Kathy McGinley, 202-785-3388

Bazelon: Laurel Stine, 202-467-5730, #34

Federation: Trina Osher, 301-434-4071

IAPSRs: Paul Seifert, 410-730-7190

NAPAS: Gary Gross and Curt Decker, 202-408-9514

NCCBH: Pope Simmons, 202-842-1240

NMHA: Andrea Price, 703-838-7509 and Brian Cooper, 703-837-4788

American Psychiatric Association

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Washington, D.C. 20005
Telephone 202.682.6000
Fax 202.682.6850
E-mail apa@psych.org
Internet www.psych.org

February 4, 2000

Audrey Tayse Haynes
Chief of Staff to Mrs. Gore
Old Executive Office Building Room 200
Washington, D.C. 20501

Dear Audrey:

On behalf the American Psychiatric Association (APA), the medical specialty representing more than 42,000 psychiatric physicians nationwide, we respectfully request a meeting with Mrs. Gore, you, and other White House staff as appropriate to discuss our grave concerns about the clinical impact of Administration efforts to limit the use of seclusion and restraint of psychiatric patients.

As you know, Mrs. Gore appeared at a press conference to announce last year's interim final rule and therefore the general public perception that she has been instrumental in the Administration's decision to move forward with the new restrictions on the use of seclusion and restraint. While we absolutely agree with Mrs. Gore that patients should not die or suffer serious injury as a result of the use of these interventions, there are very serious and legitimate clinical concerns about the scope and thrust of the HCFA regulations because they could, if not modified, have the perverse result of reducing access to psychiatric treatment in hospitals.

APA currently participates in a working group on this issue with the American Hospital Association, the Federation of American Health Systems, the American Medical Association, the National Association of Psychiatric Health Systems, and the American Nurses Association. Together, we represent hundreds of thousands of physicians, nurses, and hospitals all directly affected by the HCFA rules. We are all deeply concerned about appropriate patient care and believe it would be very helpful for all parties to have an open and straight forward exchange of concerns with Mrs. Gore.

Thank you very much for considering this request. Please feel free to contact Nick Meyers or me at 682-6060.

Best regards,

Jay B. Cutler
Special Counsel and Director of Government Relations

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Melissa
Will you ask
Trooper & Sarah
to tell me
the status of this
APA
FEB 10 2000



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February 4, 2000

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Deputy Medical Director

Christopher C. Jennings
Deputy Assistant to the President for Health Policy
Office of Policy Development
216 Old Executive Office Building
Washington, D.C. 20500

Dear Chris:

I wanted to bring to your attention the attached letter requesting a meeting with Mrs. Gore and her staff on the issue of seclusion and restraint of psychiatric patients. As I'm sure you will understand, proposed regulations and legislation on these interventions are of great interest to the membership of the American Psychiatric Association.

Assuming the referenced meeting with Mrs. Gore et al can be set up, it's our hope that you will be able to participate as well. If that's not possible, APA and the other groups mentioned in the letter would also very much like to meet with you on this issue. We think it would be useful for you to have the input of clinicians and others (i.e., nurses, administrators) directly affected by the HCFA interim final rule and proposed legislation, and I am sure our members would be very interested in your own views.

Thank you very much for considering our request. Please respond to me or to Nick Meyers at 682-6060 if you have any questions.

Best regards,

Jay B. Cutler

Special Counsel and Director of Government Relations



Psych under 21 regulation

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TELECOPIER COVER SHEET

Date: 7/23/99 Time: 11:24 AM

Fax No.: 202-456-5557 Client No.: 0007

To: Chris Jennings, Congressional Liaison for Health Policy

From: Steve Jenning

Number of Pages (excluding cover sheet) 1

Person Sending: Steve Jenning

Chris: F.Y.I., regarding physical restraints, a copy of a letter to Hash from the head of the California hospital association.

Please call me if any questions on this matter.

**IF YOU HAVE ANY PROBLEMS RECEIVING, PLEASE
CALL PERSON SENDING IMMEDIATELY**



**CALIFORNIA
HEALTHCARE
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

July 23, 1999

**Michael Hash
Acting Administrator
Health Care Financing Administration
200 Independence Avenue
Washington, DC**

Via Fax

Dear Mr. Hash:

Congratulations on your recent appointment at Acting Administrator. I look forward to continuing to work with you in your new role.

This letter is to request a telephone appointment with you to discuss a very urgent matter effecting the hospitals and health systems in California. As you know, an interim final rule was published on July 2, 1999—with implementation on August 2, 1999—adding a Patients' Rights section to the Medicare and Medicaid Conditions of Participation. The rule includes new, never before published requirements for hospitals regarding the use of behavioral restraint and seclusion.

Of specific concern is a requirement that a physician see a patient face to face within one hour after the initiation of this procedure by a nurse or other authorized professional. This is not current practice, and—contrary to the impact analysis included with the rule—is not currently required by the Joint Commission on Accreditation of Healthcare Organizations. This requirement alone will be virtually impossible for many hospitals to implement without incurring substantial unreimbursed costs. Furthermore, they certainly will not be able to do so in such a short time frame.

Because of the time sensitive nature, I hope we can discuss this matter in detail early next week. Please contact Anne Nicoll at 202-488-4494 to set up a time for us to visit. Thank you for your attention.

Sincerely,


**Duane Danner
President**

CDD/am

Post-It Fax Note 7871		Date 7/23	# of pages 1
To Mark Covall	From Anne Nicoll		
Co./Dept.	Co.		
Phone #	Phone #		
Fax #	Fax #		

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Congress of the United States

House of Representatives

Washington, DC 20515-3506

July 20, 1999

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FOUNDER AND CO-CHAIR

Nancy Ann DeParle
Administrator
Health Care Financing Administration
Room 309G
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. DeParle:

I applaud your leadership in addressing recent problems related to restraint and seclusion of psychiatric patients by releasing on July 2 the "Medicare Hospital Conditions of Participation" covering patients rights, including the use of restraint and seclusion. I wholeheartedly support the overall direction of the regulations and believe such an approach is the most effective way to provide accountability without hindering patient safety or confidentiality.

I am concerned, however, about one new requirement of the regulation pertaining to physician monitoring of seclusion and restraint that represents a far departure from current practice. That provision, which was not part of the original proposed rule issued December 1997, and the short 30-day effective date for implementing such a substantial change in current practice, would create unintended and costly consequences without evidence that it will improve patient care.

The proposed new standard would require a physician (or licensed independent practitioner) to see and evaluate the need for restraint or seclusion within 1 hour after initiation of this intervention. The problems this poses are many. First, it inappropriately dictates medical practice. A physician should be the one to decide whether such a requirement is necessary. Second, the costs would increase dramatically. It is my understanding that HCFA's impact analysis contends that 80% of hospitals would not be affected by this provision because they are JCAHO accredited. Many hospitals would be adversely affected because this is *not* the current JCAHO standard. This would result in major increases in cost at a time when resources available for the delivery of psychiatric services are as low as they have ever been. Further, I understand there is no empirical evidence that a face-to-face evaluation by a physician within 1 hour will improve patient care. Finally, this provision was not included in the original proposed rule upon which comments were solicited from the field. Although the current comment period is 60 days, this dramatic change becomes effective 30 days into the comment period. This is not sufficient time to comment on a major new provision that has such dramatic implications on the field.

I urge you to work with the hospital industry and other affected parties to come up with a reasonable and appropriate alternative before the 30-day effective period has lapsed. If that is not feasible, I urge you to immediately delay implementation of this provision until there has been a full analysis of the provision's real impact.

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254 FRONT STREET
MARIETTA, OH 45750
(740) 376-0868

Again, thank you for your leadership in promptly addressing an issue that warrants thoughtful and appropriate regulatory action.

Sincerely,

A handwritten signature in black ink that reads "Ted Strickland". The signature is fluid and cursive, with the first name "Ted" and last name "Strickland" clearly distinguishable.

Ted Strickland
Member of Congress

CC: Mrs. Tipper Gore
Mr. Christopher Jennings
Ms. Sara Biancchi

CROWELL & MORING LLP

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ROBERT P. CHARROW
OF COUNSEL
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July 15, 1999

Via Hand

Mark Covall
Executive Director
National Association of Psychiatric Health Systems
1817 F Street, N.W.
Suite 301
Washington, D.C. 20004-1105

Re: Conditions of Participation—Restraint Rules

Dear Mark:

You asked us to review whether the interim final rule on Conditions of Participation ("CoP"), issued by the Health Care Financing Administration ("HCFA") on July 2, 1999, comports with the provisions of the Regulatory Flexibility Act ("RFA"), 5 U.S.C. §§ 601 *et seq.* As you know, the RFA was amended by the Small Business Regulatory Enforcement Fairness Act of 1996, title II, Pub. L. 104-121, to provide for judicial review. See 5 U.S.C. § 611(a)(1).

The interim final rule, as discussed below, raises significant issues under the RFA.¹ In our view, the purported regulatory analysis published in the preamble fails to comply with the requirements of the RFA. In particular, the provision of the CoP that would likely have the greatest financial impact on both free-standing psychiatric hospitals and general acute care hospitals, namely the requirement that a physician (or other licensed independent practitioner) examine a patient within

¹ The interim final rule also raises significant issues under section 1102 of the Social Security Act, which requires HCFA to determine the cost of the rule on rural hospitals. HCFA claimed that the rule would have no effect on rural hospitals; this is clearly incorrect given the need to hire additional physicians to implement the one-hour rule. We also believe that the rule raises significant issues under the Unfunded Mandates Reform Act of 1995 and the congressional review provisions of the Contract with America Advancement Act of 1996, Pub. L. 104-121, codified at 5 U.S.C. §§ 801 *et seq.*

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Mark Covall
July 15, 1999
Page 2

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one hour of being placed under a restraint or in seclusion, was never factored into the regulatory analysis performed by HCFA. This is particularly troublesome since the notice of proposed rulemaking did not contain a "one-hour" rule and, therefore, the economic impact of it on small health care providers was never analyzed. As discussed below, we estimate that the one-hour requirement will cost hospitals in excess of \$50 million annually to implement and the corresponding benefits will be, as the Secretary candidly noted, immeasurable. In addition, certain facts relied upon by HCFA in performing its regulatory analysis are simply wrong. The correct information could have been easily obtained by HCFA, and if it had been used, it too would have affected HCFA's analysis.

The interim final CoP rule requires hospitals to implement a series of procedures and policies designed to safeguard patients who are restrained for medical or behavioral reasons. Among the many prophylactic requirements is one that in cases where seclusion or a restraint is used for behavior management, a "physician or other licensed independent practitioner must see and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention." 64 Fed. Reg. 36069, 36089 (July 2, 1999), to be codified at 42 CFR § 482.12(f)(3)(ii)(C). In the preamble to the rule, the Secretary has not certified that the rule would not have a significant effect on small businesses. Thus, the Secretary was required to undertake a flexibility analysis. Instead, the Secretary and HCFA noted that "we have no factual reports, studies, or data to aid in the development of cost or savings estimates." 64 Fed. Reg. at 36086. The Secretary goes on, however, to claim that since "most hospitals are already fulfilling many of the requirements of this regulation . . . there may be no significant increase in the burden to most hospitals." *Id.* Correspondingly, the Secretary asserts that with respect to the "restraint and seclusion standards, . . . there should be no significant additional burden for, at least, the 80 percent of the Medicare participating hospitals accredited by JCAHO since the requirements are modeled on JCAHO's standards" *Id.* These claims are simply wrong and underscore the fact that, putting aside the preamble's hortatory language, the Secretary failed to even attempt the type of regulatory analysis required by the RFA. In particular, the one-hour requirement is a major change in practice and is not a current JCAHO standard. In fact, JCAHO requires a physician or licensed independent practitioner to order restraint or seclusion, but the physician does not have to conduct a face-to-face evaluation for 24 hours. See JCAHO STANDARDS TX.7.1.3.1.7 and TX.7.1.3.1.8 (Nov. 1998).

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Mark Covall
July 15, 1999
Page 3

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- (1) a succinct statement of the need for, and objectives of, the rule;
- (2) a summary of the significant issues raised by the public comments in response to the initial regulatory flexibility analysis, a summary of the assessment of the agency of such issues, and a statement of any changes made in the proposed rule as a result of such comments;
- (3) a description of and an estimate of the number of small entities to which the rule will apply or an explanation of why no such estimate is available;
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- (5) a description of the steps the agency has taken to minimize the significant economic impact on small entities consistent with the stated objectives of applicable statutes, including a statement of the factual, policy, and legal reasons for selecting the alternative adopted in the final rule and why each of the other significant alternatives to

² An agency may avoid conducting a regulatory analysis if the head of the agency certifies that the rule "will not . . . have a significant economic impact on a substantial number of small entities." 5 U.S.C. § 605. A certification under section 605 must itself be based on data and cannot be used as a ruse to avoid an analysis. See *Northwest Mining Association v. Babbitt*, 5 F. Supp. 2d 9, 15 (D.D.C. 1998) (setting aside a certification because it "was without observance of procedure required by law"). Here, the Secretary filed no certification, and therefore, a full impact analysis was required.

Mark Covall
July 15, 1999
Page 4

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We believe that HCFA failed to comply with the RFA requirements concerning an estimate of the number of small entities affected (requirement 3), and a description of the steps taken to minimize the rule's impact on small businesses, including a list of the less costly alternatives considered and the reasons why they were rejected (requirement 5).

As noted above, HCFA stated that it lacked the necessary information to conduct a real cost benefit analysis. Accordingly, it relied on newspaper articles and other questionable sources for its qualitative assessment. Indeed, it made no effort to quantify the number of small entities that would be affected by the rule, especially its one-hour provision. That information, however, was readily available to HCFA in its own Part A database and certainly could have been obtained from industry sources. Specifically, there are, at minimum, 200 freestanding psychiatric hospitals that do not employ physicians 24 hours per day. Thus, to ensure compliance with the one-hour requirement, each of these psychiatric hospitals would need to employ or contract with at least two full-time equivalent physicians to provide appropriate coverage at an estimated annual cost to each hospital of \$250,000. This is so, because most freestanding psychiatric hospitals have physicians on-call around the clock and have immediate access to nearby acute care hospitals in the event of a medical emergency, but few, if any, are staffed by physicians 24 hours per day. A similar situation would exist in many general acute care hospitals—especially those in rural communities—thereby further increasing the economic impact of the rule. In short, the one-hour requirement would increase costs by at least \$50,000,000 to just these 200 psychiatric hospitals; we view that as a significant adverse affect on these small institutions. Moreover, given that the rule goes into effect 30 days after publication, the cost of retaining qualified physicians in such a short time may be higher than it ordinarily would have been.

An agency is not free to ignore existing data by claiming it is not readily available. Thus, in *North Carolina Fisheries Association, Inc. v. Daley*, 27 F.Supp.2d 650, 659-60 (E.D.Va. 1998), the court chastised the Commerce Department for ignoring existing data and relying on internally generated data that the Department knew were inaccurate. Here, as in *Daley*, the government is attempting to "soft-pedal[] around the documented results." *Id.*

Given the significant economic impact of the one-hour requirement, the agency should have considered less costly alternatives. It did not, and therefore

Mark Covall
July 15, 1999
Page 5

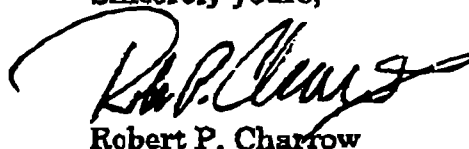
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clearly failed to fulfill its obligation under the RFA "to consider less severe alternatives." *Id.* In particular, HCFA totally failed to even mention, let alone consider, the current and accepted practice under which nurses with demonstrated competence provide the physician with the short-term clinical information necessary for the physician to make an informed decision, albeit not face-to-face.

Instead, the agency implied that the costs would be minimal because JCAHO-accredited hospitals already comply, as a condition of accreditation, with the one-hour requirement. Such is not the case. As noted above, JCAHO standards do not require a physician to be present on premises around the clock, nor do state laws impose similar restrictions. JCAHO requires that a physician or licensed independent practitioner examine a patient within 24 hours after that patient has been placed in restraints or seclusion. The one-hour requirement, far from being in harmony with existing accreditation standards, will dramatically change current standards and practices. In short, the interim final rule would impose a new, costly requirement. That requirement, however, was never subjected to the type of scrutiny required by the RFA. Quite to the contrary, the agency abdicated its statutory responsibilities under the RFA when it stated that "we have no factual reports, studies, or data to aid in the development of cost or savings estimates." 64 Fed. Reg. at 36086. This is insufficient.

Accordingly, we recommend that you request that the Secretary and HCFA delay the effective date of the interim final rule until such time as HCFA has had the opportunity to conduct the type of flexibility analysis required by Federal law.

Sincerely yours,



Robert P. Chaffow



*The National Association of
Psychiatric
Health
Systems*

Issue Brief

**HCFA CONDITIONS OF PARTICIPATION:
PHYSICIAN^{*} MONITORING OF SECLUSION AND RESTRAINT
(Proposed Modification)**

July 14, 1999

SUMMARY OF ISSUE

The Health Care Financing Administration (HCFA) has issued standards on the use of restraint and seclusion for behavioral health management. The standards will take effect as "Conditions of Participation" 30 days following the July 2, 1999 *Federal Register* notice of the Interim Final Rule and will apply to hospitals participating in the Medicare and Medicaid programs.

In releasing these (and other patient protection standards), HCFA noted its intent to ensure patients "freedom from the inappropriate use of restraints and seclusion" and to make its standards consistent with those of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The American Hospital Association (AHA) and the National Association of Psychiatric Health Systems (NAPHS) believe that a new requirement on physician^{*} monitoring of seclusion and restraint - which was not part of the original proposed rule - and the 30-day effective date for implementing such a substantial change in current practice would create unintended, costly and serious patient care problems. We believe the standards need to assure physician accountability while providing flexibility for clinical judgment and practice.

OUR VIEW

AHA and NAPHS support HCFA's leadership in issuing standards on restraint and seclusion. We believe that the regulatory process is the appropriate way to address any concerns about restraint and seclusion, and we recently wrote to HCFA encouraging them to issue final Medicare and Medicaid hospital Conditions of Participation relating to the use of restraint and seclusion for behavioral health management. (These provisions were part of a larger set of possible revisions to Conditions of Participation pending since December 19, 1997.) We believe that HCFA's issuance of regulations is the most effective way to provide accountability without hindering patient safety or confidentiality.

^{*} or licensed independent practitioner (LIP)

AHA's and NAPHS's most serious concern is about one specific standard in the July 2, 1999 interim final regulation that refers to physician monitoring of restraint and seclusion. This language was *not* in the original December 19, 1997 proposed rule on which comments were solicited and appeared for the first time in the July 2, 1999 Interim Final Rule, which becomes effective in 30 days. Currently, this new provision on physician monitoring of restraint and seclusion says:

(1) Standard: Seclusion and restraint for behavior management

(3) (ii) C A physician or other licensed independent practitioner must see and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention.

We fully support the concept of physician accountability and involvement in a timely manner whenever a patient's condition requires the use of restraint or seclusion. However, as written, we believe this provision would create unintended, costly consequences without evidence that it will improve patient care. This provision presents several problems.

- **This regulation inappropriately dictates medical practice.** It is not feasible, clinically necessary or economically viable to require a face-to-face physician evaluation in every case. It is appropriate to require a timely and clinically appropriate evaluation. We support the physician's role and responsibility in the overall evaluation and assessment of the patient. A physician assessment should always be done, but the physician should be the one to determine whether a face-to-face evaluation is necessary within one hour.
- **This regulation would increase costs dramatically.** HCFA's impact analysis contends that 80% of hospitals would not be affected by this provision because they are JCAHO accredited. In fact, no valid cost impact analysis of this provision was conducted. Many hospitals would be adversely affected because this is *not* the current JCAHO standard. This would result in major increases in cost at a time when resources available for the delivery of psychiatric services are as low as they have ever been. For example, a February 1998 Health Economics Research study on the impact of the "Balanced Budget Act of 1997" payment reductions to psychiatric facilities found that the mean Medicare revenue margin would be -8.7%.
- **There is no empirical evidence to base the assumption that a face-to-face evaluation by a physician or licensed independent practitioner within 1 hour will improve the outcome of care for patients who are restrained or secluded.**
- **This regulation is not consistent with HCFA's stated intent "to revise all of the hospital Conditions of Participation" in concert with Vice President Gore's Reinventing Government (REGO) initiative** (page 86 in 7/2/99 Interim Final Rule). The REGO initiative emphasized decreasing federal regulation to eliminate unnecessary structural and process requirements, focus on outcomes of care, allow greater flexibility to hospitals and practitioners to meet quality standards, and to place a stronger emphasis on quality assessment and performance improvement.
- **This regulation is not consistent with JCAHO standards** – which was HCFA's stated intent for the new Conditions of Participation. It would require implementation almost overnight of a substantial change in current practice by allowing *only* a face-to-face evaluation of a patient. It is important that physicians be able to use clinical judgment in

how evaluations are best accomplished based on the needs of the patient. Evaluations can be done in ways other than face-to-face as long as there are nurses with demonstrated competence on site to provide clinical input to inform the physician's decision.

- The specific language in this provision was *not* included in the proposed rules upon which comments were solicited from the field. This provides *inadequate time for comment* on a new provision with dramatic impact on the field.

RECOMMENDATIONS

1. Much of this new provision was never included in the original draft of the Conditions of Participation and will be virtually impossible to implement within the short 30-day timeframe that the regulation becomes effective. We urge delay of its implementation until there has been full analysis of the provision's real impact and the impact of the alternate proposal detailed below.
2. To ensure that this standard is consistent with JCAHO requirements and works to ensure the best interests of patients, AHA and NAPHS recommend the following revision.

"A physician, or other licensed independent practitioner, must see and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention." This evaluation may be done by the physician or licensed independent practitioner in consultation with a registered nurse who has demonstrated competency in the evaluation of a patient in restraint or seclusion and who is in face-to-face contact with the patient.

This language would allow for the following:

- The qualified registered nurse would, in many cases, be more readily accessible in the emergency situation that precipitated the restraint episode. Because of his/her involvement from the earliest stages of the event, the registered nurse would be able to provide added understanding of the situation. He/she would also be in a position to rapidly provide appropriate consultation so that the physician can make an informed evaluation. He/she could carry out the physician's orders and direct staff in the use of least restrictive methods and in the discontinuation of restraint or seclusion at the earliest possible time, as specified in the proposed regulations.

For more information, contact:

American Hospital Association: Karen Milgate, 202-626-4628 or Curtis Rooney, 202-626-2678
National Association of Psychiatric Health Systems: Cidette Perrin, 202-393-6700, Ext. 17

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TELECOPIER COVER SHEET

Date: 7/15/99 Time: 12:12 PM

Fax No.: 202-456-5557 Client No.: 0012

To: Chris Jennings, Congressional Liaison for Health Policy

From: Steve Jenning

Number of Pages (excluding cover sheet) 8

Person Sending: Steve Jenning

Chris: Per our prior communications on restraint regulations, here is a legal opinion indicating severe problems with the agency rulemaking.

**IF YOU HAVE ANY PROBLEMS RECEIVING, PLEASE
CALL PERSON SENDING IMMEDIATELY**

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July 15, 1999

Via Hand

Mark Covall
Executive Director
National Association of Psychiatric Health Systems
1317 F Street, N.W.
Suite 301
Washington, D.C. 20004-1105

Re: Conditions of Participation—Restraint Rules

Dear Mark:

You asked us to review whether the interim final rule on Conditions of Participation ("CoP"), issued by the Health Care Financing Administration ("HCFA") on July 2, 1999, comports with the provisions of the Regulatory Flexibility Act ("RFA"), 5 U.S.C. §§ 601 *et seq.* As you know, the RFA was amended by the Small Business Regulatory Enforcement Fairness Act of 1996, title II, Pub. L. 104-121, to provide for judicial review. See 5 U.S.C. § 611(a)(1).

The interim final rule, as discussed below, raises significant issues under the RFA.¹ In our view, the purported regulatory analysis published in the preamble fails to comply with the requirements of the RFA. In particular, the provision of the CoP that would likely have the greatest financial impact on both free-standing psychiatric hospitals and general acute care hospitals, namely the requirement that a physician (or other licensed independent practitioner) examine a patient within

¹ The interim final rule also raises significant issues under section 1102 of the Social Security Act, which requires HCFA to determine the cost of the rule on rural hospitals. HCFA claimed that the rule would have no effect on rural hospitals; this is clearly incorrect given the need to hire additional physicians to implement the one-hour rule. We also believe that the rule raises significant issues under the Unfunded Mandates Reform Act of 1995 and the congressional review provisions of the Contract with America Advancement Act of 1996, Pub. L. 104-121, codified at 5 U.S.C. §§ 801 *et seq.*

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Mark Covall
July 15, 1999
Page 2

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The interim final CoP rule requires hospitals to implement a series of procedures and policies designed to safeguard patients who are restrained for medical or behavioral reasons. Among the many prophylactic requirements is one that in cases where seclusion or a restraint is used for behavior management, a "physician or other licensed independent practitioner must see and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention." 64 Fed. Reg. 36069, 36089 (July 2, 1999), to be codified at 42 CFR § 482.12(f)(3)(ii)(C). In the preamble to the rule, the Secretary has not certified that the rule would not have a significant effect on small businesses. Thus, the Secretary was required to undertake a flexibility analysis. Instead, the Secretary and HCFA noted that "we have no factual reports, studies, or data to aid in the development of cost or savings estimates." 64 Fed. Reg. at 36086. The Secretary goes on, however, to claim that since "most hospitals are already fulfilling many of the requirements of this regulation . . . there may be no significant increase in the burden to most hospitals." *Id.* Correspondingly, the Secretary asserts that with respect to the "restraint and seclusion standards, . . . there should be no significant additional burden for, at least, the 80 percent of the Medicare participating hospitals accredited by JCAHO since the requirements are modeled on JCAHO's standards" *Id.* These claims are simply wrong and underscore the fact that, putting aside the preamble's hortatory language, the Secretary failed to even attempt the type of regulatory analysis required by the RFA. In particular, the one-hour requirement is a major change in practice and is not a current JCAHO standard. In fact, JCAHO requires a physician or licensed independent practitioner to order restraint or seclusion, but the physician does not have to conduct a face-to-face evaluation for 24 hours. See JCAHO STANDARDS TX.7.1.3.1.7 and TX.7.1.3.1.8 (Nov. 1998).

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Mark Covall
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Page 4

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Mark Covall
July 15, 1999
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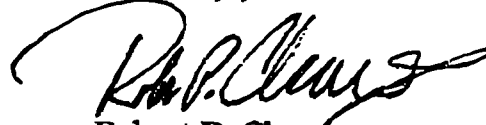
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Accordingly, we recommend that you request that the Secretary and HCFA delay the effective date of the interim final rule until such time as HCFA has had the opportunity to conduct the type of flexibility analysis required by Federal law.

Sincerely yours,



Robert P. Charrow



*The National Association of
Psychiatric
Health
Systems*

Issue Brief

HCFA CONDITIONS OF PARTICIPATION: PHYSICIAN* MONITORING OF SECLUSION AND RESTRAINT (Proposed Modification)

July 14, 1999

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* or licensed independent practitioner (LIP)

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- The specific language in this provision was *not* included in the proposed rules upon which comments were solicited from the field. This provides **inadequate time for comment** on a new provision with dramatic impact on the field.

RECOMMENDATIONS

1. Much of this new provision was never included in the original draft of the Conditions of Participation and will be virtually impossible to implement within the short 30-day timeframe that the regulation becomes effective. **We urge delay of its implementation** until there has been full analysis of the provision's real impact and the impact of the alternate proposal detailed below.

2. To ensure that this standard is consistent with JCAHO requirements and works to ensure the best interests of patients, **AHA and NAPHS recommend the following revision.**

"A physician, or other licensed independent practitioner, must ~~see and~~ evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention." This evaluation may be done by the physician or licensed independent practitioner in consultation with a registered nurse who has demonstrated competency in the evaluation of a patient in restraint or seclusion and who is in face-to-face contact with the patient.

This language would allow for the following:

- The qualified registered nurse would, in many cases, be more readily accessible in the emergency situation that precipitated the restraint episode. Because of his/her involvement from the earliest stages of the event, the registered nurse would be able to provide added understanding of the situation. He/she would also be in a position to rapidly provide appropriate consultation so that the physician can make an informed evaluation. He/she could carry out the physician's orders and direct staff in the use of least restrictive methods and in the discontinuation of restraint or seclusion at the earliest possible time, as specified in the proposed regulations.

For more information, contact:

American Hospital Association: Karen Milgate, 202-626-4628 or Curtis Rooney, 202-626-2678
National Association of Psychiatric Health Systems: Cidette Perrin, 202-393-6700, Ext. 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

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Date: 6/22From: KevinTo: Dvarah

Division: _____

Division: _____

City & State: _____

City & State: _____

Office Number: _____

Office Number: _____

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Fax Number: 456-5557Number of Pages + cover 2REMARKS: Side by side on 3 restraints bills

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COMMERCE COMMITTEE

SUBCOMMITTEE ON HEALTH
AND ENVIRONMENTSUBCOMMITTEE ON FINANCE AND
HAZARDOUS MATERIALSSUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS

Congress of the United States
House of Representatives
 Washington, DC 20515-0601

Comparison of Bills Addressing Restraint Use			
	<i>Lieberman</i> ~~106-5736~~ S. 736	<i>Dodd</i> S. 750	<i>H.R. 1313</i> <i>DeGette, Stark,</i> <i>DeLauro</i>
Populations Covered	all mental health patients receiving Medicaid/Medicare funds	all mental health patients covered by SAMHSA	all patients with mental illness, developmental, disabilities, and troubled youth receiving Medicaid/Medicare or other federal funding
Guidelines for Restraint Use	extend to mental health population existing OBRA protections	extend to mental health population existing OBRA protections	extend to mental health population existing OBRA protections and additional protections
Federal reporting of restraint use	none	none	annually
Federal reporting of deaths	requires the reporting of deaths and sentinel events	requires the reporting of deaths and sentinel events	requires the reporting of deaths and sentinel events
Training of restraint use and alternatives	none	requires HHS Sec to draft regulations for facilities to train staff	requires annual training
Staffing	none	requires HHS Sec to draft regulations for ensuring adequate staffing	none
Sanctions	none	HHS Sec has authority to sever program participation	monetary fines and loss of federal funding

*This table is based on bill summaries provided to DeGette staff

S 750 IS

106th CONGRESS

1st Session

S. 750

To protect the rights of residents of certain federally funded hospitals.

IN THE SENATE OF THE UNITED STATES

March 25, 1999

Mr. DODD (for himself and Mr. LIEBERMAN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To protect the rights of residents of certain federally funded hospitals.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Compassionate Care Act of 1999'.

SEC. 2. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

'PART G--REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES

'SEC. 581. REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES.

'(a) IN GENERAL- A public or private general hospital, nursing facility, intermediate care facility, residential treatment center, or other health care facility, that receives assistance in any form from any program supported in whole or in part with Federal funds shall protect and promote the rights of each resident of the facility, including the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience.

'(b) REQUIREMENTS- Physical or chemical restraints may only be imposed on a resident of a facility described in subsection (a) if--

'(1) the imposition of the restraints are to ensure the physical safety of the resident or others; and

`(2) the restraints and seclusion are imposed only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

`(c) DEFINITIONS- In this section:

`(1) CHEMICAL RESTRAINT- The term `chemical restraint' means the use of a psychopharmacologic drug that is imposed for purposes of discipline or convenience and is not required to treat a medical symptom.

`(2) PHYSICAL RESTRAINT- The term `physical restraint' means any mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely, that is imposed for purposes of discipline or convenience, and that is not required to treat a medical symptom. Such term does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, and other methods involving the physical holding of a resident for the purpose of conducting routine physical examinations or tests or to protect the patient from falling out of bed or to permit a patient to participate in activities without the risk of physical harm to the patient.

`(3) SECLUSION- The term `seclusion' means any separation of the resident from the general population of the facility that prevents the resident from returning to such population when he or she desires, that is imposed for purposes of discipline or convenience, and that is not required to treat a medical symptom.

`SEC. 582. REPORTING REQUIREMENT.

`(a) IN GENERAL- Each facility to which the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.) applies shall notify the appropriate Protection and Advocacy system of each death that occurs at each such facility. A notification under this subsection shall include the name of the resident and a general description of the circumstances of his or her death, and shall be provided not later than 7 days after the date of the death of the individual involved.

`(b) DEFINITIONS- In subsection (a):

`(1) FACILITY- The term `facility' has the meaning given the term `facilities' in section 102(3) of the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10802(3)).

`(2) PROTECTION AND ADVOCACY SYSTEM- The term `Protection and Advocacy system' means a system established under part C of title I of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.).'

SEC. 3. INVESTIGATIONS OF CERTAIN DEATHS AND INJURIES.

Section 105(a)(1) of the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10805(a)(1)) is amended--

(1) in subparagraph (B), by striking `and' at the end;

(2) in subparagraph (C), by striking the semicolon at the end and inserting `; and'; and

(3) by adding at the end the following:

`(D) investigate the death or serious injury (any significant impairment of the physical

condition of the individual, including any burn, laceration, internal injury, or any injury that occurs as a result of repeated harm to any organ) of an individual with a mental illness if the death or serious injury occurred at a facility to which this Act applies;'.
'.

SEC. 4. REGULATIONS AND ENFORCEMENT.

(a) TRAINING- Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, after consultation with appropriate State and local protection and advocacy organizations, shall promulgate regulations that require facilities to which the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.) applies, to meet the requirements of subsection (b).

(b) REQUIREMENTS- The regulations promulgated under subsection (a) shall require that--

(1) facilities described in subsection (a) ensure that appropriate staff levels are maintained within such facilities;

(2) appropriate training be provided for the staff of such facilities in the use of restraints and any alternatives to the use of restraints; and

(3) such facilities provide complete and accurate notification of deaths, as required under section 582(a) of the Public Health Service Act (as added by section 2).

(c) ENFORCEMENT- A facility to which this Act (or an amendment made by this Act) applies, that fails to comply with any requirement of this Act (or such an amendment), including a failure to provide appropriate training, shall not be eligible for participation in any Federally funded program.

END

HR 1313 IH

106th CONGRESS

1st Session

H. R. 1313

To amend title XI of the Social Security Act to restrict the use of physical and chemical restraints and seclusion in certain facilities receiving Medicare or Medicaid funds, to require recording and reporting of information on that use and on sentinel events occurring in those facilities, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

March 25, 1999

Ms. DEGETTE (for herself, Mr. STARK, Ms. DELAURO, Mrs. MORELLA, Mr. WAXMAN, Ms. KILPATRICK, Mr. GEORGE MILLER of California, Mr. BROWN of Ohio, Mr. SANDERS, Mr. LANTOS, Mr. MARTINEZ, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. RANGEL, Mr. CROWLEY, Mrs. CAPPS, Ms. PELOSI, Mr. FORD, Mr. MCGOVERN, Mr. WYNN, Ms. SCHAKOWSKY, Mr. CUMMINGS, and Ms. BERKLEY) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XI of the Social Security Act to restrict the use of physical and chemical restraints and seclusion in certain facilities receiving Medicare or Medicaid funds, to require recording and reporting of information on that use and on sentinel events occurring in those facilities, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Patient Freedom from Restraint Act of 1999'.

SEC. 2. LIMITATION ON USE OF PHYSICAL AND CHEMICAL RESTRAINTS AND SECLUSION IN CERTAIN MEDICARE OR MEDICAID FUNDED TREATMENT FACILITIES.

(a) IN GENERAL- Part B of title XI of the Social Security Act is amended by adding at the end the following new section:

'LIMITATION ON USE OF RESTRAINTS AND SECLUSION IN CERTAIN MEDICARE AND MEDICAID FUNDED TREATMENT FACILITIES

'SEC. 1164. (a) FREEDOM FROM RESTRAINTS AND SECLUSION- As a condition of participation or receipt of funds under the medicare program under title XVIII or under a State

medicaid program under title XIX, a covered facility (as defined in subsection (b)) shall--

`(1) protect and promote the right of each resident or patient to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints (as defined in subsection (g)) imposed for purposes of discipline or convenience;

`(2) meet the requirements of subsection (d) (relating to recording and reporting on the use of restraints and seclusion and sentinel events);

`(3) provide for annual training of all staff with direct resident or patient care responsibility on the proper use of restraints and seclusion, their alternatives, and techniques and methods to identify and defuse potential emergency situations; and

`(4)(A) make available to each resident or patient, and to the guardian of each such resident or patient, a statement of their rights to freedom from restraints and seclusion as required by this section and information on the purpose of the appropriate protection and advocacy agencies (as defined in subsection (g)(4)) and their addresses and telephone numbers; and

`(B) clearly and conspicuously post such information in the facility.

`(b) COVERED FACILITY DEFINED- For purposes of this section, the term `covered facility` means any of the following:

`(1) A facility that provides inpatient or residential psychiatric treatment or treatment of mental illness (including a psychiatric hospital, as defined in section 1861(f), and an institution for mental diseases, as defined in section 1905(i)).

`(2) An intermediate care facility for the mentally retarded (as defined in section 1905(d)).

`(3) A facility that provides residential treatment for children.

`(c) REQUIREMENTS RELATING TO RESTRAINTS AND SECLUSION-

`(1) GENERAL LIMITATIONS-

`(A) IN GENERAL- A covered facility may only impose restraints and seclusion--

`(i) to ensure the immediate physical safety of the resident or patient or others; and

`(ii) only upon the written order of a physician that specifies the duration (not to exceed 2 consecutive hours) and circumstances under which the restraints and seclusion are to be used.

`(B) EMERGENCY EXCEPTION- Subparagraph (A)(ii) shall not apply in emergency circumstances specified by the Secretary during the period before a written order can reasonably be obtained.

`(2) PROHIBITION OF USE OF STANDING ORDERS- Written orders for such restraints or seclusion shall never be written as a standing order.

`(3) USE AS LAST RESORT- A covered facility may only use restraints and seclusion as an emergency safety measure and as a last resort and only after other less restrictive approaches have failed.

`(4) LEAST RESTRICTIVE MANNER- A covered facility shall use restraints and seclusion only in the least restrictive manner possible, to protect the resident or patient or

others from harm, and must remove or end restraints and seclusion at the earliest possible time.

`(5) NO SIMULTANEOUS USE- A covered facility may not use restraints and seclusion simultaneously.

`(d) RECORDING AND REPORTING REQUIREMENTS- In accordance with the protocol established under subsection (e)(1)--

`(1) RECORDING USES OF RESTRAINT AND SECLUSION IN PATIENT RECORDS-

`(A) IN GENERAL- Each covered facility shall record and maintain, as part of a resident's or patient's medical record, the following information on each incident in which restraints or seclusion are used with respect to a resident or patient of the facility:

`(i) The uses of restraint and seclusion, including the type of restraint or seclusion used and the time and duration of its use.

`(ii) The rationale for restraint or seclusion and types of less restrictive alternatives that were tried or considered.

`(iii) Evidence of treatment planning to reduce the probability of future incidents that would lead to use of restraint or seclusion.

`(B) AVAILABILITY TO P&A AGENCIES- Each covered facility shall make available the information recorded under subparagraph (A) for inspection by staff of the appropriate protection and advocacy agencies.

`(2) SUBMISSION OF PERIODIC REPORTS ON OVERALL USE OF RESTRAINTS AND SECLUSION- Each covered facility shall submit to the Secretary and to the appropriate protection and advocacy agencies a report that specifies the number of times restraints or seclusion were used during the reporting period. Such report shall be submitted on a periodic basis specified by the Secretary, but in no case less often than annually.

`(3) SUBMISSION OF REPORTS ON ALL SENTINEL EVENTS-

`(A) IN GENERAL- Each covered facility shall submit to the appropriate protection and advocacy agency a report on--

`(i) each sentinel event (as defined in subsection (g)(6)) that occurs respecting a resident or patient, including only the name of the resident or patient and a general description of the event; and

`(ii) if information is available to the facility, information on the death of any individual who died within 14 days after the date of discharge from the facility.

`(B) DEADLINE FOR SUBMISSION- Each report under subparagraph (A)(i) shall be submitted within 7 days of the date of the incident involved and each report under subparagraph (A)(ii) shall be submitted within 7 days of receipt of information concerning the death of the former resident or patient.

`(C) ANNUAL REPORT- Each covered facility shall submit on an annual basis to the Secretary an annual report on sentinel events for which reports were made during the previous year under subparagraph (A).

`(e) IMPLEMENTATION-

`(1) IN GENERAL- Not later than 1 year after the date of the enactment of this section, the Secretary shall establish a protocol for the recording and reporting of information under subsection (d). To the extent feasible, the Secretary shall establish the protocol in a manner that is consistent with medical records recording systems and that is coordinated with other applicable health care information reporting systems. The Secretary shall consult with appropriate protection and advocacy agencies in establishing and implementing the protocol.

`(2) PUBLICATION OF SUMMARY- The Secretary shall compile and publish on an annual basis a comprehensive summary of the reports received under subsection (d)(3).

`(3) ESTABLISHMENT OF GUIDELINES FOR PEER REVIEW ORGANIZATIONS- The Secretary shall establish guidelines for the use of utilization and quality control peer review organizations (as defined in section 1152(a)) in reviewing policies and procedures of covered facilities regarding the use of restraints and seclusion consistent with this section.

`(f) SANCTIONS-

`(1) LOSS OF MEDICARE AND MEDICAID FUNDING- A covered facility that fails to comply with the requirements of subsection (a) (including failure to provide for annual training of staff in accordance with subsection (a)(3)) is subject to disqualification from participation in the medicare program under title XVIII and the medicaid program under title XIX for such period at the Secretary may specify.

`(2) CIVIL MONEY PENALTY FOR FAILURE TO FILE SENTINEL REPORTS- A covered facility that fails to file a report required to be made under subsection (b)(3) within the period so required is subject to a civil money penalty not to exceed \$5,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A(a).

`(g) DEFINITIONS- For purposes of this section:

`(1) RESTRAINTS- The term 'restraints' means any chemical or physical restraint (as defined in paragraphs (2) and (3)).

`(2) CHEMICAL RESTRAINT- The term 'chemical restraint' means the use of any medication or biological for the purpose of immobilizing the individual, inducing a state of sleep or unconsciousness, or reducing the ability to move freely. Such term does not include involuntary administration of medication when administered pursuant to a court order or the administration of medication for voluntary or emergency treatment (such as anesthesia administered before a surgical procedure).

`(3) PHYSICAL RESTRAINT- The term 'physical restraint' means any mechanical or personal restriction that immobilizes or reduces an individual's ability to move arms, legs, or head freely. Such term does not include devices, such as orthopedically prescribed appliances, surgical dressings and bandages, protective helmets and supportive body bands, and other physical holding when necessary for routine physical examinations or tests or for orthopedic surgical or other similar medical treatment purposes or when used to provide support for the achievement of functional body position or proper balance or to permit an individual to participate in ongoing activities with the risk of physical harm.

`(4) PROTECTION AND ADVOCACY AGENCY- The term 'protection and advocacy agency' means an appropriate board under the protection and advocacy system established under part C of title I of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6041 et seq.).

`(5) SECLUSION- The term `seclusion' means the involuntary confinement of a resident or patient in a room from which the resident or patient is physically prevented from leaving.

`(6) SENTINEL EVENT- The term `sentinel event' means an unexpected occurrence involving a substantial impairment of the physical or psychological condition of a resident or patient, including any burn, laceration, or abrasion of the skin, fracture of any bone, substantial hematoma, injury to any internal organ, or any injury that occurs as a result of repeated harm to any bodily function or organ (including the skin), if the occurrence is unrelated to the natural course of the individual's illness or underlying condition, and includes the death of the individual in any case.'

(b) EFFECTIVE DATES-

(1) PROTECTION AGAINST USE OF PUNITIVE RESTRAINTS AND SECLUSION- The requirements of subsections (a)(1) and (c) of section 1164 of the Social Security Act, as added by subsection (a), apply to restraints and seclusion used on or after the first date of the first month that begins more than 6 months after the date of the enactment of this Act.

(2) REPORTING REQUIREMENTS-

(A) DEADLINE FOR ESTABLISHING PROTOCOL- The Secretary of Health and Human Services shall first establish the protocol described in section 1164(e)(1) of the Social Security Act, as added by subsection (a), within 1 year after the date of the enactment of this Act.

(B) REPORTS- Covered facilities are first required to record information and submit reports under section 1164(c) of the Social Security Act, as so added, for restraints and seclusion used on and after a date (specified by the Secretary of Health and Human Services) that is not later than 2 months after the date of the establishment of the protocol under section 1164(e)(1) of such Act.

(3) ANNUAL TRAINING- The requirement of section 1164(a)(3) of the Social Security Act, as so added, applies for annual periods beginning after the effective date described in paragraph (1).

(4) POSTING INFORMATION- The requirement of section 1164(a)(4) of the Social Security Act, as so added, takes effect on such date, not later than the effective date described in paragraph (1), as the Secretary of Health and Human Services shall specify.

END

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June 22, 1999

Senate Stumbling Through HMO Debate

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Filed at 6:49 p.m. EDT**By The Associated Press**

WASHINGTON (AP) -- Democrats are threatening to bring the Senate to a standstill, demanding a debate over new rights for patients in HMOs.

"When you reach an impasse you have only one option: to turn up the pressure," said Senate Minority Leader Tom Daschle said Tuesday.

The immediate victim was the agriculture spending bill, which is on hold while the Senate sorts through the dispute.

The Senate voted 53-47 Tuesday mostly along party lines to table a Democratic amendment that would have attached the entire HMO bill to the spending measure.

But Democrats said they will keep changing their amendment a little bit, offering it again and again until Republicans give in. If the GOP tries to move onto another issue, they promised to block the move.

Sen. Don Nickles, R-Okla., the Republican assistant majority leader, said he was willing to vote on the issue if Democrats would agree to limits on debate.

"We're not just going to have the bill on the floor for ... unlimited debate," he said.

Democrats in the House were also set to push their case on HMOs. They planned a rally Wednesday to begin collecting signatures on a discharge petition that would force GOP leaders to bring their bill to the House floor.

In the Senate, a GOP-backed HMO bill cleared a committee on a party-line vote in March, but Democrats complain that it doesn't cover enough people or offer enough provisions.

They want to offer a string of at least 20 amendments, forcing Republicans to change the bill or take potentially unpopular votes against new rights.

Democratic leaders predict that many Republicans will have trouble opposing proposals guaranteeing minimum hospital stays after mastectomies, access to clinical trials and the right to see doctors outside an insurance company's network.

Other hot issues include whether to give patients the right to sue insurance companies that deny needed care and whether to include about 115 million Americans whose health plans are regulated by state government.

Republicans would prefer to vote yes or no on the entire GOP package, and do the same on the Democratic bill, but Democrats say that's not good enough.

"We want to vote on each issue," said Daschle, D-S.D.

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FAX TRANSMISSION

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Pages: 13 including this cover sheet.

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From: Chris Peacock / 690-6149

Subject: CHARTER PSYCHIATRIC HOSPITAL, NASHUA, N.H.

HERE ARE (1) NEWS STORIES (NASHUA TELEGRAM,
AP IN MANCHESTER; BOSTON; PORTLAND, MAINE).
(2) LEGAL NOTICE
(3) LETTER
(4) REGIONAL ADMINISTRATOR'S STATEMENT

THE DEFICIENCY REPORT (UGLY!) IS
50 PAGES LONG. LET ME KNOW IF
YOU'D LIKE TO HAVE THAT.

Report blasts hospital

■ Brookside analysis reveals 'significant shortcomings' in safety and health at facility.

By CAMELA ZARCONI
Telegraph Staff

NASHUA - Federal and state inspectors have uncovered numerous health and safety violations in Charter Brookside Hospital's adolescent and children's units, calling into question the future of Medicare and Medicaid funding at the psychiatric facility, authorities said Friday.

Among the more disturbing findings were that children and teen-age patients were engaging in sex and that staff members were overusing physical restraints, according to the report compiled by the U.S. Health Care Financing Administration.

Overall, the federal agency cited Charter Brookside for poor supervision of patients, understaffing, inadequate staff training, failure to provide appropriate treatment and poor record-keeping.

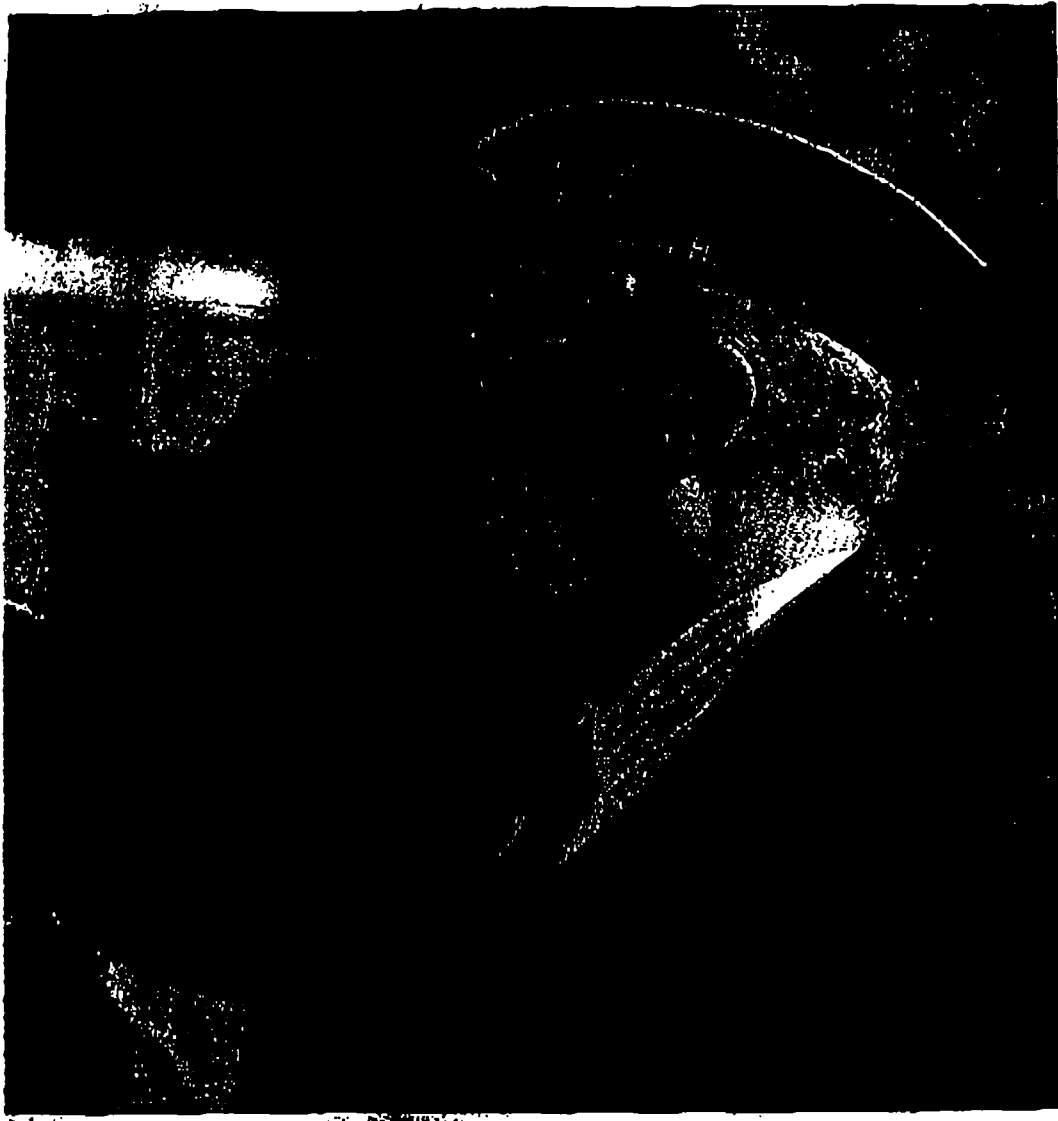
"We believe that these are serious allegations and that there were significant shortcomings," said John Wallace, associate commissioner at the state Department of Health and Human Services. "It is our position that the health and safety of the children there was in jeopardy."

The investigation focused on the hospital's three psychiatric units for children and adolescents, which as of Thursday housed 44 patients, he said. No adult units were involved.

"There are a number of questions that rise to the level of serious concern," agreed Kevin Concannon, commissioner of the Maine Department of Human Services.

Concannon's office joined in an

See BROOKSIDE, Page 15



Wmmy Nute, the first
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American Legion
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Staff photos by Peter Carvelli

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them they could con- refund," said Maroney, who heads
vince payment of the state Consumer Protection



Brookside

■ From Page 1

investigation conducted by their New Hampshire counterparts with the assistance of specialists from HCFA.

The investigation was triggered by a number of complaints made to New Hampshire authorities over the past several months, according to Wallace.

The federal agency issued a report outlining the investigators' findings to Charter Brookside this past Tuesday.

Spokesmen at HCFA and Charter Brookside declined to comment on the specific contents of that report, though Wallace and Concannon spoke in general terms about several types of problems outlined by investigators.

"A lot of the problems have to do with use of excessive restraints," Wallace said. "There were allegations of abuse of bruises."

Both he and Concannon said the report also contained allegations of

sexual encounters between patients under the age of 18.

"At the heart of all of this is inadequate staffing," Wallace charged, both in terms of the numbers of people on duty and their levels of training.

"The physical facility was not in good shape, either, in terms of cleanliness and disrepair."

George Jacobs, regional administrator for HCFA's regional office in Boston, issued a brief statement acknowledging the investigation and charging that Charter Brookside had "failed to protect the health and safety of its patients."

Because such a charge constitutes a violation of the Medicare and Medicaid provider agreement, HCFA also sent the hospital notice that its funding through these two federal health care programs will end June 9, Jacobs said.

In Wallace's experience, such a serious threat "is not a common occurrence on the part of HCFA." He said if the federal agency carries out its threat, New Hampshire authorities immediately will begin a review of Charter Brookside's state licenses.

Karen Jenkins, a Charter Brookside spokeswoman, said the hospital will work in the coming weeks to demonstrate that any alleged problems have been corrected in an effort to convince HCFA officials to reverse that decision.

"Any concerns they have outlined to us will be addressed very quickly," she said.

"At Charter, we have a zero tolerance for non-compliance."

In the meantime, Concannon said members of his staff - who got involved in the investigation based on their concerns about the well-being of 37 Maine teen-agers and children placed at the facility by Maine child welfare officials - are in the process of finding beds in other psychiatric hospitals for these patients.

"We had plans under way for placement prior to this survey," he said, based on what he characterized as a goal of housing patients closer to home. "But these findings just further confirm the urgency of developing more capacity in Maine."

The New Hampshire Division for Children, Youth and Families has

not made any so-called "state placements" of children or teens at Charter Brookside, Wallace said.

"We think we have alternatives terms of units in general hospitals and our state facility," he said, noting his office would have monitors posted at the facility until Charter Brookside and HCFA reach an agreement.

Charter Brookside was in the news earlier this month, when Nashua police announced the arrest of a 17-year-old on charges that he helped his 14-year-old roommate at the facility attempt to hang himself.

Police said the older boy lost consciousness after hanging himself from a belt he had looped over the door, but he was rushed to St. Joseph Hospital and reportedly made a full recovery.

Charter Brookside is operated by Charter Behavioral Health Systems, a national chain based in Atlanta, Ga.

□□□

Camela Zarcone can be reached by calling 594-6401 or by e-mail at zarconec@telegraph-nh.com. The Associated Press contributed to this report.

Parades, observances on tap in most towns Men

By Telegraph Staff

Here is a roundup of Memorial Day activities planned for this weekend in Greater Nashua:

■ **Nashua:** The memory of deceased veterans will be observed Monday morning with a rifle salute, a playing of "Taps" and a wreath laying at area cemeteries and monuments.

The ceremonies include an honor guard from Veterans of Foreign Wars Post 483, a color guard from area veterans organizations, and a bugler from the Post 48 Band in Hudson. The times and locations are as follows:

High School: where the units will be dismissed.

The parade's grand marshal will be Russell Mulcahy, president of the Fleet Reserve Association, Granite State Branch 338.

■ **Greenville:** American Legion Post 13 will sponsor cemetery services Monday at 10 a.m. Later, the parade will form at 1:30 p.m. at the Depot Restaurant and get under way at 2 p.m.

■ **Hollis:** The VFW and Rotary will decorate the cemeteries today beginning at 9 a.m.

On Monday, the Memorial Day observance will begin with a parade

HOLIDAY CLOSINGS

with a program organized by the Litchfield Historical Society.

The holiday activities will begin at 10 a.m. at the Old Meeting House on Charles Bancroft Highway, next to the Fire Department.

Speakers will read from letters written by residents who served in World War I and II, as well as the Vietnam War. "Taps" will be played by Gordon and Brenda Oliver, and the Litchfield Community Church Presbyterian Choir will perform accompanied by organist Sue Harmon.

A color guard from Litchfield Boy

war

id at the Pentagon say
ust get targets approved
issadors of the 19 mem-
and as yet attacks inside
not allowed.

z, Russian envoy Viktor
din on Friday made his
to Belgrade for talks
vic. Strobe Talbott, the
secretary of state, said
din was not negotiating
the alliance nor was he
mediator. Chernomyrdin
ended a halt to the
ibing, but did not re-
cily to Talbott's com-

ssian r's quits

est blow yet to Russian
in, one of his top two
ian a week after being

rs between patients (18.

Wallace charged, the numbers of people at their levels of training

facility was not in either, in terms of licensure.

regional administrator's office in a brief statement he investigation and Charter Brookside protect the health and safety of patients.

a charge constitutes the Medicare and Medicaid agreement, the hospital notice through these two care programs will be said.

experience, such as "is not a common part of HCFA." federal agency carries New Hampshire immediately will begin a Charter Brookside's state

Karen Jenkins, a Charter Brookside spokeswoman, said the hospital will work in the coming weeks to demonstrate that any alleged problems have been corrected in an effort to convince HCFA officials to reverse that decision.

"Any concerns they have outlined to us will be addressed very quickly," she said.

"At Charter, we have a zero tolerance for non-compliance."

In the meantime, Concannon said members of his staff - who got involved in the investigation based on their concerns about the well-being of 37 Maine teenagers and children placed at the facility by Maine child welfare officials - are in the process of finding beds in other psychiatric hospitals for these patients.

"We had plans under way for placement prior to this survey," he said, based on what he characterized as a goal of housing patients closer to home. "But these findings just further confirm the urgency of developing more capacity in Maine."

The New Hampshire Division for Children, Youth and Families has

not made any so-called "state placements" of children or teens at Charter Brookside, Wallace said.

"We think we have alternatives in terms of units in general hospitals and our state facility," he said, noting his office would have monitors posted at the facility until Charter Brookside and HCFA reach an agreement.

Charter Brookside was in the news earlier this month, when Nashua police announced the arrest of a 13-year-old on charges that he had helped his 14-year-old roommate at the facility attempt to hang himself.

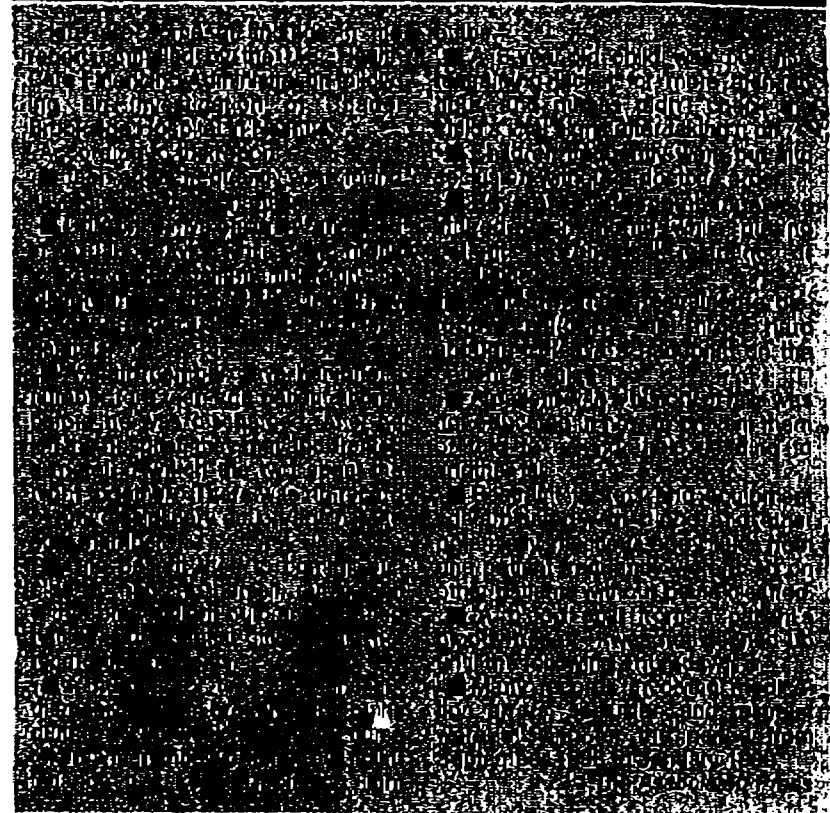
Police said the older boy lost consciousness after hanging himself from a belt he had looped over the door, but he was rushed to St. Joseph Hospital and reportedly made a full recovery.

Charter Brookside is operated by Charter Behavioral Health Systems, a national chain based in Atlanta, Ga.

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Camela Zarcone can be reached by calling 594-6401 or by e-mail at zarconec@telegraph-nh.com. The Associated Press contributed to this report.

REPORT AT A GLANCE



ances on tap in most towns Memorial Day weekend

where the units will be

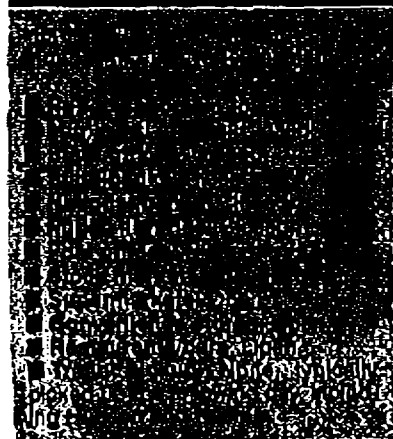
grand marshal will be the president of the Association, Granite 8.

American Legion sponsor cemetery service at 10 a.m. Later, the parade at 1:30 p.m. at the front and get under

VFW and Rotary sponsor cemeteries today at 10 a.m.

the Memorial Day parade begin with a parade. The parade will proceed to Memorial Park Common, where the

HOLIDAY CLOSINGS



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The holiday activities will begin at 10 a.m. at the Old Meeting House on Charles Bancroft Highway, next to the Fire Department.

Speakers will read from letters written by residents who served in World War I and II, as well as the Vietnam War. "Taps" will be played by Gordon and Brenda Oliver, and the Litchfield Community Church Presbyterian Choir will perform accompanied by organist Sue Harmon.

A color guard from Litchfield Boy Scout Troop 11 will participate in the observance.

A decorated bicycle and doll carriage parade also is planned.

and drum corps from Vermont.

■ Merrimack: Memorial Day activities Monday will be conducted jointly by the Merrimack Veterans of Foreign Wars Post 8641 and American Legion Post 98.

The annual parade will step off at 11 a.m. from the Rite Aid parking lot, led by the Merrimack Veterans Color Guard.

The parade will head north to Fraser Square with a pause to place a wreath at the flagpole, then proceed north to Baboosic Lake Road with another brief stop at the Civil War monument to place a wreath.

The procession then will go to the Last Rest Cemetery, where there will be brief ceremonies at the Veterans Monument. Town

Daniel Webster Highway.

■ Milford: The Allied Council will sponsor a Memorial Day parade Monday, starting at the West Street Cemetery at 9:45 a.m. It will proceed to the Elm Street Bridge, then on to the Oval, where a short program will be held.

The program includes an invocation by the Rev. Dana Miller, First Baptist Church; music from the Milford High School Band; a talk from guest speaker Robert Phibbrick, and a recitation of the Gettysburg Address.

The parade will finish at the Veterans of Foreign Wars building on Perkins Street, which is being renamed VFW Way in honor of the post's 100th anniversary.

Nashua Telegram
May 29, 1999

Report at a glance

Here are some of findings in the report compiled by the U.S. Health Care Financing Administration following an investigation of Charter Brookside Hospital in Nashua

According to the report:

- * Teen-agers frequently were found having sex with each other.
- * On April 4, five children "engaged in sexual behavior while being monitored by four staff members in the playground of the Child Unit. They exposed and touched one another's genitals."
- * A staff member gave her phone number to a teen-age patient shortly before he was discharged. After he left the hospital, they met and "rented a motel in which the two spent the night together." There was no record of any disciplinary action against the staff member.
- * One patient tried to commit suicide by hanging herself, cut herself with a broken lightbulb and scraped herself, but hospital officials did not record the incidents.
- * A number of teen-age girls cut themselves with broken lightbulbs during a two-week period. A nurse told maintenance workers, "but maintenance just keeps replacing lightbulbs."
- * A 6-year-old child was put in a restraining jacket for more than an hour, and nurses didn't check the child's vital signs after taking it off.
- * Children frequently were put into seclusion without a doctor's order.
- * Several staff members were injured each month while putting patients in physical restraints or seclusion.
- * A staff member restrained a disruptive child by the throat hard enough to leave a handprint on the patient's neck.
- * A patient with a history of falls was not educated in how to prevent them or told to ask for help, leading to another fall.
- * Restraint jackets and equipment contaminated with blood and other potentially infectious body fluids from one patient frequently were used on other patients without being cleaned.
- * "A blood spill from a patient's bloody nose ... was not cleaned up until the following Thursday."
- * Many records involving medication errors, seclusion and restraint were missing for the period from September 1998 to January 1999.

-- The Associated Press

SECTION B, P. 5
(LOCAL)
METRO

THE BOSTON GLOBE • SATURDAY, MAY 29, 1999

N.H. hospital may lose licensing, funding

ASSOCIATED PRESS

CONCORD, N.H. — A Nashua psychiatric hospital is about to lose its federal Medicaid and Medicare funding after inspectors found that children and teenage patients were having sex and staffers were overusing physical restraints on children and adolescents.

The federal Health Care Financing Administration cited Charter Brookside for poor supervision of patients, under-staffing, lack of staff

training, failure to provide appropriate treatment and poor record-keeping.

The conditions found during a surprise inspection May 20 were so disturbing that the state and HCFA have sent staff every day to monitor the hospital's child and adolescent units.

"Our concern is the kids who are in there, and their safety and well-being is paramount," John Wallace, associate commissioner of the state Department of Health and Human

Services, said yesterday.

Charter Behavioral Health Systems, a national chain based in Atlanta that operates the hospital, said in a statement it still was evaluating the inspection report and would issue a plan of correction.

HCFA has notified the hospital its Medicare and Medicaid funding will be cut off for new patients on June 9 unless it corrects the problems, a spokesman for the agency said.

The hospital will continue getting

federal funding for its current patients for another 30 days; meanwhile, the state will decide whether to revoke its operating license, Wallace said.

The hospital, which is licensed for 108 beds, mostly serves children with severe emotional and mental problems, although it currently is treating 28 adults for psychiatric and addiction problems.

As of Thursday, there were 13 children and 31 teenagers at Charter Brookside, mostly from Maine.

JUN-01-1999
14:45
BOSTON

HCFA PRESS OFFICE
JUN 01 1999

202 690 7159
P.06/13

Feds find abuses at psychiatric hospital

● Most of the children and teens in the N.H. facility are from Maine.

The Associated Press

CONCORD, N.H. — A Nashua psychiatric hospital that serves 36 youths from Maine is about to lose its federal Medicaid and Medicare funding after inspectors found that children and teen-age patients were having sex and staffers were overusing physical restraints on children and adolescents.

As of Thursday, there were 13 children and 31 teen-agers at Charter Brookside, mostly from Maine. Maine authorities said they already have started finding new placements for its 36 clients.

The federal Health Care Financing Administration cited Charter Brookside for poor supervision of patients, understaffing, lack of staff training, failure to provide appropriate treatment and poor record-keeping.

The conditions found during a surprise inspection May 20 were so disturbing the state and HCFA have sent staff every day to monitor the hospital's child and adolescent units.

"Our concern is the kids who are in there, and their safety and well-being is paramount," John Wallace, associate commissioner of the state Department of Health and Human Services, said Friday.

Charter Behavioral Health Systems, a national chain based in Atlanta that operates the hospital, said in a statement it still was evaluating the inspection report and would issue a plan of correction.

"We have a zero tolerance for non-compliance with established policies and procedures, and Charter would like to make it absolutely clear to our employees and to the communities we serve that we expect compliance to established industry and company standards or we will take swift and immediate action," the statement said.

HCFA has notified the hospital its Medicare and Medicaid funding will be cut off for new patients on June 9 unless it corrects the problems, a spokesman for the agency said.

The hospital will continue getting federal funding for its current patients for another 30 days; meanwhile, the state will decide whether to revoke its operating license, Wallace said.

The hospital, licensed for 108 beds, mostly serves children with severe emotional and mental problems, although it currently is treating 28 adults as well.

Portland Press Herald

Saturday, May 29, 1999

Pg. 2B

The Union Leader

Saturday,

May 29, 1999

pg. B14

The Union Leader, Manchester, N.H.

Charter Brookside cited for restraints, teen sex

CONCORD (AP) — A Nashua psychiatric hospital is about to lose its federal Medicaid and Medicare funding after inspectors found that children and teenage patients were having sex and staffers were overusing physical restraints on children and adolescents.

The federal Health Care Financing Administration cited Charter Brookside for poor supervision of patients, understaffing, lack of staff training, failure to provide appropriate treatment and poor record-keeping.

The conditions found during a surprise inspection May 20 were so disturbing the state and HCFA have sent staff every day to monitor the hospital's child and adolescent units.

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According to the report, teens frequently were found having sex with each other.

HCFA has notified the hospital its Medicare and Medicaid funding will be cut off for new patients on June 9 unless it corrects the problems, a spokesman for the agency said.

Charter Behavioral Health Systems, a national chain based in Atlanta that operates the hospital, said in a statement it still was evaluating the inspection report and would issue a plan of correction.

S / NOTICES

Saturday, May 29, 1999 D7

Legal Notice

Public Notice
Charter Behavioral Health System
 of Brookside/New England
 29 Northwest Blvd.
 Nashua, New Hampshire 03063

"Notice is hereby given that the provider agreement between Charter Behavioral Health System of Brookside/New England, 29 Northwest Blvd., Nashua, New Hampshire 03063, and the Secretary of the Department of Health and Human Services, as a provider of psychiatric hospital services under the Health Insurance for the Aged and Disabled Program (Medicare) will be terminated effective June 9, 1999.

The Health care Financing Administration has determined that Charter Behavioral Health Systems has failed to maintain compliance with Medicare requirements.

No payment for services rendered by Charter Behavioral Health Systems may be made under the Medicare program, except for inpatient hospital stays rendered to Medicare beneficiaries who were admitted to Charter Behavioral Health Systems on or before this date of June 9, 1999. Payment is specifically limited to services furnished through the close of July 9, 1999. No payment will be made for such services rendered after July 9, 1999.

Ronald Preston
 Associate Regional Administrator
 Medicaid and State Operations
 (UL - May 28)

Legal Notice

ENVIRONMENTAL ASSESSMENT

Project Identification
 Project Name: Sullivan County, NH
 Address: Chairman, County Commissioners, Sullivan County
 Project: Sewer System extension, Sullivan County
 SKF Project Number: CS-330159-02

Legal Notice

NOTICE OF MORTGAGEE'S FORECLOSURE SALE

By virtue of the power of sale contained in a certain Mortgage given by Martin M. Sandler ("Mortgagor") to Pioneer Financial Bank dated July 18, 1988 and recorded in the Hillsborough County Registry of Deeds at Book 2579, Page 0775 (the "Mortgage"), Federal Home Loan Mortgage Corporation, being the present holder of the Mortgage ("Mortgagee"), pursuant to and in execution of said power of sale and for breach of the conditions of the Mortgage, and for purpose of foreclosing the same, will sell at PUBLIC AUCTION on Tuesday, June 15, 1999 at 10:00 AM the premises located at 18 Kearns Drive, Unit 208, Woodbury II Condominium, Merrimack, Hillsborough County, New Hampshire, being the premises described in the Mortgage, to which reference is made for a more particular description thereof (the "Mortgaged Premises"). Said public auction will occur on the Mortgaged Premises.

A copy of the Mortgage may be examined by any interested person and any inquiries regarding the foreclosure sale may be made of the undersigned at Shapiro & Morley, LLP, 4 Bedford Farms, Kilton Road, Bedford, New Hampshire during regular business hours.

NOTICE TO THE MORTGAGOR AND ALL INTERESTED PARTIES: YOU ARE HEREBY NOTIFIED THAT YOU HAVE A RIGHT TO PETITION THE SUPERIOR COURT FOR THE COUNTY IN WHICH THE MORTGAGED PREMISES ARE SITUATED, WITH SERVICE UPON THE MORTGAGEE, AND UPON SUCH BOND AS THE COURT MAY REQUIRE, TO ENJOIN THE SCHEDULED FORECLOSURE SALE.

LIENS AND ENCUMBRANCES: The Mortgaged Premises shall be sold subject to any and all easements, unpaid taxes, liens, encumbrances and rights, title and interests of third persons of any and every nature whatsoever which are or may be entitled to precedence over the Mortgage.

Legal Notice

ADVERTISEMENT FOR BIDS
 Town of Greenville (Owner)
 Town Office - Main Street
 Greenville, NH 03048

Separate sealed BIDS for the construction of the Water Treatment Plant Improvements and Upgrades. The Work is located in Temple, New Hampshire. Work will include the carefully sequenced addition of four flocculation basins, a sedimentation basin, two (2) automatic backwashing dual media filters, chlorine contact tank and generator. Existing units will be replaced and/or renovated. Work includes upgrade to the chemical systems, lab, rapid mixer, clarwell, raw and finished water pumps and raw water intake, instrumentation, the electrical system, heating and ventilation system and other ancillary systems as shown of the drawings and described in the specifications necessary for a complete water treatment plant.

Each bid shall be accompanied by a five (5%) Bid Bond. The project will be funded in part by Rural Development and the NHDES State Revolving Fund Program. Contract completion shall be within 300 days of the Notice to Proceed. Bidders will be required to comply with the President's Executive Order No. 11246 entitled "Equal Employment Opportunity as amended by Executive Order 11375 and amendments or supplements to that Executive Order and as supplemented in Department of Labor Regulations (41 CFR Part 80). Bidders on this work must demonstrate compliance with the United States Environmental Protection Agency's Minority and Women's Business Enterprises (MBE's and WBE's) policy in order to be deemed a responsible bidder. Additional information can be found in the Contract Documents.

A Pre-bid meeting will be held on June 16, 1999 at 9:00 A.M. at the Water Treatment Plant located in Temple, New Hampshire (non-mandatory).

Bids will be received by the Town of Greenville at the Town Office, Main Street, Greenville, NH 03048 until 3:00 P.M., local

The Union Leader

Saturday,
May 29, 1999

Pg. D7



DEPARTMENT OF HEALTH & HUMAN SERVICES

HEALTH CARE FINANCING
ADMINISTRATION

Division of Medicaid and State Operations
Region 1
J.F.K. Federal Building
Government Center
Boston, MA 02203

May 25, 1999

Terry Cartwright, Acting CEO
Charter Behavioral Health Systems
29 Northwest Blvd.
Nashua, New Hampshire 03063

Dear Mr. Cartwright:

Institutions accredited as hospitals by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are deemed to meet all of the Medicare Conditions of Participation for hospitals, with the exception of utilization review and the special staffing and medical record requirements for psychiatric hospitals. Section 1864 of the Social Security Act authorizes the Secretary of Health and Human Services to conduct surveys of accredited hospitals participating in the Medicare program as a means of validating reliance on the accreditation process.

When a hospital, regardless of its JCAHO accreditation status, is found to be out of compliance with the special staffing or medical record requirements for psychiatric hospitals, a determination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case of Charter Behavioral Health System and accordingly, the Medicare provider agreement between Charter Behavioral Health System and the Secretary of the Department of Health and Human Services is being terminated on June 9, 1999.

A survey conducted at Charter Behavioral Health Systems on May 19 - 21, 1999, found that the hospital was not in compliance with the Medicare health and safety requirements for Special Medical Records (42 CFR 482.61) and Special Staff (42 CFR 482.62) for psychiatric hospitals, **and the findings constitute a serious and immediate threat to the health and safety of people receiving services at this facility.**

Since these deficiencies have been determined to be of such a serious nature as to substantially limit the hospital's capacity to provide adequate care, the Health Care Financing Administration will deny payment for any admissions effective June 9, 1999. In addition, onsite monitoring will be provided by the New Hampshire Bureau of Health Facilities and the Health Care Financing Administration.

The date on which the provider agreement terminates is **June 9, 1999**. The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after June 9, 1999. For patients admitted prior to June 9, 1999, payment may continue to be made for a maximum of 30 days of inpatient hospital services furnished on or after June 9, 1999. You should submit, as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your hospital as of June 9, 1999, to the Boston Regional Office of the Health Care Financing Administration to facilitate payment for these individuals.

We will publish a public notice in the Manchester Union Leader and the Portland Herald Free Press prior to the date of termination.

Termination can only be averted by the removal of the deficiencies which constituted the immediate threat, prior to June 9, 1999; specifically identified under the following regulations;

- 42 CFR 482.61 (c)(2)
- 42 CFR 482.62
- 42 CFR 482.62 (a)(3)
- 42 CFR 482.62 (d) (1) and (2)

A listing of all deficiencies is enclosed. Your credible allegation of compliance (written on the enclosed Statement of Deficiency and Plan of Correction, HCFA 2567) should address the systemic problems resulting in the immediate threat determination, and should be returned to us as soon as possible.

After termination, if you wish to be readmitted to the program, you must demonstrate to the New Hampshire Bureau of Health Facilities Administration, Division of Public Health Services and HCFA that you are able to maintain compliance.

If you do not believe this termination decision is correct, you may request a hearing before an Administrative Law Judge (ALJ) as outlined in title 42 of the Code of Federal Regulations, Part 498.

To be effective, a written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to:

Ronald Preston
Associate Regional Administrator
Division of Medicaid and State Operations
Health Care Financing Administration
JFK Federal Building, Room 2275
Boston, Massachusetts 02203

Cartwright - Page 3

At your option, you may instead submit a hearing request directly (accompanied by a copy of this letter) to:

Departmental Appeals Board
Civil Remedies Division
Room 637-D
HHS Building
200 Independence Avenue, S.W.
Washington, D.C.

Please send a copy of your request to this office also.

The request for a hearing must satisfy the requirements stated in 42 CFR 498.40, and should be accompanied by any evidence and arguments you may wish to bring to the attention of the Department of Health and Human Services. Evidence and arguments may be presented at the hearing, and you may be represented by counsel.

Sincerely yours,

Ronald Preston
Associate Regional Administrator

Enclosures

cc: New Hampshire State Agency
Maine Medicaid Agency
Massachusetts Medicaid Agency
JCAHO

**STATEMENT BY GEORGE JACOBS
Regional Administrator, Boston Region
Health Care Financing Administration
May 26, 1999**

When patients are admitted to hospitals for psychiatric care, they and their families expect and deserve to receive quality care in a safe environment.

Based on a survey conducted by the state on May 21, 1999, the Health Care Financing Administration (HCFA) determined that Charter Behavioral Health System of Brookside, Nashua, New Hampshire, failed to protect the health and safety of its patients. Since this is a violation of the Medicare and Medicaid provider agreement, on May 25, 1999, HCFA sent the hospital notice that they will be terminating their Medicare and Medicaid funding as of June 9, 1999.

HCFA and state health officials from New Hampshire and Maine are on site to monitor conditions at the hospital.

HCFA and the states will continue to take appropriate steps as needed to ensure that patients receive the quality care that they deserve and that their families demand.

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