3417

November 27, 2024
Re: Proposed 5330 Psychiatric Residential Treatment Facility (PRTF) regulations as developed by the Office of Mental Health & Substance Abuse Services (OMHSAS)

Dear Commission,

The Rehabilitation and Community Providers Association (RCPA) is a statewide association representing nearly 400 providers of health and human services across the Commonwealth, and our member organizations serve well over 1 million Pennsylvanians annually. RCPA is among the largest and most diverse state health and human services trade associations in the nation. RCPA members offer mental health, substance use disorder, intellectual and developmental disabilities, children's, brain injury, criminal and juvenile justice, medical and pediatric rehabilitation, and physical disabilities and aging services, across all settings and levels of care.

On behalf of RCPA and our members, please accept these comments and recommendations on the proposed Regulation #14-555: Psychiatric Residential Treatment Facilities Chapters §1330 and §5330 regarding the payment of the psychiatric residential treatment facilities and the minimum licensing requirements.

RCPA applauds OMHSAS's efforts to ensure that children, adolescents, and young adults receive excellent behavioral health treatment. With that, these public comments outline the concerns that the promulgated regulations would have serious negative effects on the children and families they serve. These proposed regulations have been reviewed by members of RCPA's Children's Residential Services Committee, who are some of the most experienced and knowledgeable leaders and organizations in the Commonwealth's child welfare system. RCPA's regulation by regulation comments and recommendations that follow this introduction will outline these various issues as well as potential pathways.

First, and perhaps the most critical of these areas is related to staffing. The proposed model represents a workforce structure that the PRTF providers have not been able to meet for more than a decade. The national shortage of psychiatrists, mental health professionals, and nurses, coupled with inadequate Pennsylvania MA funding models show that, even if these staff were available, PRTFs are not adequately funded to hire them. In fact, access to psychiatrists alone has forced OMHSAS to waive these staffing requirements across multiple licensed programs, to the point that waivers have become the operational rule, rather than the exception.

This confluence of inadequate rate structures, multiple layers of regulatory and payer administrative burden, and the challenges of working with the most behaviorally complex youth in the system has driven the staff from these programs and the Medicaid space. The lack of staff has created such a chasm to access that the governor's office and DHS have embarked on a multiyear blueprint project to redesign this very system of care for youth with complex needs.

These proposed staffing requirements will make it virtually impossible to be in compliance with several sections of the proposed regulations, including:

- Delivery of treatment services;
- Delivery of medical care and services;
- Supervision of youth and staff;
- Transportation; and
- Restrictive procedure.

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In an effort to ensure this regulatory staffing model has the most qualified personnel, the standards have raised the requirements of work experience at entry level positions as well as for nursing staff. The proposed regulations fail in growing a much needed workforce, with requirements that limit potential workers from entering the field. Overall the staffing design of these proposed regulations seem counterintuitive with the known systems access barriers. The promulgation of these rules does not address the workforce barriers in delivering this level of care to our most vulnerable children and youth.

From a treatment perspective, these proposed regulations would require a significant increase in the amount of psychiatric and clinical time that the programs would need to deliver.

The clinical requirements, as outlined, may represent OMHSAS's preferred clinical approach, but the department has not met the burden of the commission's inquiry regarding the impact on the youth these regulations would serve. There is no validation, evidence-based, or best practice reference as to why these proposed treatment standards are in the best interest of the child. Simply, a one size fits all clinical approach to intensity, duration, and frequency of treatment sits juxtaposed to commonly accepted best practice standards, and in opposition to the CASSP standards for individualized treatment that OMHSAS has steadfastly considered a foundational principle to their mission.

Additionally, as we review the types of programs under the current licensing umbrella of OMHSAS and OCYF, we hope the state considers that there are facilities that serve a different population of individuals with physical and intellectual disabilities. To address these specialized needs, the current one size fits all treatment regulations may not be appropriate for their needs, and in some cases may impact treatment success. Without the flexibility to waiver these programs, the result will be a reduction in bed capacity, thus creating another gap in the residential care continuum.

So a daily schedule would have a youth go from a full day of school on to multiple therapeutic interventions with very little time for prosocial skill development, off-campus activities, sports, clubs, or downtime. Our members feel this does not represent a normalized experience, yet one of institutional programming. While all systems' stakeholders strive to have a youth return to their home as soon as possible, we ask the department to reconsider this modality and allow the onsite clinicians to determine the best course of treatment. The process of learning and behavioral change cannot be forced or rushed.

We appreciate the department's fiscal overview and understand the difficulty in estimating costs, especially during a time of uncertainly in the budgeting for Pennsylvania Medicaid. RCPA recommends that a different approach be considered in determining the funding for this regulatory implementation. The costs as outlined by the department do not capture the critical variables in the funding equation. The first being the actual cost of care for which, as outlined in the Chapter 1330 payment conditions, a provider cost analysis would occur three months after promulgation. In this case, if the actual costs of care exceed the projected costs, what is the provider's alternative? A rate request at a later date? Historically, rate increases in residential care have yielded very little positive movement towards meeting the cost of delivering these services.

Another area of concern is the department's calculation on the staffing costs, as providers unilaterally agree that these salaries do not reflect current market trends, regardless of what regionalized analysis formulary was utilized. These calculations also do not take into account the individualized staffing patterns of a facility based upon organizational and programmatic structures. Where one facility may be able to employ 1 full-time psychiatrist at $289,000 to meet regulatory and operational needs, another may need 1.5 or 2 full-time psychiatrists.

Lastly, the proposed regulations outline several non-allowable costs that include many of the child's basic rights as outlined in Chapter 5330.31-34. Basic needs like haircuts, clothing, or funds to support parental visits and engagement are all considered non allowable; essentially unfunded mandates. In a time where DHS has committed its focus and resources to addressing the Social Determinants of Health (SDoH) this seems counter to the overarching mission of the department.

We again offer our thanks for the opportunity to provide these comments and recommendations on behalf of our members and those they serve. We understand how difficult this process is and the great lengths the department has gone to in order to develop, promulgate, and implement regulations. Despite these concerns, we are confident that OMHSAS, under the direction of Deputy Secretary Jen Smith, represents a renewed spirit of collaboration and partnership. Unfortunately, the last provider consultation on these proposed regulations occurred in June 2020, and the final draft includes several rules that PRTFs were not afforded the opportunity to review or comment on. We hope that during this process the provider system, stakeholders, and families can come back to the table to develop standards that reflect the needs and current climate impacted by workforce and funding challenges.

We believe what we offer in the following review reflects the general consensus among providers, associations, families, and stakeholders. The urgency is not the promulgation timeline, but ensuring that what we are building can be fairly and equitably implemented, so we may achieve the desired outcomes we all seek for our youth.

Sincerely,

Jim Sharp
RCPA COO and Director of Mental Health, BH Division

ANNEX A

TITLE 55. HUMAN SERVICES

PART III. Medical Assistance Manual

Chapter 1330. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

GENERAL PROVISIONS

§ 1330.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly demonstrates a different meaning:

*PRTF - psychiatric residential treatment facilit*y - A residential facility that provides services to treat the behavioral health needs of children, youth or young adults under the direction of a psychiatrist.

Comments
Is this determined by license or by program? What if multiple distinct programs are co-located at one site and each is licensed independently?

Can the nursing and supervisory responsibilities be shared between licensed programs co-located at one site although under separate license? Some agencies offer specialized programs that are distinct by service description/license, but that are co-located within one main facility as separate units. Requiring these roles per licensed unit will be financially and operationally prohibitive to providers.

Recommendation
Ensure that the regulations support the allocation of the medical director, clinical director, social work supervisor, program director, and director of nursing within one organization.

Allow for onsite nursing coverage (overnight) per building and not per licensed program.

Visit – When a child, youth or young adult is under the approved temporary supervision of an individual at the individual's residence or in the community and not under the supervision of PRTF staff.

Comment

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Visit – please clarify if this includes on-site visits or on premises

SCOPE OF BENEFITS

§ 1330.11. Scope of benefits.

Children, youth and young adults who are MA recipients with a behavioral health diagnosis may receive medically necessary services in a PRTF.

Comments
Does not include individuals who are private insurance or county funded only. How would this affect audits/licensure?

Recommendations
Clarify whether these regulations will be applied for all payer groups.

PROVIDER PARTICIPATION

§ 1330.21. Participation requirements for a PRTF.

To participate in the MA Program, a PRTF shall:

(1) Comply with the special provisions applying to psychiatric hospitals set forth in 42 CFR 482.60 (relating to special provisions applying to psychiatric hospitals).

Comment
42 CFR 482.62(d) – Nursing services – Each agency will be required to designate a Director of Nursing, which will add additional cost. Is there a minimum nurse: patient ratio? (We'd been previously advised this is 1:12; however, that is not identified in these proposed regulations)

Recommendations
Clarify whether a director of nursing is required within the staffing complement.
Clarify whether there is a recommended nurse to patient ratio.

Comment
42 CFR 482.62 (f) Social Services – The director of the social work department or services must have a master's degree from an accredited school of social work or must be qualified by education and experience in the social services need of the mentally ill. If the director does not hold a master's degree

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in social work, at least one staff member must have this qualification. This additional requirement is not articulated in the required staffing information. Agencies will need to recruit a social work director or at least one staff who is an MSW.

Recommendation
Unless required by CMS, remove this portion of the regulation so that the staff qualifications align with the Clinical Director or Mental Health Professional qualifications.

PAYMENT

§ 1330.31. General payment.

(b) The MA Program will pay for medically necessary services provided to a child, youth, or young adult who is an MA recipient by a residential treatment facility licensed under Chapter 3800 and certified by the Department as of [*effective date of final-form rulemaking*] for 12 months after [*effective date of this final-form rulemaking*].

Comment
This proposed rule starts the countdown to an inevitable licensing crisis among providers. Requiring PRTFS to acquire extra psychiatric, clinical, and nursing hours against the setting of a well-documented national shortage of these providers while providing no realistic assurance of adequate remuneration is confrontational and endangering to behavioral health providers.

12 months to comply is a short period given the extensive recruitment activity that will need to occur to fill key positions, particularly psychiatry and mid-levels.

Many of these professional positions have 120- to 180-day contract exit obligations at current employers.

Additionally, these positions will need to be credentialed internally by organizations, and perhaps will need state licensure. Providers may also need to be enrolled/credentialed with PROMISe, and other private insurers, which can take an extensive period of time. Finally, given the increase in psychiatric workforce needed and the expanded responsibilities for supervision and treatment planning and the current psychiatric workforce shortage, it may be necessary to recruit psychiatrists from out of the US. This would involve an extensive and costly Visa process, which can take many months.

Recommendation
RCPA and its members fail to appreciate the urgency to promulgate and enforce these regulations without OMSHAS consulting with PRTFs and the Behavioral Health Managed Care Organizations to ensure the financial viability of the model. The agency requests that the IRRC call for this collaboration to occur

before considering promulgating these regulations.

(c) If a PRTF is rendering services to a young adult before the young adult turns 21 years of age, the Department will continue to pay for services if they are medically necessary and the young adult is under 22 years of age.

Comment

Continuing to provide this service beyond the age of 20.99 will force PRTFs to develop policies that acknowledge the rights of that adult, potentially including choices to use tobacco, purchase firearms, use alcohol, etc. How would agencies be trained/advised to handle these types of situations? What would be the ramifications for refusal? Would involuntary commitment protocols be needed for these adults who disagree with continued treatment but systems, families, stakeholders believe they should remain? Would a 304 process be necessary?

Recommendations

Provide clarification in this area.

Provide guidance to providers if there is a requirement to consider to serve adults age 21+.

Establish workflow for involuntary commitment of these individuals, and provide training to PRTF providers to ensure compliance with the MHPA.

§ 1330.32. Conditions for payment.

(a) MA will pay a PRTF if the following conditions are met:

(1) A psychiatric evaluation of the child, youth, or young adult that is a result of a comprehensive in-person diagnostic examination which has been completed.

Comment

Are there restrictions on who can complete and sign off on a psychiatric evaluation?

(3) The independent team is independent of the psychiatrist who completed the psychiatric evaluation and the PRTF that is being recommended.

Comments

The independent team is independent from the psychiatrist who completed the psychiatric evaluation and the PRTF that is recommended – With the additional psychiatric needs that will be required, it will potentially be more difficult to obtain an independent evaluation. Many psychiatrists in rural areas serve

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dual roles. Areas that have PRTF programs often share resources with outpatient practices or other providers. This regulation already inhibits ease of access to local PRTF programs for youth who reside in the areas in which PRTFs operate.

How will the state assist in creating a system to ensure that these youths are eligible for it?

PRTF treatment in their home communities will be a challenge as this barrier will only increase, as the systems will need to recruit additional psychiatrists to meet the required supervision, oversite, and clinical involvement.

Please define who is on the independent review team (this should also be included with the definition section) and how this team will be accessed by families and treatment providers. Is this the BH-MCO team? At the OMHSAS Level or MA level, what team would this be?

(4) The independent team certifies the following:

(b) The child's, youth's, or young adult's treatment team leader shall review the need for continued PRTF level of care every 30 days and certify that the child, youth, or young adult continues to meet the requirements in subsection (a)(4).

Comment

Treatment team leader reviews the need for treatment every 30 days to certify need – Will this affect the reauthorization process in any way moving forward?

Recommendation

Clear guidance to MCOs MA FFS will need to be provided as to whether this regulation will require payers to reauthorize services each 30 days, or if authorizations can continue for longer periods of time. To avoid unnecessary administrative burden on providers, it is recommended that payers be advised that the current authorization time frames will remain the same.

§ 1330.33. Limitations on payment.

(a) MA will pay for hospital-reserved bed days for a PRTF that is currently participating in MA as follows:

(1) Payment will only be made to a PRTF to reserve a bed when a child, youth, or young adult is hospitalized; if the child, youth, or young adult is admitted to a licensed hospital or hospital unit accredited as a hospital; the hospitalization

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occurs during the child's, youth's, or young adult's PRTF stay; and the child, youth, or young adult is expected to return to the PRTF upon discharge from the hospital.

(2) Payment for hospital-reserved bed days is limited to 15 cumulative days per calendar year, for each child, youth, or young adult, regardless of whether the child, youth, or young adult was in continuous or intermittent treatment at one or more PRTFs during the calendar year.

Comment

It was hoped that these regulations would remove/change the 15 cumulative day cap on payment for hospital bed days. Oftentimes youth who are referred to PRTF, particularly specialty PRTF, are referred from current inpatient hospitalization. Many of these hard to place youth have well exceeded this cap. When a high risk youth is admitted to a new PRTF, it may at times be necessary to utilize inpatient hospitalization to facilitate major medication changes, stabilization, etc., particularly when the youth has failed to adjust in multiple placements. This regulation penalizes providers who are willing to admit challenging youth whose clinical needs may require temporary return to secure hospital facilities. Hospital facilities can use PRN medication, or chemical and mechanical restraint to monitor excessively high risk behavior that is outside the scope of PRTF.

Recommendations

It is recommended that hospital bed days be reloaded at each new admission to PRTF for those youth who are identified as complex. Additionally, is recommended that the complex case review teams develop a system for collaboration between hospitals and providers that allow for ease of admission/readmission to a designated in patient facility if the need arises.

(3) Payment for hospital-reserved bed days begins on the date of a child's, youth's, or young adult's admission to the hospital and will be paid at the rate of 1/3 of the PRTF's approved per diem payment rate.

(b) MA will pay for up to two days of elopement from a PRTF per calendar year for each child, youth, or young adult.

Comment

If the provider only has to hold the placement for two days, does this mean that the provider then has the right to discharge the client immediately? Please also define elopement in more detail.

(c) MA will pay for a day of care if the child's, youth's, or young adult's bed is reserved while the child, youth, or young adult is on a visit.

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Comment

Please define the day in more detail. Is this the overnight rule? Please also use terms such as "therapeutic leave" or define visit to include this term.

(d) MA will not pay a PRTF for the following:

(1) A day of care during which a child, youth, or young adult was absent from the PRTF for one of the following reasons:

(i) Elopement, unless the absence meets the criteria in subsection (b).

(ii) Leaving the PRTF against medical advice.

(iii) Hospitalization, unless the hospitalization meets the criteria in subsection (a).

(iv) Visits, unless the visit meets the criteria in subsection (c).

(2) Admissions and days of care that do not meet the requirements of this chapter.

Comment

CMS regulations already limit days.

Recommendation

Please replace with language that refers to the CMS regulations.

§ 1330.34. Allowable costs.

The Department uses Medicare principles as established by the Social Security Act (42 U.S.C.A.)

§§ 301—1397mm) and Federal regulations and instructions as a basis for determining what cost items are allowable for the purposes of MA reimbursement.

Comment

Please provide reference to the specific chapter that is referenced.

Recommendation

DHS should consider requesting amendment or waiver to the State Plan to accommodate those necessary costs that are considered by state regulation as non-allowable.

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§ 1330.37. Related-party transactions.

(a) A PRTF shall include in its allowable costs, services and supplies furnished to the PRTF by a related party at an amount equal to the cost of such services and supplies to the related party.

Comment

If an agency is affiliated under a management services organization (509(a)(3), do these expenses need to be identified individually by function provided? It is not uncommon that such an organization would charge an administrative fee rather than invoice directly for the service provided. Direct expense will be challenging as it is not uncommon to have multiple individuals within the MSO completing similar functions across affiliates.

Recommendation

It is recommended that DHS consider allowing providers to report by one of two means, either by direct expense or through management fees. If through management fee, this threshold should be 20%.

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§ 1330.38. Nonallowable costs.

(a) The following costs are excluded from the operating costs described in § 1330.34 (relating to allowable costs) and are not included in a PRTF's per diem rate:

(2) Administrative costs of more than 13% of allowable MA costs.

Comment

Need clarification on what is considered in this. Agencies that use any type of management services organization/related parties through an affiliation may reflect these administrative costs in this line item rather than in individual line items, due to the nature of the affiliation. Typically, these admin costs reflect HR, IT, Compliance, Medical Records, Fiscal, Billing, DON, Marketing, Communications, and Recruitment. Additionally, agencies will also have local administration (which would include medical director, clinical director, executive director, insurance, etc.)

Recommendation

The 13% threshold should increase to account for management services organizations (related party). Recommendation for threshold of 15%.

(5) Education costs associated with a child's, youth's, or young adult's individual educational plan, individual family service plan, or treatment plan which are to be paid for by the child's, youth's, or young adult's school district.

Comment

How does OMHSAS intend to collaborate with districts to ensure that this regulation is met? Youth enrolled in regular education may not be funded for some education services that may be required due to their mental health disability. It is not uncommon that youth are not identified as disabled through the Child Find process, despite having a behavioral health diagnosis. Districts who cannot accommodate students within the public school setting will establish programs on site at PRTF locations. Support from staff provided is not necessarily billed to the home school district for cases in which the student is identified as regular education. Will districts be required to reimburse PRTFs when homebound or onsite instruction requires support from PRTF staff? Will there be an updated BEC to follow?

Recommendation

Further collaboration and joint clarification from PDE and DHS is needed. PRTFs should not be expected to provide supervision during onsite education without reimbursement.

(5) Costs for a service if payment is available from another public agency, insurance, or

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health program or any other source.

Comment

Separating program expenses by clients who are MA versus those covered by other payers creates an administrative burden.

(7) Costs associated with the following:

(i) Advertising, excluding employment opportunities.

(ii) Charitable contributions.

(iii) Staff recognition, such as gifts, awards, or dinners.

(iv) Staff social functions, such as picnics or athletic teams.

Comment

(7) (iii), (iv)

Employee reward and retention strategies such as gift cards, recognition breakfasts, T-shirts, bonuses, the employee picnic, sports teams, and referral awards would no longer be allowable in the cost report. These strategies are valuable to show appreciation to the PRTF employees, contribute to a sense of teamwork, and aid with retention.

(ix) Meals for visitors.

Comment

Providers host parent engagement weekends twice a year in which we educate them in the Sanctuary Trauma-informed model. We also host a Thanksgiving Dinner to promote family engagement. This proposed rule would make it difficult to continue these practices.

(xv) Bad debts and contractual adjustments.

Comment

The third party liability process remains an issue for several MCOs with some not accepting EOBs from private insurers. Some MCOs indicate that EOBs don't contain necessary information for processing. In addition, the PROMISe system doesn't update timely enough to include TPL at admission. This can result in providers not being aware until well after the fact that authorization with a third party is necessary. Unfortunately, private insurers are not required to backdate authorizations, which leads to unpaid days of service/bad debt. These issue need to be addressed at the state level. In order to collect, PRTF providers are spending a great deal of time resolving these issues, leading to additional admin costs, which is why the 13% threshold is ineffective. DHS needs to further examine this area as it is outside of the PRTF's control and very much individualized to MCO/private payer.

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Recommendation

Review and resolve ongoing TPL challenges to ensure that providers are appropriately reimbursed for services rendered. Make necessary upgrades to PROMISe reporting system to ensure accuracy.

(xvi) Barber and beautician services.

Comment

Barber and Beautician Services are an important aspect of self-care for our youth.

Recommendation

This necessary activity should be an allowable cost if not it is an unfunded mandate

(xvii) Clothing and shoes for children, youth or young adults receiving services

Comment

It is unreasonable to expect PRTF programs not to be reimbursed for room and board. Is this an oversight? These areas should be included in the allowable costs if counties are no longer going to be responsible for paying for room and board and these are not covered in the rate determination process. When parents and guardians are unable to adequately clothe their clients, this agency absorbs the cost of clothing without reimbursement. These are basic needs and fall within the state's vision of meeting the social determinants of health needs for all Pennsylvanians. Under the new proposed regulations (§5330.31), clean and seasonal clothing are not categorized as a client right, placing the burden of purchasing these items on the PRTFs without providing appropriate reimbursement.

Supporting families is an important aspect of continuity of care, clinical practice, and fostering a healing environment for our families and youth. Agencies often must cover tolls, gas, or hotel expenses in order for parents/families to be able to visit their child. We ask that these costs be allowable.

Recommendation

Consider barber and beautician services, allowances, clothing, and shoes for children, youth, and young adults as allowable expenses as they are necessary to the individual's well-being and are basic needs. These activities should be an allowable cost; if not, they are an unfunded mandate.

(xxi) Meals for staff, except for meals provided during training activities documented in a child's, youth's, or young adult's treatment plan.

Comment

Staff are expected to take meals with the youth to ensure adequate supervision. Additionally, these

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mealtimes are an opportunity for skill development and engagement. This should be reimbursed as part of the cost of providing this level of service without articulation in each individual treatment plan.

Recommendation
Reimburse for staff meals for those staff supervision/in ratio during mealtimes.

(xxiii) Personal hygiene items for children, youth, or young adults receiving service in the PRTF.

Comment
Personal hygiene items are an important aspect of self-care for our youth and fall within the state's vision of meeting the social determinants of health needs for all Pennsylvanians. When parents and guardians are unable to adequately clothe their clients, this agency absorbs the cost of clothing without reimbursement. Under the new proposed regulations (§5330.31) clean and seasonal clothing are not categorized as a client right, placing the burden of purchasing these items on the PRTFs without providing appropriate reimbursement.

Recommendation
We ask that these costs be allowable. Otherwise, this necessary benefit is an unfunded service.

(xxv) Transportation and living costs associated with onsite visits by parents, legal guardians, or caregivers.

Comment
These visits are considered therapeutic in nature and are part of the treatment process, particularly related to therapy and skills transfer. Sometimes excessive travel is necessary due to location of the PRTF, and PRTFs do provide gas cards when families are not able to afford this travel. Parents/caregivers/guardians traveling to the facility for these sessions should be eligible for reimbursement through MATP, if not through the PRTF.

The agency currently provides parents with gas cards and hotel rooms to help economically challenged parents who live a distance from the PRTF visit their children. There is an obvious benefit to the client through the strengthening of the parent-child bond. Disallowing this expense will make it difficult for the agency to continue this practice.

Recommendation
Establish MATP reimbursement for parents traveling to medically necessary visitation/therapy in a PRTF or allow PRTF providers to account for this cost.

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(xxxiv) Parties and social activities not related to providing care to children, youth, or young adults receiving services in the PRTF.

Comment
If agencies will be expected to fundraise in order to support unreimbursed room and board, staff incentives, staff meals during supervision, onsite educational activities, and bad debt related to unresolved TPL/EOB issues, then functions to raise funds to support these activities should be allowable.

Recommendation
Reconsider non-allowable costs.

(e) The following services are not included in the per diem and may not be included as a cost for the PRTF:

(1) Health care, including dental, vision, and hearing care, which is not related to the child's, youth's, or young adult's behavioral health needs.

Comment
In rural areas, there may be no or limited providers of these services available who are contracted with certain private insurances. It can be incredibly challenging to schedule appointments within the regulatory required timeframes. At times, providers pay out of pocket for these services in order to meet the regulatory deadlines and avoid citation.

Recommendation
Consider reimbursement to providers who must pay out of pocket for required services.

(f) The Department will not contribute to a return on equity for proprietary programs.

Comment
Please explain this regulation. Is it related to retained revenue?

§ 1330.39. Annual cost reporting and independent audit.

(j) The annual cost report for the preceding fiscal year ending June 30 must be submitted to the Department by September 30 of that year.

Comment

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This is a very tight turnaround from year end close (August), audit, to then complete the cost report submission process. The cost reporting process remains cumbersome and ineffective.

§ 1330.40. Rate setting.

(a) Per diem rates will be established as follows:

(2) A per diem rate for a PRTF will be established by dividing the total projected operating costs by the number of days of care reported in the annual cost report subject to a minimum of 85% of the maximum number of days based on the number of beds specified on the PRTF's certificate of compliance.

Comment

The regulation does not encourage providers to exceed 85% capacity, as to do so decreases the rate/bed day. Youth are waiting in hospitals longer than necessary, are unsafely being discharged home to wait for a PRTF bed, or are boarding in OCYF offices awaiting placement due to census caps. A value based or other arrangement should be offered to providers who maintain adequate staffing and safely exceed this minimum 85% threshold.

Recommendation

Develop a bonus structure for those providers effectively managing expenses, maintaining stable staffing, and operating at a census capacity above 85%.

(3) The total actual days of care provided include all days of service provided plus hospital-reserve bed days as specified by § 1330.33 (relating to limitations on payment). Reserved beds counted as actual days of service may not be filled.

Comment

Days in which an individual is hospitalized but the reserve bed days is exceeded should be counted in the determination of per diem rates, particularly if PRTF providers are required to ensure that they will accept hospitalized youth to return to care when stabilized. Presently, OCYF/OMHSAS require providers to give a minimum of 30 days' notice of discharge from care in such cases.

Recommendation

Establish method to reimburse providers for unpaid hospital bed days if the youth is expected to return to care. Either eliminate the hospital bed day cap, or allow providers to claim these days on cost reports**.**

(4) The total projected operating cost will be calculated as follows:

(ii) For an existing PRTF, an annual cost report filed September 30 as specified in §

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1330.39, including adjustments for income and non-allowable, limited and excluded costs, as determined by the Department is used to determine projected operating costs.

Comment

Annual rate setting in this manner doesn't allow for adjustment of rates should additional unplanned expenses be realized. With the current staffing shortage and market fluctuations, it may be necessary for providers to adjust salaries as the market dictates. It is recommended that a method for rate adjustment midyear be considered so that providers who realize increased expenses or decreased revenue (driven by staff vacancies and impact on bed days) have an opportunity to respond prior to entering a deficit position.

Recommendation

Create a process for mid-year review as necessary based on a provider's financial position.

(5) Once established, a per diem rate will remain in place, unless the per diem rate is adjusted.

(b) The costs incurred in providing behavioral health treatment and room and board are included in the per diem payment for services in a PRTF, and may not be billed separately or in addition to the per diem payment rate by the PRTF or any other entity with which the PRTF may have an agreement to provide such services.

Comment

While meals, activities, and facility are provided for in the rate determination, personal hygiene items, haircuts, and clothing expenses are not. These are necessary items and activities for client self-care, and also basic needs. Providers should not be expected to independently fund these areas.

Recommendation

Allow personal hygiene items, haircuts, and clothing expenses to be considered in the PRTF rate determination.

§ 1330.41. Third-party liability.

(a) A PRTF shall utilize available third-party resources, including Medicare Part B, for services a child, youth, or young adult receives while in the PRTF.

(b) If a PRTF receives reimbursement from a third party subsequent to payment from the Department, the PRTF shall repay the Department by submitting a replacement of prior claim according to the Department's instructions.

(c) If a child, youth, or young adult or the legal guardian of a child, youth, or young adult

requests a copy of the record of payment or amounts due, the PRTF shall submit a copy of the invoice and the request to the Department.

(d) Except as specified in subsection (e), if a child, youth, or young adult has third-party resource benefits, the MA Program will pay the lesser of the following:

(1) A PRTF's per diem payment rate multiplied by the number of covered days, minus any payment from available third-party resources, including any Medicare Part B payment.

(2) The amount of the insurance plan's deductible and coinsurance minus any other payment from an available third-party resource, including any Medicare Part B payment.

Comment

The third party liability process remains an issue for several MCOs with some not accepting EOBs from private insurers. Some MCOs indicate that EOBs don't contain necessary information for processing. In addition, the PROMISe system doesn't update timely enough to include TPL at admission. This can result in providers not being aware until well after the fact that authorization with a third party is necessary. Unfortunately, private insurers are not required to backdate authorizations, which leads to unpaid days of service/bad debt. These issue need to be addressed at the state level. In order to collect, PRTF providers are spending a great deal of time resolving these issues, leading to additional admin costs, which is why the 13% threshold is ineffective. DHS needs to further examine this area as it is outside of the PRTF's control and very much individualized to MCO/private payer.

Recommendation

Review and resolve ongoing TPL challenges to ensure that providers are appropriately reimbursed for services rendered. Make necessary upgrades to PROMISe reporting system to ensure accuracy.

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PART VII. MENTAL HEALTH MANUAL

Subpart E. Residential Agencies, Facilities and Services

Chapter 5330. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

GENERAL PROVISIONS

§ 5330.1. Purpose.

The purpose of this chapter is to establish minimum requirements and service standards that shall be met for a facility to obtain a license as a psychiatric residential treatment facility (PRTF).

§ 5330.2. Scope.

This chapter applies to PRTFs that operate in this Commonwealth and serve children, youth, or young adults with a behavioral health diagnosis. This chapter does not apply to providers that offer services for substance use disorder or provide services for a primary diagnosis of substance use disorder, which must be licensed by the Department of Drug and Alcohol Programs under 28 Pa. Code Part V.

Comment:
There are programs under the current licensing umbrella of OMHSAS and OCYF, we hope the State considers that there are facilities that serve a different population of individuals with physical and intellectual disabilities. To address these specialized needs the current one size fits all treatment regulations may not be appropriate for their needs and in some cases may impact treatment success. Without the flexibility to waiver these programs the result will be a reduction in bed capacity thus creating another gap in the residential care continuum.

§ 5330.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings unless the context clearly indicates otherwise:

PRTF – Psychiatric residential treatment facility – A residential facility that provides services to treat the behavioral health needs of children, youth, or young adults under the direction of a psychiatrist.

Comments
Is this determined by license or by program? What if multiple distinct programs are co-located at one site and each is licensed independently?
Can the nursing and supervisory responsibilities be shared between licensed programs co-located at one site although under separate license?
Some agencies offer specialized programs that are distinct by service description/license, but that are co-located within one main facility as separate units.
Requiring these roles per licensed unit will be financially and operationally prohibitive to providers.

Recommendation
Ensure that the regulations support the allocation of the medical director, clinical director, social work supervisor, program director, and director of nursing within one organization.

Allow for onsite nursing coverage (overnight) per building and not per licensed program.

Visit – When a child, youth, or young adult is under the approved temporary supervision of an individual off the facility premises at the individual's residence or in the community and not under the supervision of PRTF staff.

Comment
Visit – please clarify if this includes on-site visits or on premises.

§ 5330.7. Exemptions.

(a) This chapter does not apply to community residences for persons with mental illness that provide care to both children, youth, or young adults and adults in the same facility or community residential host homes for persons with mental illness that are licensed under Chapter 5310 (relating to community residential rehabilitation services for the mentally ill).

(b) This chapter does not apply to residential facilities that serve children, youth, or young adults that are licensed under Chapter 3800 (relating to child residential and day treatment facilities).

GENERAL REQUIREMENTS

§ 5330.11. Service description.

(a) As part of the initial certificate of compliance application, a facility shall submit to the department for review and approval a written service description that includes the

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following:

Comment

Clarification is needed. Is this the agency's address, phone number, and website? Or the accreditation agency's?

(b) A PRTF's updated service description must be approved by the Department prior to a change in services specified in subsection (a).

Comment

Providers often wait months before they receive notification of approval or denial.

Recommendation

We recommend that the language be added "The Department (OMHSAS) has 60 days from submission to respond to the provider. If a determination has not been made on day 60, then the request will be automatically deemed approved."

§ 5330.12. Coordination of services.

(a) A PRTF shall have written agreements to coordinate services with other service providers, including the following:

(6) Educational providers.

(b) A PRTF shall update the written agreements with the other service providers annually or when the PRTF becomes aware that the agreements are no longer accurate.

Recommendation

If there are no changes, then the agreements remain in effect. If there are changes or the information is inaccurate, then we would update that information.

(3) Services are available to each child, youth, or young adult at all times.

Comment

§5330.12 (c) (1)(3) The PRTF has no control over whether a hospital admits a child for care. In addition, we have no control over the availability of all services for all children in a health care or inpatient hospital setting.

Recommendation

Language has to reflect reasonable efforts to accomplish this.

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§ 5330.13. Abuse.

(a) A PRTF shall have a written policy and procedure on the identification of abuse, reporting abuse, and plan of supervision for any PRTF staff implicated in abuse and plan for the protection of the child, youth, or young adult who was subject to abuse.

Comment

When speaking of abuse, the language should include the words alleged abuse or subject to the abuse.

(c) A PRTF shall comply with the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704).

Comment

This requirement creates an extra administrative and training burden as staff will need an additional half-hour of Mandated Reporter Training annually.

Are there licensed Children's PRTFs with kids over 21 or is this in reference to 18 and older?

Recommendation

Eliminate this training, as it is redundant in view of the current required abuse trainings.

§ 5330.14. Reportable incidents.

(b) A PRTF shall call the Department and complete an incident report through the Department's information management system within 12 hours after the following reportable incidents are known to the PRTF:

(1) Fire requiring the children, youth, or young adults of a PRTF to shelter in place or relocate.

(2) Death of a child, youth, or young adult.

(3) Serious injury to a child, youth, or young adult.

(4) Disruption to water, heat, power, or cooling at a PRTF.

Comment

Providers currently report within 24 hours and request that this remains in place in consideration of staffing and workforce issues. The only area we feel should be reported immediate would-be death of child, serious injury to a child.

If dealing with a fire or disruption to water, heat, power, and cooling, the agency will be working on ensuring children and staff are safe and should have additional time to take time out for notifications, which consume staff time.

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Reporting incidents of disruption to water, heat, power, and cooling could consume much of the staff time.

Will the Department have the same expectation to follow up within 12 to 24 hours of report submission? Currently, the Department does not respond in the same time frames as the providers.

Recommendation

The current reporting standard remain at 24 hours.

(c) A PRTF shall complete an incident report through the Department's information management system within 12 hours after the following reportable incidents are known to a PRTF:

(1) Use of a prohibited restrictive procedure specified in § 5330.183 (relating to prohibited restrictive procedures).

Comment

Does this include a restraint that is not performed correctly?

Reducing the window for completing reportable incidents from 24 hours to 12 hours creates an unreasonable burden on the residential staff who often complete multiple reportable incidents throughout a single shift. In addition to completing the incident reports in the Department's information system, staff must also complete serious incident reports regarding the same events for the clients' Behavioral Health Managed Care Organizations (BH-MCOs), as well as notifications to parents and referring agencies. The condensed deadline creates the potential for the reduced quality of documentation as staff strain to submit their documentation within the twelve-hour window.

It is also unclear how this requirement improves client care as there is no indication that the Department will be offering support to the provider or client in a more expedited manner.

Recommendation

The current §3800 regulation allowance of 24 hours to inform the Department of a reportable be maintained in the §5300 regulations.

(2) An incident where a child, youth, or young adult requires hospitalization or outpatient treatment at a hospital or other medical facility.

(3) Physical act by a child, youth or young adult to attempt suicide.

(4) Child's, youth's or young adult's elopement from a PRTF.

Comment

Please clarify what is meant by elopement from PRTF. Does this mean the actual site? Is there a time limit on what is meant by elopement?

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(5) Incidents of physical assault involving a child, youth, young adult, or PRTF staff.

(7) Intimate sexual contact involving a child, youth, or young adult.

Comment

§5330.14 (c) (5) & (7)

Please clarify what is meant by physical assault and what is meant by intimate sexual contact (these should be defined in the definition section of the regulations).

(11) A PRTF shall document in the child's, youth's, or young adult's record the date and time a report was made to the State-designated Protection and Advocacy system and the name and title of the individual from the State-designated Protection and Advocacy system that received the report.

Comment

Please provide clarification regarding the "State designated Protection and Advocacy system." If this is a new State Department, then providers will be duplicating the amount of required documentation after a reportable incident occurs. Is it the DRN pathway? Is the HCSIS? DOH?

Recommendation

The Department information management system be configured in such a way that reportable incidents filed by providers are automatically forwarded to the information system of the State-designated Protection and Advocacy system.

(13) A PRTF shall document in the child's, youth's, or young adult's record the date and time the Department was called about a reportable incident identified in subsection (b) and the name and title of the individual from the Department who was notified of the reportable incident.

Recommendation

Please add the following language to further clarify while under the supervision of the PRTF Staff and would not apply to incidents that occur while the child is on therapeutic leaves with family.

(14) A PRTF shall document in the child's, youth's, or young adult's record the date and time the parent, legal guardian, or caregiver was called about a reportable incident identified in subsections (b) and (c) and the name of the parent, legal guardian, or caregiver who was notified of the reportable incident.

Recommendation

(13) Please add the following language to further clarify "while under the supervision of the

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PRTF Staff and would not apply to incidents that occur while the child is on therapeutic leaves with family.

§ 5330.15. Recordable incidents.

(4) Search of a child, youth, or young adult or the child's, youth's, or young adult's property.

Comment

PRTF programs frequently treat individuals who engage in self harm or other destructive behavior. OMHSAS-10-02 and BEC 22 Pa. Code Section 14.102 (a)(2)(xiii) require that youth be allowed to attend the public schools of the hose school district when not limited by court order, IPE/NOREP recommended educational placement, or current expulsion due to a weapons offense. PRTFs often have youth who attend public school, and who have exposure to other individuals who could provide weapons, contraband, or other devices (staples, paper clips, thumb tacks, batteries, metal pieces from pens, nails, screws, etc.) which the youth can use to self-harm, or give to others to self-harm. Youth also have the ability to access these same items while on home visits. Some magnetron devices will not detect these items due to size, and therefore PRTFs frequently search individual's pockets, clothing, bags, hems, etc. when they return from school, community outings, or home visits, or when there might be suspected contraband in their possession. Based on the information provided it will be necessary to complete these reports daily — sometimes multiple times per day — when these events occur.

Recommendation

This level of documentation appears as another level of excessive administrative burden and defies the principles of youth supervision and engagement by spending more staff time documenting information.

(5) A reportable injury or reportable illness while the child, youth, or young adult is on a visit.

Comments

This section expands the reportable, creating additional administrative burden for a group of employees whose primary job is to supervise and engage youth as opposed to reports that the department has failed to justify as time critical.

Please define OMHSAS role and accountabilities in this reporting process.

These records should not be part of the medical record.

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Please provide a clear definition of search.

If a child is on a visit, how or what is the expectation of the provider to assess the child while on the visit? If we contact the family every 24 hours, and there was an injury or illness, is the provider expected to report this immediately and if so, will they provide a waiver for not meeting the required proposed 12 hours notification?

Recommendation
This section needs a better defined scope of activities and reporting that are congruent with the vision of the regulations as opposed to creating over-reaching administrative burden.

(b) A PRTF shall notify a child's, youth's, or young adult's parent, legal guardian, or caregiver of a recordable incident specified in subsections (a)(1) – (5) no later than 12 hours after a recordable incident occurs. The notification shall be documented in the child's, youth's, or young adult's record.

§ 5330.18. Confidentiality of records.

Comment
Please clarify and provide the list of all consent to treatment policies and regulations applicable to (11) other applicable statutes and regulations.

(b) Information relating to a child, youth, or young adult may only be shared if a signed authorization of release is obtained from the youth or young adult or the child's, youth's, or young adult's parent, legal guardian, or caregiver.

Comment
What is the applicability to HIPPA protections?

(d) A PRTF shall have a written policy and procedure on protecting the confidentiality and privacy of a child's, youth's, or young adult's information that includes the following:
   (1) The process to obtain permission to release a photograph of a child, youth, or young adult.
   (2) The use of photographs of children, youth, or young adults.
   (3) How the PRTF will ensure that children's, youth's, or young adults' and PRTF staff's social media activity does not contain identifying information about a child, youth, or young adult served by the PRTF.

Comment
If a client or family refuses to consent for treatment, we are not permitted to treat.

§ 5330.20. Visits.

(a) A PRTF shall have a written policy and procedure on visits.

Comment
Please clarify if visit means onsite or offsite.

(c) A PRTF shall develop a visit plan for a child, youth, or young adult when the child, youth, or young adult is not under the supervision of PRTF staff that includes the following:

(1) Identified coping skills for the child, youth, or young adult.

(2) Telephone numbers for local crisis intervention services and for the PRTF.

Comment
Please clarify if this means onsite or offsite.

(g) A PRTF shall contact the child's, youth's, or young adult's parent, legal guardian, or caregiver at least once every 24 hours if a visit lasts more than 24 hours to check on the safety, health, and well-being of the child, youth, or young adult.

Comment
While the agencies appreciate the spirit of this regulation, which provides additional support to families during therapeutic visitation, the regulation has unintended consequences. Many of these contacts would be made over the weekends by staff members who are least familiar with the parents or guardians. Moreover, the staff available to make these contacts have the potential to be ill-equipped to adequately respond to a parent or guardian experiencing distress during a visit.

It should also be remembered that the proposed regulations place other demands on the weekend staff, such as involving parents or guardians in the client restraint debriefs and the proposed twelve-hour window for completing reportable incidents.

During the holiday season, when client visits increase, the administrative burden becomes increasingly difficult to manage.

PRTFs already account for the potential need to provide additional support for families through visit safety plans, which provide contact information for parents to reach PRTF staff or crisis services when

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needed. The proposed regulation places an increased administrative burden on the PRTF without significantly improving care for families.

Recommendation

That the Department requires PRTF's visit safety plans include contact information allowing them to access support from the PRTF when requested by the family within two hours of the call.

§ 5330.21. Awake hours and sleeping hours.

A PRTF shall have a written policy and procedure that designates the PRTF's awake hours and sleeping hours.

Comment

In addition to awake and sleeping hours, we recommend that this section also include school day of the children as they will not be in the building.

RIGHTS

§ 5330.31. Rights.

(b) A child, youth, or young adult has the right to the following:

(5) To clean and seasonal clothing that is age and gender appropriate

Comment

Clothing is basic needs and falls within the state's vision of meeting the social determinants of health needs for all Pennsylvanians. Under the new proposed regulations (§5330.31), clean and seasonal clothing is not categorized as a client right, placing the burden of purchasing these items on the PRTFs without providing appropriate reimbursement.

(21) To have access to a telephone designated for use by children, youth, or young adults.

Comment

This proposed right needs to be complemented with PRTF's discretion to set reasonable phone call times to ensure reasonable bedtimes, times for the provision of the required group therapy and psychosocial education, as well as staff supervision to ensure that clients are only having conversations with appropriate contacts as identified on their approved contact list.

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Recommendation
PRTFs will be required to have a Client Phone Call Policy that will establish phone call hours, monitoring and supervision protocols, and contingencies if phone calls cannot occur during a crisis in the unit.

STAFFING

§ 5330.41. Supervision of staff.

General Comment
Throughout this section of the proposed rules, it is unclear whether OMHSAS is prescribing solid or dotted lines on each PRTF's organizational charts. The agency seeks clarity on this issue.

(a) A PRTF shall have a written policy and procedure on the supervision of PRTF staff that includes the following:

(1) A medical director shall provide the following supervision to an RN, clinical director, or an APP:

(i) One hour of face-to-face supervision every month.

(ii) Thirty minutes of direct observation of the provision of services every six months.

Comments
This regulation is inappropriate for Registered Nurses. A Registered Nurse is typically supervised intensively by a Senior Nurse or other Clinical Director. Many organizations have a nursing supervisor or director of nursing who ensures quality control of nursing practice. MD/DO resources are scarce and should be used in other ways. Additionally, MD scope doesn't allow for direct supervision of nursing practice. In addition, 1330.21 requires compliance with 42 CFR 482.62(d)- Nursing Services, which requires a qualified Director of Nursing Services (see response to 1330.21 making this an ineffective use of high level position and an additional cost to the provider.

Currently in many agencies a licensed psychologist provides supervision to the director of nursing, an RN, who in turn provides supervision to each nurse at residential. Additionally, the Residential Clinical Director receives direct supervision from the Vice President of Clinical Service, who is a licensed psychologist. The additional time required by the Medical Director to provide supervision and observation detracts from the available time the Medical Director must serve as treatment team leader and to provide medication management.

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Recommendation
It is recommended that RN supervision can occur in group format with the psychiatrist or Clinical Director as a standard part of clinical supervision of the team and that supervision of nursing practice and direct observation can be provided by a designated nursing supervisor or Director of Nursing.

(2) A clinical director or medical director shall provide the following supervision to a mental health professional:

(ii) One hour of direct observation of the provision of services every six months. Each occurrence of direct observation of services shall be for at least 30 minutes.

Comment
The requirement for direct observation of clinical practice is excessive. Review of videotaped sessions are considered a standard of supervisory practice in multiple domains and will often lead to better outcomes, as insertion of unfamiliar individuals in the treatment process can be disruptive to engagement and participation.

Recommendation
Allow this regulation to be met by utilizing clinical review/supervision/feedback of videotaped sessions as a less intrusive method that may demonstrate better outcomes for individuals/families.

(3) A clinical director, medical director, or mental health professional shall provide the following supervision to a mental health worker supervisor:

(i) Two hours of supervision each month. Of the two hours of supervision, one hour shall be face-to-face.

Comment
This is inconsistent with current outpatient telehealth under OMHSAS and should be changed to reflect the value and flexibility of telehealth for supervision and treatment. To that end, under Pa Act 98, the use of audio only is also permitted and approved by OMHSAS for these purposes.

(ii) One hour of direct observation of the provision of services every six months. Each occurrence of direct observation of services shall be for at least 30 minutes.

Comment
It is common practice that the mental health worker supervisors are directly supervised by the program director. For one agency, the proposed regulations would consume 38 hours a month of our Clinical Director's time to provide supervision and an additional 38 hours annually of providing direct observation. This time demand detracts from the Clinical Director's proper role of establishing and training the clinical best practices of program and the supervision of the mental health professionals and

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case managers.

Recommendation
Propose the supervision of the mental health workers remains with program director.

(c) Face-to-face supervision may be delivered through secure, real-time, two-way audio and video transmission that meets technology and privacy standards required by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191).

Comment
The fact that these supervision activities do not meet the standards of Act 98 and the current OMHSAS Telebehavioral Health Interim Guidance for the use of audio only creates two separate standards.

Recommendation
Change standards so that supervision that can be facilitated through two-way audio visual as well as audio only platform. This should be accepted and consistent throughout this proposed regulation, whether for communication between staff and/or with parental contact and communication.

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§ 5330.42. Staff requirements.

(a) Staff working in a PRTF shall be 21 years of age or older.

Comment

This change in regulation excludes individuals over 18 who may be furthering education in a clinically related field. It limits the ability to build pathways from high school to higher education and inhibits the ability for individuals with associates degrees or 60+ credit hours, or even bachelor's degrees for qualifying for community based positions that require 1 year+ of prior experience working with children to be eligible for community based positions (FBMH, BCM, CSBBH (IBHS), MST).

Many PRTF providers offer tuition assistance or educational loans to assist workers to advance in the field, thus assisting in growing the behavioral health workforce.

This rule will have a negative impact on PRTFs being able to develop an employee pipeline by providing clinical field experiences (practicums and internships) to students at local colleges and universities.

While there may be some county contracts that prohibit this the Department, with this change, is decreasing an already shallow pool of candidates eligible to do this work.

Recommendations

It is recommended that consideration be given to allow continuation of the hiring of individuals 18+, with the department focusing on finalizing the direct support professional certification that was initiated by OCYF, and then requiring that DSP's (particularly those under the age of 21) complete this certification process within three months of hire. Ideally, DHS would partner with local community colleges and workforce development boards/career links to offer this certification after identifying service worker positions on all high priority occupation lists throughout the state. Alternatively, there could be an exception for students enrolled in clinical field work, or higher education in a clinical field.

(b) At least two PRTF staff persons who are trained in the use of manual restraints shall be present and available at the PRTF at all times.

Comments

This regulation negates the ratio provided in (c)(1) At least one mental health worker or a PRTF staff person who meets the qualifications of a mental health workers shall provide supervision to every six children, youth, or young adults. It is not uncommon for a PRTF program to split into groups for

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activities, or for 1 or 2 youth to remain at a facility waiting for visitation, appointments, home sick from school, etc. Per this regulation, 2 staff trained to implement manual restraints would be required to remain with 6 or less clients at the facility. This would also require 2 individuals trained in the use of manual restraints to be available during all sleeping hours, negating the proposed ratio of 1:12 indicated in d1. PRTFs that are individually licensed units with a census of 12 or below that are collocated in a facility or on a campus would be required to have 2 individuals who are trained in the use of manual restraint present at all times within the licensed unit, including overnight shifts, and excludes staff or supervisors who may float within a facility for coverage.

This regulation also affects individuals who may require accommodations due to temporary or permanent physical limitations. In these cases, these additional staff who can adequately supervise but may not be able to physically intervene due to accommodations limiting their participation in restraint/training, can engage in supervision, support, and monitoring. These individuals would be ineligible to count in the ratio if they cannot complete the required training due to their restriction/accommodation, potentially adding significant additional worker's compensation costs to organizations in addition to exposing facilities to discriminatory practices. There is no rationale to include anyone who cannot be or is not trained in manual restraints to be present on the unit, as to do so when not needed will be cost prohibitive.

Recommendation

Consider eliminating this regulation. If the intent is to ensure that there is adequate ability to manage manual restraint/crisis situations at all times utilizing two staff, this can also be achieved by allowing staff who are trained in manual restraint to float between units within a facility, as long as there is a crisis management response plan in place. This would allow those individuals who cannot be trained in manual restraint to continue to be counted in the ratio.

(c) During the PRTF's awake hours, the following requirements must be met:

(1) At least one mental health worker or a PRTF staff person who meets the qualifications of a mental health worker shall provide supervision to every six children, youth, or young adults.

(2) PRTF staff providing supervision shall always be within auditory and visual range of children, youth, or young adults.

Comment

This is not feasible when staff supervise clients who are in their bedrooms during waking hours.

Recommendation

During the PRTF's awake hours, the following requirements must be met:

(2) PRTF staff providing supervision shall always be within auditory and visual range of children, youth, or young adults. If clients are in their bedrooms and visual contact with each child cannot be maintained, staff will remain within auditory range of all clients and conduct room checks every 15 minutes.

(3) A mental health professional shall be present at the PRTF.

Comments

Clarification is needed as to whether this regulation intends that separately licensed units co-located in a facility will be required to staff a mental health professional per each unit, or per the facility. Agencies are experiencing unprecedented challenges in recruiting Master's level and Licensed Clinicians due to the current workforce shortages. Competition with telehealth providers, private practices, and the expansion of the need for this level of clinician at the DHS, primary contractor, and MCO level has added to recruitment issues. It is already challenging to find clinicians willing to work in this level of care. It is unreasonable to expect that agencies will be able to recruit clinicians willing to work evening shifts, particularly in rural areas.

As noted in the comment to § 5330.48 (d), requiring non-traditional hours for MPHs will make the PRTF's recruiting and retention of MPHs more difficult.

Recommendation

A mental health professional shall be present at the PRTF for 75% of the waking hours. A mental health professional shall be on call for the remaining 25% of the hours and available to provide telehealth or report to campus to provide support if needed.

(d) During sleeping hours, the following requirements must be met:

(1) At least one mental health worker or a PRTF staff person who meets the qualifications of a mental health worker shall provide supervision to every 12 children, youth, or young adults.

(2) PRTF staff providing supervision to children, youth, or young adults shall remain within auditory range of the children, youth or young adults being supervised.

(3) PRTF staff supervising children, youth, or young adults shall conduct visual observations of each child, youth, or young adult at least every 15 minutes.

Comments

Oftentimes clients will utilize personal timeouts to their room as an effective coping mechanism when upset. This practice involves them keeping the door open, however may involve staff remaining in earshot and alert, but not direct site, particularly if their presence is activating the child. This is a planned for intervention in the treatment, safety, and crisis plan. This regulation effectively removes the

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opportunity for youth to use this coping mechanism. Additionally, this regulation inhibits the ability for individuals who are further along in the treatment process to have independent time, which is necessary as they are preparing for discharge. It is not uncommon for youth to be allotted quiet time in their room to do independent activities such as play, reading, coloring, etc. This regulation implies that staff would need to be available to visually supervise each child in their room or in the bathroom at all times, and not allow for closed doors, which is invasive and contradicts an individual's right to privacy.

This is not feasible when staff supervise clients who are in their bedrooms during waking hours.

Recommendation
It is recommended that staff are to remain in auditory and proximal range of the youth at all times in order to intervene if necessary and that room checks should be completed at least every 15 minutes when a child is alone in any room.

(e) PRTF staff shall be supervised as follows:

(2) When 12 or more children, youth or young adults are physically present at a PRTF, at least one PRTF supervisory staff person shall be physically present at the PRTF for every 12 children, youth or young adults.

Comment

A facility that has 3 separately licensed units (8, 10, and 10 clients) per this regulation would be required to have 3 supervisors in the building per shift. The current regulation requires that for facilities serving 16 or more children, whenever 16 or more children are present at the facility, there shall be at least one child care supervisor present at the facility. The proposed regulation would require the addition of 2 supervisors on all shifts in which 12 or more youth are present, including overnights in that facility. Not only will this be a costly addition, it is unlikely that programs will be able to recruit the additional supervisory level staff necessary to meet this regulation.

Recommendation

Clarification is needed as to whether each licensed unit will require a supervisor if census is less than 12, or if due to the units being collocated in a facility, if the addition of supervisory staff is needed. Having a supervisor on site and then another available as on call is effective, regardless of the number of clients in the facility at the time.

§ 5330.43. Medical director.

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§ 5330.45. Clinical director.

(a) A PRTF shall have a clinical director.

Comment

Clarification is needed as to whether this regulation intends that separately licensed within one agency can allocate a clinical director between these programs.

§ 5330.47. Registered nurse.

(c) The RN shall have at least one year of experience in treating children, youth, or young adults with behavioral health needs.

Comments

In a time when there are significant nursing shortages, it is unrealistic to require that nurses have at least one year of experience in treating children, youth, or young adults with behavioral health needs. Many agencies have worked diligently to establish collaborations with local nursing schools to develop practicum placements for nursing students within PRTF facilities. Additionally, agencies have also created general nurse positions as a recruitment technique, allowing general nurses to practice within scope under supervision of an RN nursing supervisor or director of nursing. To now limit agencies' ability to hire nurses by implementing this regulation, when even hospitals can and do use general nurses, is placing PRTFs at a recruiting disadvantage (see 49 Pa Code 21.7 Temporary Practice Permits for reference).

According to The Hospital-Health System Association of Pennsylvania, the nursing shortage in the Commonwealth is among the starkest in the nation due to an aging workforce, burnout, and shortage of nursing programs. This additional requirement will only further increase the difficulty of hiring nurses in the PRTF setting. It is already difficult hiring RNs due to PRTF's inability to offer competitive pay due to the current MA fee structure, and the need for staff RNs on second shifts and weekends. This additional requirement will further challenge the PRTF's ability to be appropriately staffed. RNs are already trained to work with individuals across the entire human life span. They also work in the context of a milieu and team who also possess this knowledge.

Recommendations

Remove the one year of experience requirement for nurses from the regulation. The PRTF will provide OMSHAS with records of each nurse's measured competencies regarding an understanding of child development as required by the accrediting bodies. If a nurse's measured competencies reveal a deficit in an understanding of human development in children, youth, or young adults, the PRTF will be

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required to provide the nurse with additional training.

§ 5330.48. Mental health professional.

(d) The mental health professional's assigned caseload may not exceed eight children, youth, or young adults.

Comments

While it is preferred to maintain a 1:8 ratio of therapists to individuals served, it is unrealistic to expect agencies to do so at all times. There are circumstances when an assigned therapist may be unavailable to provide care due to personal time off or due to staff turnover/inability to recruit. Mandating a ratio will result in providers consistently out of compliance with this regulation.

MHPs have been increasingly difficult for PRTFs to recruit due to the highly regulated environment of the PRTFs compared to the flexibility and competitive salaries offered in private practices. The proposed regulations will require MHPs to work non-traditional hours, making the position much more difficult to recruit. This agency already schedules evening and weekend hours for the therapists as best practice. However, due to instances of staff turnover, there are occasionally uncovered shifts. In those circumstances, we would be out of compliance instead of being out of best practice. Turnover in this position is common and the likelihood of occasionally being out of compliance is significant, placing PRTFs at risk of receiving citations for being unable to overcome labor trends beyond their control.

Recommendations

Eliminate the mandated ratio for mental health professionals and instead adopt: "A sufficient composition of Mental Health Professionals shall be available in the PRTF to meet the Treatment Services identified in 5330.145."

(e) The mental health professional shall meet one of the following:

(4) Completed a clinical or mental health direct service practicum and have a graduate degree with a least nine credits specific to clinical practice in psychology, sociology, social work, education, counseling, or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or have an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.

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Comment

The agency requests that consideration be given to internships as well as practicums to fulfill the educational requirements of this rule. Without this revision, the proposed rule unnecessarily limits qualified applicants from consideration.

Consideration should be given to individuals with "lived experience" to fulfill this requirement. The practicum requirement has been a barrier for other licensed OMHSAS programs such as IBHS.

Recommendation

The term "practicum" be replaced with "clinical field work," so as to not unnecessarily eliminate qualified applicants from being able to apply.

§ 5330.49. Mental health worker.

(c) The mental health worker shall have a high school diploma or the equivalent of a high school diploma and at least one year of experience working with children, youth, or young adults.

Comment

Requiring mental health workers (also known as direct support professionals) to have at least one year of experience working with children, youth, or young adults will drastically reduce the amount of individuals eligible to enter the behavioral health field, and then also progress to community based programs as they gain experience and education, effectively disrupting the development of an adequate behavioral health work force. Consideration should be given to individuals who have worked in any program providing services to individuals with behavioral health or intellectual/developmental disabilities. In some regions, "Social and Human Services Assistants" and "Psychiatric Aides" have been added to the WDA High Priority Occupations lists in order to develop pathways to the human services field, allowing local CareerLinks to approve funding for workforce education and training in this area. Direct support positions in PRTFs have been a means to introduce individuals to the field and provide the intensive supervision and training needed to develop these staff. Outside of licensed daycare, teacher's aide positions, paid coaching positions, or IBHS BHT (see Title 55 5240.71 (d)(5)), there is no other way for individuals to gain the experience that this regulation requires. Our agency provides trained mentors who work intensively with new staff for a minimum of 90 days, who work with them during shifts, teaching/modeling the therapeutic interventions and de-escalation techniques required to be successful in this role. We also offer educational loans and tuition assistance to encourage those in entry level positions to pursue higher education. At a time when there is a current workforce shortage, which is only projected to exacerbate over the next five years (particularly in rural

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areas), such a regulation is counterintuitive. DHS should be assisting in workforce development by encouraging and incentivizing high school graduates to consider the field of human services. Also due consideration should be given to individuals with lived experience. These individuals are becoming increasing valuable to aid in the workforce shortage, as witnessed by national and state initiatives that are promoting and implementing peer services with individuals who have lived experience.

Recommendation
Remove the one year of experience for behavioral health workers from the regulation. Provide opportunities for training or DSP certification facilitated by DHS, similar to IBHS BHT (see Title 55 5240.71 (d)(5)). The Department could achieve this by finalizing the direct support professional certification that was initiated by OCYF (Western Region), and then requiring that DSPs (particularly those under the age of 21) complete this certification process within 3 months of hire. Ideally, DHS would partner with local community colleges and workforce development boards/CareerLinks to offer this certification after identifying service worker positions on all high priority occupation lists throughout the state. Alternatively, the three could be an exception for students enrolled in clinical field work, or higher education in a clinical field.

§ 5330.50. Additional staff positions.

The following PRTF staff positions, if utilized, shall meet the following requirements:

(1) If within the scope of the APP's practice, an APP may do the following:
  (i) Evaluate the physical or psychological condition of a child, youth, or young adult who takes a prescribed medication.
  (ii) Review, update, sign, and date the child's, youth's, or young adult's treatment plan.
  (iii) Perform initial or routine specific screenings and assessments to assess the physical or psychological condition of a child, youth, or young adult.

Comment
As the Commonwealth struggles to gain access to psychiatric care, the use of APPs has been not only an accepted practice, but one by which OMHSAS has granted and repeatedly extended waivers for this in the outpatient setting. The potential promulgation of these regulations can permanently address this scenario through these regulations. This could result in greater access and flexibility to these critical services and not require future legislation, bulleting, or state plan amendments. This should be considered wherever there is a need for a psychiatrist in these PRTF regulations and such amended to allow an APP to fill this role.

(2) The APP shall be licensed in this Commonwealth and have at least one year of experience

working with children, youth, or young adults.

(3) If within the scope of the LPN's practice, an LPN may do the following:

(i) Accept verbal orders for a manual restraint.

(ii) Participate in the planning, implementation, and evaluation of nursing care provided to a child, youth, or young adult.

(4) The LPN shall be onsite at a PRTF whenever an RN is not onsite at the PRTF.

Comment

Clarification as to whether individually licensed units with different specializations co-located in a facility are required to have an LPN on site per unit or per facility. There is concern that PRTFs will not have the ability to recruit LPNs to provide the coverage as identified in this regulation due to current and ongoing workforce shortages.

Recommendation

Provide clarification as to whether individually licensed units with different specializations co-located in a facility are required to have an LPN on site per unit or per facility.

(5) The LPN shall have at least one year of experience working with children, youth, or young adults.

Comments

Given the current workforce shortages in all levels of nursing it will be impossible for PRTF programs to effectively recruit LPNs with this level of experience. Hospital systems and inpatient units are not required to hire only LPNs with 1+ year of experience. Requiring PRTF providers to do so puts these agencies at an unfair disadvantage, with an inability to competitively recruit LPNs compared to all other disciplines that use this level of staff.

This proposed regulation will make it more challenging for PRTs to staff appropriate nursing rosters. According to the National Center for Health Workforce Analysis, the number of licensed practical nurses declined by over 9% in 2022. LPNs are already trained to work with individuals across the entire human life span. They also work in the context of a milieu and team who also possess this knowledge.

Recommendation

Eliminate this requirement from the regulation. The PRTF will provide OMSHAS with records of each nurse's measured competencies regarding an understanding of child development as required by the accrediting bodies.

(7) The mental health worker supervisor shall have one of the following:

i. At least one year of experience in the delivery of behavioral health services to children, youth, or young adults and a bachelor's degree in psychology, sociology, social work, counseling, education, human services, public administration, business administration, or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.
ii. At least two years of experience in the delivery of behavioral health services to children, youth, or young adults and an associate's degree in psychology, sociology, social work, counseling, education, human services, public administration, business administration, or a related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation or an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.
iii. At least three years of experience in the delivery of behavioral health services to children, youth, or young adults and a high school diploma or the equivalent of a high school diploma.

Comment

Providers have noted that the turnover of a "mental health worker" (aka direct support professional) increases in frequency once that individual hits 1 to 2 years of tenure in an organization, particularly associated with lack of advancement opportunities. Expecting an individual to remain in a mental health worker role for a 2- to 3-year period (assuming 2 years if they enter with the 1 year of experience required in 5330.50(b)) is unrealistic. Many of these individuals will have already engaged in efforts toward higher education. In order to effectively build the engagement necessary toward continued development of the behavioral health workforce, in all levels of behavioral health care it is recommended that consideration be given to other training/competency based options rather than allow only years of experience to dictate proficiency toward supervisory status. Additionally, many of the community based services for adults and children require 2 years of supervisory experience for consideration of a supervisor role. There are limited options for individuals to gain that experience

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currently and the PRTF's programs could allow for this career path development. Consideration should be given to individuals who have worked in any program providing services to individuals with behavioral health or intellectual/developmental disabilities.

Recommendation
Consider development of a Mental Health Worker (Direct Support Professional) certification program as indicated previously. Expand this to include a supervisory competency training program facilitated by the Department. Upon completion of both levels of competency allow an individual with a high school diploma to be considered for a supervisory position with (a) 2 years of experience working with individuals with mental illness or intellectual/developmental disabilities or (b) 1 year of experience in working with mental illness or intellectual/developmental disabilities, 9 credit hours in a related human services field.

§ 5330.51. Initial staff training.

(2) The requirements of 23 Pa.C.S. §§ 6301 — 6388 (relating to the Child Protective Services Law) and Chapter 3490 (relating to protective services).

Comment
Applying the staffing requirements to all PRTF volunteers, regardless of how often they directly work with clients, will result in individuals becoming dissuaded from working with clients due to the requirement to complete 30 hours of annual training. For example, this agency has a volunteer auxiliary that primarily meets to raise money for the residential program. However, a few times a year, the auxiliary plans holiday parties for our clients. Representatives of the auxiliary attend these parties, but are never alone with the clients, and are never part of the staff ratio. From a cost perspective, the proposed regulations propose an increase of 20 additional training hours annually for indirect staff. The agency currently has 36 staff in this category, and it would cost the agency an additional $22,700 annually.

Recommendation
This agency recommends that volunteers who have limited contact with clients (auxiliary members, speakers at an assembly, etc.) be exempted from the staff training requirements.

(3) The requirements of the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704).

Comment
See previous comments in clarifying requirements of the Adult Protective Services Act and how they differ from already required and established children's services trainings.

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(d) The medical director, treatment team leader, clinical director, program director, RN, mental health professional, mental health worker, and if utilized, an APP, an LPN, and a mental health worker supervisor shall complete the training required by subsection (c) prior to working directly with children, youth, or young adults.

Comment

Applying the staffing requirements to all PRTF volunteers, regardless of how often they directly work with clients, will result in individuals becoming dissuaded from working with clients due to the requirement to complete 30 hours of annual training. For example, this agency has a volunteer auxiliary that primarily meets to raise money for the residential program. However, a few times a year, the auxiliary plans holiday parties for our clients. Representatives of the auxiliary attend these parties, but are never alone with the clients, and are never part of the staff ratio.

Recommendation

This agency recommends that volunteers who have limited contact with clients (auxiliary members, speakers at an assembly, etc.) be exempted from the staff training requirements.

§ 5330.52. Annual staff training.

(b) PRTF staff shall have at least 30 hours of annual training in the areas specified in § 5330.51(c) (relating to initial staff training).

Comment

Currently, PRTF staff who are not working with clients are not regulated by any annual training requirements in the 3800s. PRTFs are responsible for establishing their own training standards based on their policies and any professional standard accompanying each staff role. However, the 5330s prescribe 30 hours of annual training, with many of the topics having no relevance to the staff's role. For example, billing agents do not need to be trained in the use of manual restraints, verbal de-escalation, mental health diagnoses, or principles of child development.

Recommendation

PRTF workers not working with clients must have annual training in fire safety, blood-borne pathogens, first aid, CPR, the agency's trauma-informed model, harassment training, and cultural competency.

FIRE SAFETY

§ 5330.91. Compliance with fire safety statutes, regulations and ordinances.

A PRTF shall comply with applicable federal and state laws, regulations, and local ordinances regarding fire safety.

(c) Doors with delayed egress must be equipped with a mechanism that unlocks after no more than a 15-second delay and must meet the requirements of the International Building Code § 1008.1.9.7 (relating to delayed egress locks).

Comment

Most facilities utilize a 30-second release system which has been approved by local code enforcement. The 30-second timeframe is often still not sufficient when attempting to intervene. Youth will lean on the door but not demonstrate such imminent risk during attempts at de-escalation that restraint is required. Some of our facilities are only a short distance from major roadways or other areas that are considered hazardous. Staff may not have the physical agility or ability to quickly chase youth who will now have more opportunity to succeed in exiting the facility. Setting a maximum of 15 seconds for delayed egress creates an additional safety risk to these youths.

HEALTH

§ 5330.111. Health and behavioral health services.

(b) Medically necessary physical and behavioral health treatment, diagnostic services, follow-up examinations and services, such as medical, nursing, pharmaceutical, dental, dietary, hearing, vision, blood lead level, psychiatric and psychological services that are planned or prescribed for the child, youth, or young adult, shall be arranged for or provided.

Comment

Current regulation is blood lead levels under the age of 5. The new proposed regulation does state the age. Age limit requirements should be added for clarification. The recommended ages for lead screening for children vary by state and program, but generally include:

Medicaid

'Children enrolled in Medicaid are required to be tested for lead at 12 and 24 months of age. If they are older than 24 months and have no record of a previous test, they must also be tested.'

CDC

'Children enrolled in Medicaid are required to get tested for lead at ages 12 and 24 months. They are

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also required to get tested if they are ages 24–72 months and have no record of ever being tested. For children not enrolled in Medicaid, CDC recommends focusing testing efforts on high-risk neighborhoods and children.'

§ 5330.112. Initial medical assessment.

(e) If a physician did not complete the initial medical assessment, a physician shall review and sign the initial medical assessment within three days from the date the initial medical assessment was completed.

Comment
It would prove to be very difficult to have a physician review this assessment in 3 days. Our PCP comes to HYS every 7 days. Having the attending psychiatrist review would not always be available within 3 days, especially for Friday admissions. An RN is currently permitted to review and sign the assessment and is qualified to make a clinical judgement if the resident needs medical treatment immediately.

This proposed regulation will have unintended consequences regarding the PRTFs capacity to admit clients. For example, if a client were to be admitted on Thursday or Friday and a physician were not present either of those days, a physician's signature would not be able to be secure over the weekend, playing the PRTF in a state of noncompliance.

PRTFs will be required to increase the number of contracted hours with PCPs, an expense that is not accounted for in OMSHAS' estimated financial impact statements. PRTFs are dependent on the availability of contracted PCPs who are willing to accept MA rates, and will find it difficult to find enough doctor's time to meet the demands of this regulation, which will result in needless delays in admissions.

Recommendation
We ask that section (e) be removed and continue with current practice which is in line with 5330.114.: If a physician did not complete the initial medical assessment, a physician shall review and sign the initial medical assessment within 15 days from the date the initial medical assessment was completed.

§ 5330.114. Medical examination.

(a) If a child, youth, or young adult did not have a medical examination, or there is no documentation of a medical examination 12 months prior to admission to a PRTF that meets the requirements of the State Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program Periodicity Schedule, a medical examination by a physician

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or APP shall be completed within 15 days of the child's, youth's, or young adult's admission to a PRTF.

Comment

It would prove to be very difficult to have a physician review this assessment in 3 days. Our PCP comes to HYS every 7 days. Having the attending psychiatrist review would not always be available within 3 days, especially for Friday admissions. An RN is currently permitted to review and sign the assessment and is qualified to make a clinical judgement if the resident needs medical treatment immediately.

Recommendation

We ask that section (a) be removed and continue with current practice.

TREATMENT SERVICES

§ 5330.141. Treatment planning requirements.

(b) A treatment team leader shall ensure that only PRTF staff who are trained and experienced in the use of the modalities proposed in the treatment plan participate in its development, implementation, and review.

Comment

"Only" PRTF staff who are trained. The principals should be experts in the modalities. But the presence of nonprofessionals like the parent, youth, and external parties shows that there's value in all the perspectives, too. Childcare staff may have a valuable perspective in the development of the plan.

Recommendation

We would recommend to eliminate the word "only."

§ 5330.142. Treatment plan.

(a) The following requirements must be met prior to the development of a child's, youth's, or young adult's treatment plan:

(1) A multi-disciplinary assessment and screening must be completed within 48 hours of a child's, youth's, or young adult's admission to the PRTF.

Comment

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A multi-disciplinary assessment and screening should take longer than 48 hours. The value of PRTF is an opportunity to provide comprehensive assessment including observations within the milieu to inform assessment and evaluation.

This is also the period of time when a youth is adjusting to a new living situation and peers. The program must take care not to overwhelm newly admitted youth and allow them time to acclimate. How would this be achieved if a youth was admitted to a facility on a Friday afternoon?

Recommended
Recommend the multi-disciplinary assessment and screening take place within 7 days of the youth's admission, to give the youth proper time to adjust to the setting and the assessment professionals time to complete the task. This is also the same period of time allowed for the psychiatric evaluation.

§ 5330.143. Maintenance of treatment plan.

(a) A child's, youth's, or young adult's treatment plan must be revised at least every 30 days in accordance with 42 CFR 441.155(c) (relating to individual plan of care).

Comment
Some facilities track progress on the treatment plan in another document (e.g., "Monthly Progress Review"). Will this continue to be OK, or must the treatment plan itself be altered on a monthly basis?

Recommendation
Permit PRTFs to fulfill this requirement using clearly documented means but not exclusively by altering the treatment plan monthly.

§ 5330.145. Treatment services.

(c) The following must be provided in accordance with the child's, youth's, or young adult's treatment objectives:

  (1) Individual therapy with the child's, youth's, or young adult's treatment team leader must be provided for at least one hour each month.

Comment
This regulation is problematic for two reasons. Since the 1990s, there has been a steady decline in the amount of psychotherapy provided by psychiatrists. The percentage of psychiatric visits which involve psychotherapy dropped to 21.6% of patient visits between 1996 and 2016. There is no data to suggest a reversal in this trend. This data suggests PRTFs will have difficulty hiring psychiatrists proficient in

providing psychotherapy.

Against this backdrop, there is a well-documented shortage of psychiatrists in Pennsylvania. According to the American Academy of Child and Adolescent Psychiatrists, Pennsylvania has 18 child and adolescent psychiatrists per 100,000 children, placing the state in the "High Shortage" category (18-46%). 45% of Pennsylvania counties do not have a single psychiatrist with a specialty in children and adolescents. The average child and adolescent psychiatrist is age 54, which indicates that the workforce may continue to contract due to retirement. A 2018 article published in the National Library of Medicine stated that it was unclear if the current psychiatric shortage would be resolved by 2050. It should be noted that those projections were made before the pandemic and the subsequent increased demands for behavioral health and substance use treatment services. The Kaiser Foundation estimated that as of April 1, 2024, Pennsylvania would require an additional 59 psychiatrists to remove the 118 Health Professional Shortage Areas that have been identified in the Commonwealth.

Against this backdrop, OMHSAS proposes that each PRTF client have one hour of individual therapy each month with the treatment team leader. To comply with this regulation, several provider members would have to hire an additional treatment team leader at an estimated cost of $289,300 annually, plus recruiting incentives to maintain regulatory compliance at its current average census of 30 clients. The agency would have to hire two more treatment team leaders to return to its licensed capacity of 57 beds.

This proposed regulation places the impossible burden of the Commonwealth's PRTFs having to recruit and hire a high volume of psychiatrists against the setting of the state and national psychiatric shortage. This will inevitably result in the closure of PRTFs and a further unwelcome reduction in the number of beds.

(2) Individual therapy with the child's, youth's, or young adult's mental health professional must be provided for at least two hours each week.

Comment

The increased demand for psychiatry may not be implementable, as there is a shortage of child psychiatrists.

The requirement for psychiatrists to do therapy is costly. This agency would need to hire an additional psychiatrist at an estimated salary package of $120,000/yr., not including recruiting expenses. An additional $480,000/annually would need to be spent to hire additional psychiatrists to return to the agency's 76-bed capacity.

Research shows that being engaged in individual therapy with multiple clinicians is contraindicated due to the potential of confused messaging it provides the client.

OMSHAS makes this proposal against the backdrop of our current shortage of psychiatrists in Pennsylvania.

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Psychiatrists at most PRTFs are not privileged to provide individual therapy.

Few psychiatrists are trained and proficient in providing individual therapy due to the emphasis on their providing medication management.

The proposed regulations will compound the current difficulty agencies have recruiting MHPs. PRTFs already compete with private practices and programs offering traditional work schedules and greater salaries. In addition to recruitment challenges, the proposed regulations would require hiring additional MHPs due to the proposed cap on their caseloads. The agency would need to immediately hire two therapists, at a combined $113,00 salary package annually to be compliant with the proposed regulations to meet the requirements of our current census. It would require an additional estimated $452,000 in MHP salaries to grow the program back to its licensed seventy-six beds. The role of the treatment team leader is already highly engaged with the team via supervision and consultation. Additionally, providing Individual therapy could lead to triangulation and role confusion.

This section does not recognize the role of APPs as clinicians, which has been a longstanding need for revision in the existing regulations.

Conducting therapy is not necessarily within the practice scope of many psychiatrists.

Increasing therapy to a minimum of two hours per week with the therapist will likely require facilities to adjust caseloads for therapists downward and hire additional staff at a cost.

Recommendation

It is difficult to see the additional benefit to the resident of meeting with the psychiatrist/treatment team leader for therapy when the other therapy requirements are greatly increased in this section. Given that and the limited resource and no ability to use APPs, this requirement could be eliminated.

There are also job-market realities that may prevent facilities from finding all the therapists they need. The state might refrain from doubling (or greater) therapy requirements or cite evidence in the literature that the increased therapies will lead to desired outcomes before making such requirements.

(3) Group therapy must be provided for at least three hours each week. PRTF staff that meet the qualifications of a mental health professional, clinical director, or treatment team leader shall facilitate group therapy.

Comment

Increasing demands for group therapy and psychoeducation groups to three hours each per week may be stressful for the residents who already have to attend school and other therapy sessions. These youths require down time like any other kids. We should be careful not to over-program.

Increasing group therapy demands will again put pressure on facilities to adjust caseloads for therapists

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and hire additional staff to fulfill the requirements.

(5) Psychoeducation group therapy must be provided at least three hours each week.

PRTF staff that meet the minimum qualifications of a mental health worker shall facilitate psychoeducation groups.

Comment

We would like to point out that the Department has provided no evidence-based research to support these arbitrary standards for treatment. Furthermore, these standards violate the Pennsylvania-mandated CASSP Principle of "Child Centered Treatment" which states that services are planned to meet the individual needs of the child, rather than to fit the child into an existing service.

This lack of individualization creates the potential for children, youth, and young adults to be over-saturated with therapy. When individuals become therapy fatigued due to the constant focus on their mental health issues and past trauma, they can become overwhelmed and exhausted. This results in decreased motivation and engagement in therapy sessions, which could result in longer placements in the PRTF.

In some cases, clients become dependent on therapy and then struggle to cope with their issues independently, which can hinder their ability to develop self-reliance and resilience, leading them to be ill-prepared for discharge. At the time of admission, parents/guardians are sometimes unable to tolerate family therapy and need time to process their own frustrations before engaging.

Lastly, these standards do not account for a constellation of factors, including client's age, diagnoses, developmental delay, cognitive level, or family system.

Recommendation

Follow what is regarded as clinical best practice and permit the treatment team to determine the frequency of the child's treatment based on the frequency, intensity, and duration of the child's problematic behavior.

Increasing demands for group therapy and psychoeducation groups to three hours each per week may be stressful for the residents who already have to attend school and other therapy sessions. These youths require down time like any other kids. We should be careful not to over-program.

Increasing group therapy demands will again put pressure on facilities to adjust caseloads for therapists and hire additional staff to fulfill the requirements.

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(f) Family therapy may be provided in person or through secure, real-time, two-way audio and video transmission that meets technology and privacy standards required by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191).

Comment
Families may not have the money, technology, or Wi-Fi/data access to participate by video teleconferencing.

Recommendation
Families should be permitted to use telephones for family therapy if their circumstances do not permit them to afford other devices, technology, or Wi-Fi access. If the state will not accept this, they could provide funding for facilities to give cell-enabled tablets to families for the purposes of family therapy only.

TRANSPORTATION

§ 5330.151. Transportation.

(d) There shall be at least one PRTF staff person present for every three children, youth, or young adults being transported.

Comment (b) (c) (d)
Most PRTFs are currently not operating at their licensed capacity due to chronic staffing shortages. The proposed transportation ratios will make it difficult for the agency to assist in the transportation of clients on family visits, especially around the holidays when client visits increase. Providing transportation to court hearings and required health care appointments could become increasingly difficult.

It should be noted that meeting the transportation staffing ratios will only increase the difficulty of meeting the on-campus staffing ratios, which is proposed to change to 1:6.

5330.1469(d) provides clients with the right to participate in educational extra-curricular activities, personal enrichment, and vocation events that are reasonably available. However, the proposed transportation ratios will diminish the PRTF's capacity to help clients participate in these activities. The cost of creating alternative experiences on campus would only create additional expenses for the PRTFs. The proposed staffing ratios during transports will make it difficult to integrate the clients into the community during regular therapeutic activities due to the above-mentioned challenges of recruiting and retaining qualified staff. Agencies will have trouble honoring contracted signed county OCYF and JPO agencies regarding the transportation of clients to and from court hearings and visits. Without additional

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funding, this agency would no longer be able to subsidize the cost of transportation and lodging for out-of-county parents visiting their children, as those funds would be diverted to meet the costs inherent in the transportation ratios.

The proposed transportation ratios will be a significant challenge for PRTF providers to meet and will affect the ability for youth to benefit from prosocial activities and community outings that enhance treatment. In addition, required evacuation in the event of an emergency plan activation will be nearly impossible without the purchase of additional vehicles and scheduling of many additional staff on all shifts. A 1:3 staff to client ratio without the driver included in that ratio means that 10 passenger vehicles can only transport 6 youth at a time. A facility serving 10 children will require 2 vehicles and 4 staff (one of whom is a driver) on any shift on which there could be any type of transportation, including an unpredicted emergency event, that affects the facility. Per the proposed regulations, it is only necessary to staff 1:6 during awake hours; however, this will be impossible as there will need to be staff on site, or on call to respond to the decreased staff to client ratio in the event of an emergency evacuation need.

Additionally, any current transportation that occurs now to court, appointments, home-based family therapy sessions, visits, etc. that can effectively be completed by one well-trained staff, will now require two staff as the driver can no longer be counted in the ratio. It is not uncommon to have multiple vehicles transporting one youth at the same time throughout the day to different places. All programs will need to increase the staff compliment significantly in order to provide supervision during transport, provide a driver, provide supervision to youth who remain on the unit, and then provide enough staff to be able to transport in the event of an emergency evacuation of the facility. Programs are already struggling to meet staffing needs, so having to increase the complement by several staff per shift will be challenging. If the intent is to require that agencies move to a different transportation model, it should be noted that many transportation agencies in local communities would also not have the staff resources available to contract for such work.

(e) A manual restraint may not be utilized on a child, youth, or young adult during transport.

Comment

The agency seeks clearer language. Does transport mean "while the vehicle is in motion" or the entire trip including stops and time spent at the destination?

Recommendation

A manual restraint may not be utilized on a child, youth, or young adult while a vehicle is in motion.

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MEDICATION

§ 5330.164. Medication log.

(a) A prescription and nonprescription medication log must be kept for each child, youth, or young adult.

Comment

What is a medical log? Is regulation referencing a Medication Administration Record (MAR)? They reference nonprescription medication. Even over the counter medication is ordered from the doctor, so no nonprescription medicine is administered.

(2) For each prescription and nonprescription medication taken by the child, youth, or young adult, the following:

(i) Name of the medication, including brand name and generic name.

Comment

Pharmacies may not be able to accommodate this. Generic medication names may have many brand names.

Recommendation

Permit current practice standard.

(vii) Possible side effects.

Comment

If the "medication log" is referencing the MAR, this could be a long list and not fit on the MAR.

Recommendation

The information be maintained on the medication information sheet that is in the medical record.

§ 5330.165. Medication error.

(a) A medication error includes the following, regardless of whether the medication error resulted in an adverse reaction:

(1) Failure to administer the prescribed medication.

(2) Utilizing the incorrect method to administer the medication.

(3) Administering the incorrect medication.

(4) Administering the correct medication in an incorrect dosage.

(5) Administering the correct medication at the incorrect time.

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(b) Documentation of a medication error that includes detailed information about the medication error must be recorded in the child's, youth's, or young adult's medication log.

Comment
Is the "medication log" the MAR? There is not enough room for all the information that is being requested. It is currently documented in the medical record.

Reporting individual medication errors, which can simply be (among many other things) that a medication was not available due to pharmacy related issues, a youth was administered a medication a small period of time outside of the required timeframe due to a behavioral incident, or a youth refused to take a medication, is ineffective without full context. At one member's organization, for example, they state — we administer around 16,000 doses of medication monthly within our PRTF programs. Our medication error rate is between .006% and .12% monthly. All JCAHO
accredited PRTF programs report on this monthly and these reports could be reviewed during licensing visits. It would be understandable to report those errors with a negative outcome or that require hospital assessment. What is the rationale in reporting individual medication errors that do not result in any negative outcome to the youth?

Recommendation
Permit current practice to remain documenting information in the medical record.

§ 5330.166. Medication refusal.

(c) A PRTF shall inform the child's, youth's, or young adult's treatment team leader of the refusal to take prescription medication as soon as possible, but no later than one hour after the refusal.

Comment
To notify the psychiatrist ASAP and no longer than one hour after medication refusal is excessive. There are many medications that would not have any significant impact with one refusal. Routine refusals are reported to the psychiatrist but not in one hour.

This time window is excessively restrictive as it does not account for the potential of the nursing staff being pulled away to observe a restraint or other crisis.

Recommendation
Maintain current regulation/practice and/or the PRTF shall inform the child's, youth's, or young adult's

treatment team leader of the refusal to take prescription medication as soon as possible, but no later than two hours after the refusal.

RESTRICTIVE PROCEDURES

§ 5330.181. Use of manual restraints.

(3) A performance improvement process that must be reviewed every 30 days to monitor and reduce the use of manual restraints.

Comment

This PRTF has multiple systems in place for reviewing restraints, including the use of video review to coach/debrief staff and the weekly clinical review of clients with a high number of restraints the prior week. A monthly review of these established processes is unnecessarily frequent and could result in superficial reviews of our processes.

§ 5330.182. Ordering a manual restraint.

(2) Less intrusive techniques and resources appropriate to address the behavior have been tried and failed.

(i) An order for a manual restraint and the application of a manual restraint may not exceed 30 minutes.

Comment

This proposed rule is far more stringent than what is required by the Federal regulations (see 42 CFR 483(e)(2)), which permits a manual restraint for no more than 4 hours if the individual being restrained is between 18–21 years old; no more than 2 hours if the individual being restrained is 9–18 years old; and for no more than 1 hour if the individual is under the age of 9.

To minimize the excessive use of restraints and to minimize the trauma that can arise due to the use of a restraint, this agency already places a one-hour limitation on restraints for clients of any age, and requires that an attending psychiatrist be contacted when the restraint exceeds a half hour.

Limiting restrictive procedures to a half-hour length has the potential to create an unnecessary safety risk for both staff and the client, as it is possible that clients may need to be released from the restraint before they have physically de-escalated. It would also necessitate the creation of a second restraint form and the required additional reporting and debriefing requirements.

Recommendation

§ 5330.182 (i) An order for a manual restraint and the application of a manual restraint may not exceed

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one hour. When the restraint exceeds 30 minutes, the attending psychiatrist must be updated.

§ 5330.185. Application of a manual restraint.

(a) A PRTF shall have at least two PRTF staff persons present during the application of a manual restraint.

Comment

The providers agree that having two staff persons present during the application of a restraint is ideal. However, there are circumstances where this is not possible. For example, if a client who has expressed suicidal intention attempts to elope, a staff person would pursue the client, and if necessary, restrain the client for their safety. At the start of the restraint, it is possible that a second staff person may not be available. Other circumstances include when a staff person transitions the client from one building to another. It is highly unlikely that a second staff person would be physically present to assist with restraint in those circumstances. However, to ensure client staff, our agency has video surveillance cameras monitoring the campus grounds as well as inside the buildings.

There are some providers that are located in well trafficked residential neighborhoods with nearby major highways. They provide services to young and impulsive clients capable of endangering themselves by running in front of passing cars.

Our staff are trained in the state-approved Safe Crisis Management Program, which includes training in applying single-person manual restraints safely.

This proposed rule would result in PRTFs exercising greater caution when considering admitting clients with a history of acute crisis behavior.

Recommendation

We propose that this rule be eliminated.

(e) The following must occur at 10-minute increments during the application of a manual restraint:

i. Within 30 minutes of initiation of a manual restraint or immediately after a manual restraint is removed, a treatment team leader, physician, APP, or RN, who is certified in the use of manual restraints, shall conduct a face-to-face assessment of the following:

(1) The child's, youth's, or young adult's physical and psychological condition.

(2) The child's, youth's, or young adult's behavior.

(3) Appropriateness of the intervention measures.

(4) Complications caused by the use of the manual restraint.

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Comment
This proposed rule halves the federal standard of a one-hour window for the face-to-face assessment to occur. It is likely that clients may not be sufficiently deescalated after the restraint to cooperate with the face-to-face assessment. This standard could be impossible to meet if multiple restraints occur simultaneously on campus. Reducing this window will make it difficult for nurses to meet this standard if multiple manual restraints are being administered on campus simultaneously. It will also make it more challenging for on-call registered nurses to respond on time when called in to complete a face-to-face evaluation, especially in rural areas or in the event of inclement weather.

Recommendation
We propose that the time window for the face-to-face evaluation not be changed from the one-hour time frame prescribed in CFR §483.358.

(k) A PRTF shall notify the child's, youth's, or young adult's parent, legal guardian, or caregiver of the manual restraint within one hour after the manual restraint has ended.

Comment
At times this proposed rule will create an unrealistic burden on the PRTF staff as on occasion multiple clients can be dysregulated at once. The CFR states that the parent/legal guardian contact happen "as soon as possible" but not place a specific time frame in which the contact must take place. Our agency policy requires the contact to occur within the 24-hour window. The proposed one-hour window for parent contact is excessively short by comparison and creates unnecessary potential for regulatory non-compliance on the part of the PRTFs. These regulations do not account for the staff sometimes having to attend to multiple crises on campus and the subsequent administrative tasks that follow.

Recommendation
A PRTF shall notify the child's, youth's, or young adult's parent, legal guardian, or caregiver of the manual restraint as soon as possible, but not longer than within 24 hours after the manual restraint has ended.

§ 5330.187. Documentation of a manual restraint.

(b) Documentation of the use of a manual restraint must include the following:

(10) Written statements from PRTF staff describing the events prior to, during, and following the manual restraint from each PRTF staff person who was directly involved or who observed the manual restraint.

Comment
Federal regulations (§483.358(h)(4) require the documentation of the emergency safe situation that necessitated the restraint. The agency satisfies those requirements by having the restraint team leader document the narrative in the restraint form that includes the client's antecedent behaviors, using the

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Behavior, Intervention, Response (B.I.R.) format.

It should be noted that federal regulations already require the presence of an observer during a restraint and that many PRTFs also utilize recorded video surveillance.

Requiring each participant in the restraint to submit their own written statements is an excessive administrative burden that exceeds federal regulation. This agency notes that if there was an injury or a complaint to arise from the result of a restraint, the Residential Director will require statements from all involved staff members as part of their investigation.

Recommendation
In the event that the restraint results in a client injury, written statements from PRTF staff describing the events prior to, during, and following the manual restraint from each PRTF staff person who was directly involved or who observed the manual restraint.

§ 5330.188. Debriefing.

(b) Within 24 hours after the use of a manual restraint, a face-to-face discussion with the child, youth, or young adult must occur and include the following:

(2) Representatives from the child's, youth's, or young adult's treatment team.

Comment
Requiring representatives of the treatment team, in addition to the PRTF staff involved in the restraint, creates a scheduling and administrative burden and reduces the likelihood that the debrief can occur within the CFR-mandated 24-hour window for the debrief to occur. Representatives of the treatment team are frequently not scheduled to work in the evenings or weekends. Moreover, there is no corresponding federal regulation.

Recommendation
Within 24 hours after the use of a manual restraint, a face-to-face discussion with the child, youth, or young adult must occur and include the following:

(b) Representatives from the child's, youth's, or young adult's treatment team, if available.

(c) The child's, youth's, or young adult's parent, legal guardian, or caregiver, if available.

Comment
This proposed rule exceeds federal regulations regarding child debriefing following a restraint. A client's mental health professional already has the discretion of discussing the events leading up to a manual restraint in family therapy with the client and parent or guardian. Requiring parent or guardian

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participation in each child debrief, when possible, combined with the requirement of having a representative of the client's treatment team in the debrief, will necessarily make it increasingly difficult to schedule these debriefs within the required 24-hour window.

The regulation does not account for the fact that state workers assigned to adjudicated youth will not be available during the evenings and weekends to participate in the debrief.

Recommendation

The agency recommends that this rule be omitted.

(d) Within 24 hours after the use of a manual restraint, the PRTF staff involved in the manual restraint, supervisory and administrative staff, shall conduct a debriefing that includes, at a minimum, a review and discussion of the following:

(1) The circumstances that led to the use of the manual restraint, including a discussion of the precipitating factors.

(2) Alternative techniques that may have prevented the use of a manual restraint.

(3) The procedures, if any, that PRTF staff are to implement to prevent a recurrence of the use of a manual restraint.

(4) The outcome of the manual restraint, including any physical or emotional injuries resulting from the use of the manual restraint.

Comment

This proposed rule appears to require the presence of both a mental health worker supervisor and a PRTF administrator in the staff debrief. We ask for clarification as to who administrative staff are as defined by the regulations. Our concern is that, depending on their definition, administrative staff may not be available to participate in the debriefs due to their schedules.

Recommendation

Propose to eliminate this section.

SECURE PRTF

§ 5330.201. Requirements for a secure PRTF.

(a) A secure PRTF shall meet the following staffing requirements:

(1) During awake hours, at least one mental health worker or PRTF staff person who meets the qualifications of a mental health worker shall provide supervision to every four children, youth, or young adults.

Comments

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Clarification is needed as to whether this regulation intends that separately licensed units co-located in a facility will be required to staff a mental health professional per each unit, or per the facility.

Agencies are experiencing unprecedented challenges in recruiting Master's level and Licensed Clinicians due to the current workforce shortages. Competition with telehealth providers, private practices, and the expansion of the need for this level of clinician at the DHS, primary contractor, and MCO level has added to recruitment issues. It is already challenging to find clinicians willing to work in this level of care. It is unreasonable to expect that agencies will be able to recruit clinicians willing to work evening shifts, particularly in rural areas.

As noted in the comment to § 5330.48 (d), requiring non-traditional hours for MPHs will make the PRTF's recruiting and retention of MPHs more difficult.

Recommendation
A mental health professional shall be present at the PRTF for 75% of the waking hours. A mental health professional shall be on call for the remaining 25% of the hours and available to provide telehealth or report to campus to provide support if needed.

§ 5330.202. Exceptions for a secure PRTF.
A secure PRTF shall comply with the requirements of this chapter, except for the following:

(1) Section 5330.42(d)(1) (relating to staff requirements).
(2) Section 5330.42(e)(1).
(3) Section 5330.82(c) (relating to bedrooms).
(4) Section 5330.92 (relating to unobstructed egress).

RECORDS

§ 5330.211. Emergency contact information.

(c) The emergency contact information for each child, youth, or young adult shall accompany the child, youth, or young adult when the child, youth, or young adult is not at the PRTF.

Comment
Is this including every outing? Increase of chances that information could be lost in the community and be a HIPAA violation. If there is an emergency, the staff would call 911 and the center immediately. The family would be notified but most likely not by the staff dealing with the emergency.

Recommendation
Permit current standard to remain in place.

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§ 5330.212. Child, youth or young adult record.

(a) A PRTF shall store child, youth, or young adult records in a secure location.

Comment

Please define a secure location.

(b) A PRTF shall maintain a record for each child, youth, or young adult it serves that includes the following:

Comment

All of this information is requested but not always provided by agencies and/or parent, guardian, etc.

(1) Identifying information as follows:

(i) The child's, youth's, or young adult's name, gender, gender identity, admission date, birth date, and social security number.

Recommendation

Propose birth certificate ***or*** SSN

(ii) The child's, youth's, or young adult's race and ethnicity, height, weight, hair color, eye color, and identifying marks.

Comment

Information requested but do not always receive.

(5) A treatment plan and updates to the treatment plan.

(7) Documentation of each service provided, including the following:

(i) Date and time a service is provided, duration of service, and setting where the service is provided.

Comment

Does duration refer to how long the appointment is?

(iii) Description of the outcome of the service provided.

Comment

Please define outcome? e.g., dental cleaning – what is the outcome – clean?

(10) Plan for discharge in accordance with § 5330.147 (relating to discharge).

Comment

The guardian sometimes will just state "less restrictive" with no further detail.

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§ 5330.213. PRTF record.

(a) A PRTF shall store its records in a secure location.

Comment

Please define secure location.

(b) A PRTF shall maintain records that contain the following for at least four years:

Comment

This is significantly shorter than the current standard.

(5) Written agreements to coordinate services in accordance with § 5330.12 (relating to coordination of services) that must be maintained by a PRTF and updated annually.

Comment

Purpose of updating annually if nothing has changed? The proposed regulation represents additional excessive administrative burden.

(6) Daily schedules for services and activities.

Comment

Please clarify daily schedules; is this for a unit? For a specific child?

(c) A PRTF shall maintain PRTF staff personnel records that include the following for at least four years after the PRTF staff is no longer employed by the agency:

(2) Work schedules and time sheets.

Comment

This is maintained by the time clock or electronic systems. Would a hard copy be required?

QUALITY ASSURANCE

§ 5330.221. Quality assurance requirements.

(a) A PRTF shall establish and implement a written quality assurance plan that meets the following:

(2) Provides an annual report of services provided by the PRTF that includes the following:

General Comment

The §5330 regulations do not have quality assurance requirements. This agency already has a quality

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assurance program which already accomplishes several of the requirements of the proposed annual report, including a restraint reduction analysis, program review, and staff, client, and parent satisfaction surveys. However, meeting 5330.221(a)(2)(iii) "Assessment of delivered service outcomes and if treatment plan goals have been completed" would require additional staffing hours from a qualified staff person, at least a mental health professional, adding additional annual expenses.

(i) Review of individual records for compliance with this chapter.

(ii) Review of individual and parent, legal guardian, or caregiver satisfaction information.

(iii) Assessment of delivered services outcomes and if treatment plan goals have been completed.

Comment

Please clarify this section – our children have many treatment goals. Is this a general review of our outcomes and if so, please provide us with further guidance on the components of such a report.

(iv) Evaluation of compliance with the PRTF's approved service description.

Comment

Would a licensing certificate be satisfactory in satisfying this section?

(c) A PRTF shall provide written notification that a copy of the annual report may be requested at any time by a child, youth, young adult, parent, legal guardian, or caregiver upon the child's, youth's, or young adult's admission to the PRTF.

Comment

Is the annual report based on licensing date, calendar year, or fiscal year? Please clarify.

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