California Alliance members letter to Congressional Representatives on the House Ways and Means Committee:

I am writing in support of an amendment to the *Family First Prevention Services Act* scheduled to be marked up by the Ways and Means Committee on Wednesday, June 15, 2016.

Our agency is supportive of all parts of the bill with one exception: as currently written, the bill would require all Qualified Residential Treatment Programs (QRTP)to have on-site clinical and nursing staff during all business hours, and on-call 24/7.

We support the following amendment to page 63 lines 17-18:

"(A) has a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the assessment of the child required under section 475A(c);

"(B) has registered or licensed nursing staff and other licensed clinical staff who—

"(i) provide care within the scope of their practice as defined by State law;

"(ii) are on-site according to the treatment model referenced in section (4) (A) ~~during business hours~~; and

"(iii) are available 24 hours a day and 7 days a week;

The problematic part of the bill is its requirement for clinical and nursing staff on-site during all business hours. There are at least two built-in assumptions to this requirement: first, that the treatment being provided is medical in nature, otherwise there is no need for on-site nursing staff; second, that youth are on-site during business hours, otherwise why have clinical and nursing staff there.

But, many youth are placed in residential programs that do not have medically based needs. Their needs are largely behavioral, and while those youth have trauma-informed behavioral treatment needs, they do not have needs that would require the presence of a nurse. Requiring a nurse to be on-site during business hours would be a waste of scarce nursing staff and artificially and unnecessarily inflate costs, wasting federal and state dollars.

California's Residentially-Based Services (RBS) Reform initiative, which has involved Los Angeles, Mendocino, Sacramento, San Bernardino, and San Francisco Counties has reduced lengths of stay and improved outcomes for youth by having staff transition with youth out of residential care to their families and communities. While some clinicians are on-site some of the time, they are also in the community some of the time; and while they work during business hours, they also work evenings, weekends and holidays to be with youth and families at times that are convenient to them. Requiring a licensed clinician on-site during business hours severely limits the flexibility needed to provide necessary services to youth transitioning back to their families and communities.

Some California agencies, moreover, are experimenting with "individualized residential treatment programs" in which only one or two youth are served in a residential facility. Their behavioral needs are such that the risk is too great to place them in a family-based setting, or no family-based setting will accept them, even with 24-hour support, and placing them with 5 or more other youth with similar challenges could be extremely counterproductive. This bill would require both a nurse and a licensed clinician on-site during business hours even for those individualized residential treatment programs serving just one or two children, and even when those one or two youth may not actually be on-site themselves. It is economically unfeasible and would squelch this type of innovation.

Finally, many parts of California are as you know quite rural, residential programs are small, and qualified nursing and clinical staff are few and far between. These requirements would virtually preclude QRTPs in such communities, driving youth into care in larger more institutional settings far from their homes and communities, and creating challenges to the type of follow-along care envisioned in the bill.

The nursing requirement in the bill makes sense if the residential program serves youth with conditions that are primarily medically based and require a nurse to coordinate care, but many do not. The clinical staff requirement flies in the face of what we've learned over 25 years: we want clinical staff not just on-site but in the community, and we don't want them working just business hours.

We therefore request your support for the proposed amendment that would make QRTPs adopt clinical and nursing staff schedules that support the trauma informed treatment model of the QRTP.