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Independent Regulatory Review Commission

November 26, 2024

BEACON LIGHT
BEHAVIORAL HEALTH SYSTEM
AN AFFILIATE OF JOURNEY HEALTH SYSTEM

To the Members of the Independent Regulatory Review Commission:

Children's Center for Treatment and Education, D.B.A., Beacon Light Behavioral Health System has extensive experience in providing Psychiatric Residential Treatment Facilities (PRTF), Children's Community Based Services, Adult Community Based Services, Licensed Outpatient Clinic, Education, Student Assistance Program and Prevention Services throughout rural Pennsylvania. It is our vision to "advocate passionately for the individuals and families we serve", and we do this by focusing on providing high quality trauma informed care throughout the organization. Our PRTF programs have been designed to serve the most complex of youth and we consistently provide the staffing levels, clinical interventions and supervision necessary to facilitate positive outcomes. We are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

We support the department's intent of improving care, safety and outcomes for those individuals receiving treatment in a PRTF, however recognize that there will be significant programmatic and financial barriers to implementation of these proposed regulations. Pennsylvania is experiencing unprecedented shortages in the behavioral health workforce, which are anticipated to continue for years. There is limited availability of Psychiatrists, Psychologists, Advanced Practice Professionals, Registered Nurses, Licensed Practical Nurses and Licensed Counselors throughout the state. There is also a decline in individuals interested in choosing behavioral health or in remaining in such a role as a long term career. These issues are exacerbated in our more rural communities.

As the need for behavioral health services have grown, seasoned clinicians have been migrating from providing direct services to Medicaid/Managed Care recipients through licensed providers. Licensed clinicians have been moving to independent private practice models that are not obligated to the regulations, documentation and quality activities that are required of licensed providers. They have moved to models of care that encourage telehealth and flexible schedules as a primary means of service delivery. They are content with providing quality and oversite activities within managed care organizations and primary contractors, that remove them from providing direct services to those individuals most in need. Licensed behavioral health programs are in direct competition for staff with hospitals, school districts, private practices, managed care organizations, human services organizations and primary contractors. There simply aren't enough qualified staff within the state, and particularly in rural communities, to support the current needs. It is improbable to assume that PRTF's will be able to secure the staff to the level required by these regulations.

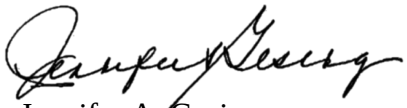
As a member of the Northwest Region Workforce Development Board, I have been involved in ensuring that the High Priority Occupations List for this region has been updated to include those behavioral health occupations critical to developing career pathways that enhance the behavioral health workforce and ultimately improve access and outcomes for those needing care. By limiting the age of mental health workers to 21 and requiring one year of prior experience working with children, these regulations will effectively remove the ability for high school graduates or those engaged in higher education to develop an interest in human services as a profession, or to gain the experience requirements necessary to work in other OMHSAS licensed programs. These proposed regulations and the requirements for entry level mental health workers will have a devastating impact on the behavioral health continuum long term.

There is data to support that PRTF's will be unable to effectively recruit to the levels mandated within these proposed regulations and will therefore be unable to maintain the current PRTF bed capacity. This will create additional strain on a system that is already experiencing the effects of the lack of availability of both PRTF and Inpatient levels of care, particularly for those individuals with the most complex needs. These proposed regulations will only add to the lack of availability of services in all levels of care, which is contradictory to the Governor's efforts to improve access to behavioral health services. Similar outcomes were realized with the implementation of the Intensive Behavioral Health Services regulations in 2019 due to the changes in staffing and documentation requirements therein, and the availability of services has not rebounded.

There will also be negative financial impact to providers, managed care organizations, and to the current state Medicaid/managed care budget should these proposed regulations be approved as presented and implemented within the timeframes and procedures that have been outlined. There is no evidence to support that the changes proposed in these regulations will improve overall quality, safety, access or outcomes for those individuals and families utilizing PRTF services.

I have included a detailed review of the barriers to implementation of these regulations and have provided alternative recommendations. I appreciate the committee's review and consideration.

Respectfully Submitted,



Jennifer A. Gesing
Executive Director

Number	Description	Regulation	Comment	Recommendations
1330.2	Definitions	PRTF- A residential Facility that provides services to treat the behavioral health needs of children, youth or young adults under the direction of a psychiatrist.	Are the proposed regulations herein determined by licensed site or by agency? Some agencies offer specialized programs that are distinct by service description/license, but that are co-located within one main facility as separate units. Can the staffing, nursing and supervisory responsibilities be shared between licensed programs co-located at one site although under separate license? Requiring these roles per licensed unit will be financially and operationally prohibitive to providers.	Ensure that the regulations support the allocation of the medical director, clinical director, social work supervisor, program director, director of nursing within one organization. Allow for onsite nursing, staff and supervisor coverage (particularly overnight) per building and not per licensed program.
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.	Does not include individuals who are private insurance or county funded only. How would this affect audits/licensure and rate determination?	Clarify whether these regulations will be applied for all payer groups.

1330.21	Participation	Comply with the special provisions applying to psychiatric hospitals set forth in 42 CFR 482.60 (relating to special provisions applying to psychiatric hospitals- (d) Meet the staffing requirements specified in §482.62.	42 CFR 482.62(d)- Nursing services- (d) Standard: Nursing services. T*he hospital must have a qualified director of psychiatric nursing services.* In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient's active treatment program and to maintain progress notes on each patient. *(1) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill.* The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished. (2) The staffing pattern must insure the availability of a registered professional nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program. Each agency will be required to designate a Director of Nursing who meets these requirements. This will add additional cost that is not accounted for in the cost	Clarify whether a director of nursing is required within the staffing compliment. Clarify whether there is a recommended nurse to patient ratio.

			projections. Related to the staffing pattern, is there a minimum nurse: patient ratio? (We'd been previously advised by OMHSAS this is 1:12 however that is not identified in these proposed regulations). Alignment of PRTF regulations with inpatient hospital requirements is excessive if not required in the Federal PRTF regulations. Providers will be unable to recruit the staff necessary to comply with these proposed regulations.	

1330.21	Participation	Comply with the special provisions applying to psychiatric hospitals set forth in 42 CFR 482.60 (relating to special provisions applying to psychiatric hospitals (d) Meet the staffing requirements specified in §482.62.	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 needs of the mentally ill. If the director does not hold a master's degree in social work, at least one staff member must have this qualification. This additional requirement is not articulated in the required staffing. Agencies will need to recruit a social work director or at least 1 staff who is an MSW.	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.

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 [the effective date of this final form rulemaking].	b. 12 months to comply is a short period given the extensive recruitment activity that will need to occur to fill key positions, particularly psychiatrists and mid-levels. Many of these professional positions have 120-180 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.	Provide 24 months from promulgation for providers to meet these requirements.
1330.31	General Payment	c. If a PRTF is rendering services to a young adult before the 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.	c. Continuing to provide this service beyond the age of 20.99 will force PRTF's to develop policies that acknowledge the rights of that adult, including potentially 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?	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 Mental Health Procedures Act (MHPA).

1330.32	Conditions for Payment	(a)3 MA will pay a PRTF if the following conditions are met: The independent team is independent of the psychiatrist who completed the psychiatric evaluation and the PRTF that is being recommended.	a3- 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 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 PRTF's operate. How will the state assist in creating a system to ensure that these youth are eligible for PRTF treatment in their home communities, as this barrier will only increase as the systems will need to recruit additional psychiatrists to meet the required supervision, oversite and clinical involvement?	Consider removing this proposed regulation, or develop a system at the state level that provides for independent review of necessity in such cases.
1330.32	Conditions for Payment	(b) MA will pay a PRTF if the following conditions are met: The child's, youth 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).	b. 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?	Clear guidance to MCO's 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	a2 Payment for hospital reserved bed days is limited to 15 cumulative days per child, youth or young adult regardless of whether the child, youth, young adult was in continuous or intermittent treatment at one or more PRTFs during the calendar year.	a2- 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, chemical and mechanical restraint to monitor excessively high risk behavior that is outside the scope of PRTF.	It is recommended that hospital bed days be reloaded at each new admission to PRTF for those youth who are identified as complex. Additionally, it is recommended that the complex case review teams develop a system for collaboration and joint care planning between hospitals and providers that allow for ease of admission/readmission to a designated in patient facility if the need arises.
1330.34	Allowable costs	The Department uses Medicare principles as established by the Social Security Act (42 USCA 301-1397mm) and Federal regulations and instructions as a basis for determining what cost items are allowable for the purposes of MA reimbursement.	Please provide reference to the specific chapter that is referenced.	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. Standards should be applied consistently between ODP, DDAP and OMHSAS licensed programs.

1330.37	Related Party transactions	(a) A PRTF shall include in its allowable costs, service 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.	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.	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%.
1330.38	Nonallowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs and are not included in the PRTF's per diem rate. a2- Administrative costs of more than 13% of allowable MA costs.	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, Recruitment. Additionally, agencies will also have local administration (which would include medical director, clinical director, executive director, insurance, etc.)	The 13% threshold should increase to account for Management services organizations (related party). Recommendation for threshold of 15%.
1330.38	Nonallowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs) and are not included in the PRTF's per diem rate. a5. Education costs associated with a child's, youth's or young adult's individual educational plan, individual	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	Further collaboration and joint clarification from PDE and DHS is needed. PRTF's should not be expected to provide supervision during onsite education without reimbursement.

		family service plan or treatment plan which are to be paid for by the child's, youth's or young adult's school district.	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 in cases in which the student is identified as regular education. Will districts be required to reimburse PRTF's when homebound or onsite instruction requires support from PRTF staff? Will there be an updated BEC to follow?	
1330.38	Nonallowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs and are not included in the PRTF's per diem rate. (a)(7) Costs for a service if payment is available from another public agency, insurance or health program or any other source.	Providers will be required to redesign accounting systems in order to remove expenses related to individuals with private insurance in order to meet this regulation. This will be a costly and time consuming endeavor. Does the department intend to financially assist providers in meeting this mandate?	Further consideration needs to be given as to the financial and operational impact to providers.

1330.38	Nonallowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs and are not included in the PRTF's per diem rate. a9 (all) Costs associated with the following : Staff recognition such as gifts, awards or dinners, staff social functions such as picnics or athletic teams	These incentives are necessary to recruitment/retention activities.	Define a reasonable percentage of expenses that providers may utilize for incentives to staff.
1330.38	Nonallowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs) and are not included in the PRTF's per diem rate. (a)(9)(ix) Meals for visitors.	On-site visitation with family is encouraged and is a valuable part of the treatment process. At times, the visits occur during mealtimes, which allows the staff to assist the family in skill development with the youth. Such meals should be allowable when identified as interventions on the treatment plan.	Reimburse providers for medically necessary treatment engagement activities with parents/guardians/custodians.
1330.38	Nonallowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs and are not included in the PRTF's per diem rate. (xv) bad debt and contractual adjustments.	The third party liability (TPL) process remains an issue for several MCO's with some not accepting EOB's from private insurers. Some MCO's indicate that EOB's don't contain necessary information for processing. In addition, the PROMISe system doesn't update timely 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	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.

			authorizations, which leads to unpaid days of service/bad debt. These issues need to be reviewed and addressed at the state level. In order to collect, PRTF providers are spending a great deal of time resolving TPL issues, leading to additional admin costs, which is why the 13% administrative cost 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.	
1330.38	Non allowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs) and are not included in the PRTF's per diem rate. (xvi-xviii, xxii) Barber and beautician services, personal hygiene items, children, youths' or young adults allowances, clothing and shoes for children, youth or young adults receiving services in the PRTF.	It is unreasonable to expect PRTF programs to not be reimbursed for these costs if the facility is required to provide. 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. Clean and seasonal clothing that is age and gender appropriate is considered a right, as per 5330.31 (5). Additionally, personal care and hygiene are basic needs that PRTF's are required to provide (5330.83), and can be tremendous drivers in the treatment process. These are part of the social determinants that play a critical role in overall health and should be addressed as part of the clinical process. Programs should be reimbursed to provide these areas accordingly. ODP presently reimburses such costs for ICF's.	Consider Barber and beautician services, allowances, clothing and shoes, for children, youth, young adults as allowable expenses as they are necessary to the individual's well-being and are basic needs.

1330.38	Non allowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs) and are not included in the PRTF's per diem rate. (xx) Meals for staff, except for meals provided during training activities documented in a child's, youths or young adult's treatment plan.	Staff are expected to take meals with the youth to ensure adequate supervision. Additionally, these mealtimes are an opportunity for skill development. This should be reimbursed as part of the cost of providing this level of service without articulation in each individual treatment plan.	Reimburse for staff meals for those staff supervision/in ratio during mealtimes.
1330.38	Non allowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs) and are not included in the PRTF's per diem rate. (xxiv) Transportation and living costs associated with onsite visits by parents, legal guardians or caregivers.	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 for family members due to location of the PRTF, and PRTF's do provide gas cards or hotels fees 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.	Establish MATP reimbursement for parents traveling to medically necessary visitation/therapy in a PRTF or allow PRTF providers to account for this cost.
1330.38	Non allowable costs	The following costs are excluded from the operating costs described in 1330.34 (relating to allowable costs) and are not included in the PRTF's per diem rate. (xxxiii) Parties and social activities not related to providing care to children, youth or young	If agencies will be expected to fundraise in order to support unreimbursed incidentals, 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.	Reconsider Nonallowable costs.

		adults receiving services in the PRTF		
1330.38	Non allowable costs	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.	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.	Consider reimbursement to providers who must pay out of pocket for required services.
1330.38	Non allowable costs	The following services are not included in the per diem and may not be included as a cost for the PRTF. The department will not contribute to a return on equity for proprietary programs.	Please explain this regulation. Is this related to retained revenue?	Clarification is needed.
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.	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.	Consider extending until October 30. Provide on-going web based training to DHS staff as well as providers as to the expectations and process.

1330.40	Rate Setting	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.	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.	Develop a bonus structure for those providers effectively managing expenses, maintain stable staffing and operating at a census capacity above 85%.
1330.40	Rate Setting	Per diem rates will be established as follows (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 bed days counted as actual days of services may not be filled.	Days in which an individual is hospitalized but the reserve bed days cap 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.	Establish method to reimburse providers for unpaid hospital bed days if the youth is expected to return to care. Eliminate the hospital bed day cap and allow providers to claim these days on cost reports.

1330.40	Rate Setting	Per diem rates will be established as follows a(4) The projected operating costs will be established as follows (ii) for an existing PRTF, an annual cost report filed September 30 as specified in 1330.39, including adjustments for income and Nonallowable, limited and excluded costs, as determined by the Department is used to determine projected operating costs.	Annual rate setting in this manner doesn't allow for adjustment of rates should additional unplanned expenses be realized. In addition, it has been conveyed that providers will not see rate increases prior to the activation of these regulations. Providers will be expected to complete an initial cost report within 90 days of the implementation of these regulations, effectively not receiving reimbursement for the increased costs associated with these regulations. The similar rate setting process for ICF's can take months before final rate approval. With the current staffing shortage and market fluctuations, it will be necessary for providers to adjust salaries as the market dictates. It is recommended that rates be determined prior to implementation and that ongoing, a method for rate adjustment mid-year 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.	Establish a process for initial rate determination prior to implementation of the regulations. Create a process for mid-year review as necessary based on a provider's financial position.
1330.40	Rate Setting	Per diem rates will be established as follows: (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	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.	Allow personal hygiene items, haircuts, and clothing expenses to be considered in the PRTF rate determination.

		by the PRTF or any other entity with which the PRTF may have an agreement to provide such services.		

5330.30	Definitions	Staff- Individuals employed by a PRTF on a full-time or part-time basis. Staff includes contracted staff, temporary staff, volunteers and interns.	In some circumstances, interns may be onsite for a brief period, as observers only, depending on the type and scope of the placement. Similarly, there may be situations in which volunteers are participating with the facility for short periods of time. In these examples, these individuals would never be responsible for care or control of the youth.	Consider clarifying the definition of Staff to "Individual's employed by a PRTF on a full-time or part-time basis. Staff includes contracted staff, temporary staff, volunteers or interns who may be responsible for care, treatment or supervision of the children, youth or young adults receiving care in the facility."	
5330.40	Licensure and Certificate of Compliance	(b) A residential treatment facility licensed under Chapter 3800 that provides the services of a PRTF as of [*the effective date of the final-form rulemaking*] shall comply with this chapter by *[12 months after the effective date of the final-form rulemaking*].	Given the level of additional professional staff required by these regulations, specifically licensed professionals, it is unlikely that PRTF's will be able to meet the requirements within a 12 month period of time. Many of these professional positions (MD/DO, APP, Licensed therapists) have contracts that require a minimum of 90-120 days notification of contract termination. Additionally, with the current staffing shortages of these professionals within Pennsylvania and nationally, it can reasonably be expected that the licensing process for out of state professionals will be lengthy. Finally, all providers will need to be enrolled/credentialed with third party insurances and PROMISe, which is also a lengthy process. Lastly, it is expected that there will be a need to recruit MD/DO's from outside of the country in order to fill the needs articulated in these regulations. The Visa process takes an excessive amount of time and will also have significant financial ramifications or organizations.	Extend the timeframe for implementation to 24 months. DHS should also plan to streamline and expedite the licensing and enrollment processes prior to this implementation. Finally, DHS should revisit recruitment incentives related to the Visa process for MD/DO, Advanced Practice Professionals and Licensed therapists.	

5330.40	Licensure and Certificate of Compliance	(4) Comply with the requirements of Articles IX or X of the Human Services Code (62 P.S. §§901-1088) Section 916 Recommendations- The department shall have the power, and its duty shall be, from time to time, to recommend and bring to the attention of the officers or other persons having the management of the State and supervised institutions such standards and methods as may be helpful in the government and administration of such institutions and for the betterment of the inmates therein, whereupon it shall be the duty of such officers or other persons to adopt and put into practice such standards and methods.	The agency would like to take the opportunity to address this regulation related to the implementation of recommendations made by licensing representatives. It is not common for each licensing representative to have a distinct perspective on the implementation and applicability of certain practices, language, or procedures. We've had scenarios where representatives have asked our agency to make changes to forms or processes to make it easier for representatives to review the information. At times these recommendations are subjective and vary vastly between licensing representatives. This leads to confusion between providers and within organizations, particularly when opinions are not applied with uniformity. Modifications to E HR's, processes and workflows can be costly and should not occur unless absolutely necessary due to a potential safety concern.	Provide clarification as to the recommendation process such that recommendations should be offered following the summation of the visit and after supervisory approval by DHS (OMHSAS). Additionally, regulatory guidance documents need to be established for all licensed programs, with detailed instruction to representatives as to the nature of the regulation and the content/processes therein.	

5330.12	Coordination of Services	(a) A PRTF shall have written agreements to coordinate services with other service providers, including the following (3) Peer Support Providers.	In most areas, Youth Peer Support has not been established. Does the department intend for providers to form agreements with Adult Peer Support providers? There may be barriers in execution of this regulation.	Acknowledge the establishment of letters of agreement with Peer Support providers for children, youth, and young adults, if available. Provide clarification to agencies and licensing representatives.	
5330.12	Coordination of Services	(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.	Updating letters of agreement annually is excessive and leads to additional administrative activities for the PRTF. Providers should be able to work together to arrange for standing letters of agreement with provisions that include updating when there are significant changes that would critically affect the agreement.	Clarify that multi-year letters of agreement are acceptable when there are provisions to address when updates are required within the agreement.	
5330.12	Coordination of Services	(c) A PRTF shall have an affiliation or a written transfer agreement with at least on hospital that participates in the Medical Assistance Program. The affiliation or transfer agreement must reasonably ensure the following: (1) A child, youth, or young adult will be transferred from a PRTF to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care. (3)Services are available to each child, youth or young adult at all times.	Few, if any hospitals are willing to work with PRTF providers to allow for direct admission, even when the PRTF MD/DO agrees to collaborate with the physician at the hospital. In almost all circumstances, evaluation through the emergency department (ED) is required prior to the hospital considering admission and there are no guarantees that the child will be admitted. Similarly, there is no method for transferring an individual (who has not completed a referral process or is not a current admission), to a PRTF from the hospital without completing a referral process. How will the department assist in establishing guidelines for inpatient hospitals that will require transfer in a timely manner, effectively bypassing the ED? (See Title 28 Ch. 105.12) How will the department ensure processes that allow PRTF providers to also	The department will need to facilitate collaboration with inpatient hospitals, in partnership with the Department of Health, to encourage them to alter the processes associated with assessment for inpatient care (specifically medical clearance), prior authorization of care, and requirements for admission. Similarly, the department will need to establish a prior authorization process for PRTF's that encourages effective transition when necessary.	

			admit timely? This would include the development of preauthorization, insurance verification and contracting processes at the department level that allow for timely access to care.		
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:	The change in reporting requirements to 12 hours rather than 24 places undue administrative burden on providers. There is no rationale to decrease reporting timeframes unless the department intends to decrease departmental in person response times as a result. Additionally, not all incidents required to be reported are considered critical events, specifically relating to short term utility outages.	Reconsideration should be given to decreasing response times in an effort to reduce administrative burden on providers. The proposed regulation implies that death of a child is similar in severity to temporary utility outage, which is not the case. Additionally, the level of additional reporting will require the addition of clerical/administrative staff for organizations (particularly on weekends), which is not included in the budget analysis.	
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: (4) Disruptions to water, heat, power or cooling at a PRTF.	This regulation places excessive reporting demands on PRTF providers, particularly those in rural areas that may be prone to frequent but minor outages. It is not uncommon to have temporary outages, particularly electrical, that may involve disruption for minutes to hours, with no significant impact to the facility or individuals within. Additionally, at times there may be forced outages within the facility to make necessary repairs or to test equipment. It is not necessary to report all outages, only those which cause disruption or involve activation of the emergency plan.	Consider revising to indicate that "unscheduled disruption to water, heat, power or cooling at a PRTF that results in disruption to facility activities and/or activation of the facility's emergency plan". Additionally the department should consider that this level of disruption is not and should not be treated as a critical event, such as death of a child.	

5330.14	Reportable Incidents	(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. (5) Incidents of physical assault involving a child, youth, young adult or PRTF staff.	Further definition is needed related to "physical assault" to include clarification related to peer to peer aggression and client to staff aggression. It is not uncommon, particularly when working with individuals with developmental disabilities/autism, for these individuals to physically strike at each other or at staff. Although the incident may not result in physical injuries to the victim, as written, this regulation would require facilities to report minor aggressive acts that would typically be appropriately addressed through a behavior plan. Would facilities effectively utilizing Ukeru as an alternative to restraint be required to report assaultive behavior although blocking pads may be utilized successfully for safety? Additionally, what is the intent of requiring this information? Will the department utilize the data collected to assist in transfer or alternative programming for a highly aggressive individual? Collecting data without an informed plan on how that data will be utilized is misguided.	Consider clarifying the definition of physical assault to include "any incident that results in physical injury requiring treatment (including first aid) and/or which results in criminal charges".	

5330.14	Reportable Incidents	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. (13) Medication error as specified in 5330.165 (relating to medication error.	Further clarification is needed regarding regulating medication errors by requiring them to be entered into the information management system. Providers, particularly those who are JCAHO accredited, have comprehensive quality performance processes related to this issue. What is the intent of requiring this information? If the intent is to review provider performance (i.e. safety), there is no way to do so without also reporting the total number of dosages administered during that same timeframe. For example, within our agency in October 24, there were 13 total medication errors impacting 8 youth out of 16,140 medications passed. This is a medication error rate of 0.08%.	Consider modifying this regulation to require providers to report only, "medication errors that result in adverse effects to the child, youth, transition age youth". Review of performance related issues can (medication error rates) better be achieved by reviewing quality performance activities in this area during on site licensing reviews.	
5330.15	Recordable Incidents	(a) A PRTF shall maintain a record of the following recordable incidents: (2) Suicidal gesture or verbal threat of suicide or harm to self or others.	Many of the children, youth, and young adults in care resort to verbal threats to self or others as a means of aggression, although there is no intent, plan or furtherance to these acts. Requiring all such threats to be recorded within the record is unreasonable, given the frequency to which these occur. Clinical teams should be addressing these issues through behavioral analysis/behavioral planning, which should suffice for documentation in this areas. It is reasonable to expect providers to record incidents in which there is determined to be intent, plan or furtherance however providers should maintain the ability to determine when such reporting is necessary.	Consider revising to include: " Suicidal or homicidal threats or ideations when, upon clinical assessment by a mental health professional, there is determined to be intent, plan and/or furtherance of the act."	

5330.15	Recordable Incidents	(a) A PRTF shall maintain a record of the following recordable incidents: (4) Search of a child, youth or young adult or the child, youth or young adult's property.	Many children, youth or young adults in a PRTF program receive education in the public school or in a private institution as directed by OMHSAS bulletin 10-02 Educational Portions of "Non-Educational" Residential Placement and the subsequent BEC provided by PDE. Residential staff do not have care and control of these youth during the course of the school day, and these youth can and do have contact with students from the community. Given that many of the youth in care, who may receive education outside of the PRTF program, display behaviors associated with self-injurious, risky or aggressive behavior, PRTF programs frequently search youth upon return to the facility from school or other pro-social activities, to ensure that there are no materials in the youth's possession that could be used to further any act of harm to self or others, or any risk of drug/alcohol/tobacco use or supplying that could affect the youth or other youth's in the program. Individually documenting each of these searches with a recordable incident report is a documentation burden that can be reduced by requiring these type of searches be identified in the restrictive procedure plan instead of as recordable events.	Consider revising to include: "searches of a child, youth or young adult's property that are not related to on-going behavior or standard program processes as defined in the restrictive procedure plan".	

5330.18	Confidentiality of Records	(b) Information relating to a child, youth or young adult may only be shared if a signed authorization or release is obtained from the youth or young adult or the child's, youth's or young adult's parent, legal guardian or caregiver.	This regulation is more restrictive than the current Health Insurance Portability and Accountability Act. Programs do have the ability to determine release of information for treatment, payment or healthcare operations purposes or in the course of incident reporting to various entities.	Consider revising to "Information relating to a child, youth or young adult may be shared if a signed authorization or release is obtained from the youth or young adult or the youth's or young adult's parent, legal or guardian or caregiver, or as per the requirements set forth in the Health Insurance Portability and Accountability Act and 42 CFR Part 2, or when a valid Business Associate Agreement is in place, as applicable."	
5330.18	Confidentiality of Records	(c) Information relating to the parent, legal guardian or caregiver of a child, youth or young adult may not be shared without an authorization of release of information from the child's, youth's, or young adult's parent, legal guardian or caregiver.	This regulation is more restrictive than the current Health Insurance Portability and Accountability Act. Programs do have the ability to release information for treatment, payment or healthcare operations purposes or in the course of incident reporting to various entities. It is not uncommon for such information to be shared during the course of multidisciplinary team consultation that is pertinent to the care and treatment of the family. Additionally, such information may be shared during incident reporting or incident investigation.	Consider revising to "information related to a parent, legal guardian or caregiver of a child, youth or young adult may be shared if a signed authorization or release is obtained from the youth's or young adult's parent, legal or guardian or caregiver, or as per the requirements set forth in the Health Insurance Portability and Accountability Act and 42 CFR Part 2, or when a valid Business Associate agreement is in place, as applicable."	

5330.18	Confidentiality of Records	(d)(3) 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: (3) How the PRTF will ensure that the 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.	A PRTF program has no way to "ensure" that a child, youth's or young adults or staff's social media does not contain identifying information about a child, youth or young adult served by the PRTF. No organization has the capability to monitor activity to the level perceived in this regulation. While agencies can train clients on the risk of social media, and can train staff on the policies related to social media, and can enforce sanctions against staff who do not comply (when identified) agencies cannot "ensure" that this will never happen. Is the expectation for agencies to monitor clients and staff's social media accounts as implied in this regulation? If so, this will be administratively cumbersome and costly for agencies to execute.	Consider revising to: (d)(3) "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: (3) social media use."	
5330.20	Visits	(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.	This regulation is restrictive to PRTF's but also intrusive to families. In some circumstances such level of contact may be necessary, however the frequency of such contact should be determined by the treatment team, which includes the family. PRTF's should determine frequency of contact as based on the assessment of clinical needs of the youth and family, and revise the visit plan to include the level (restrictiveness) of facility contact necessary to support the family, in collaboration with the family.	Consider revising to: "A PRTF Treatment Team, in collaboration with the family, shall assess the need for frequency of communication between the family and PRTF during visitation. The visit plan shall include this information."	

5330.31	Rights	A child, youth or young adult has the right to the following: (5) clean and seasonal clothing that is age and gender appropriate.	Under the proposed regulation 1330.38, clothing is considered a non-allowable cost. If considered a basic right that PRTF's are obligated to provide when families can't, it should be considered an allowable cost and thereby included in the rate determination process.	Include clothing as an allowable expense for PRTF's.	
5330.31	Rights	(b) A child, youth or young adult has a right to the following: (18) To visit with the child's, youth's or young adult's parent, legal guardian or caregiver at reasonable hours at least once each week, at a time and location convenient for the parent, legal guardian or caregiver, the child youth or young adult and the parts, unless the parent, legal guardian, or caregiver is prohibited from visiting by court order or the child's, youth's or young adult's treatment team has determined that the visit with the parent, legal guardian or caregiver would negatively impact the child's youth's or young adult's treatment, safety or well-being.	This regulation defines visitation as a right however regulation 1330.38 (xxiv) indicates that Transportation and living costs associated with onsite visits by parents, legal guardians or caregivers are not allowable. PRTF's frequently assist in financing transportation and living costs for such visitation, particularly when families cannot afford to do so. This level of visitation is often necessary to the treatment process.	Include transportation and living costs associated with onsite visits by parents, legal guardians or caregivers as allowable costs.	

5330.31	Rights.	(b) A child, youth or young adult has a right to the following: (21) To have access to a telephone designated for use by children, youth or young adults.	It is agreed that youth in care should have the ability to make telephone calls however PRTF providers need to be able to manage utilization of the telephone. It is not uncommon for youth to attempt to contact individuals that they should not be contacting, or to use the telephone to make arrangements for elopement. Additionally, there is a risk of inappropriate contact of emergency services when these calls aren't monitored. PRTF's should have the ability to limit access during certain times, monitor contacts, and also supervise calls when needed. Parents, caregivers, legal guardians should have the ability to determine individuals whom the youth may contact.	Consider revising to: "have the ability to telephone individuals identified on the individual's contact list, during times established by the PRTF program and with the frequency and supervision as determined by the youth's treatment team."	

5330.41	Supervision of Staff	a. A PRTF shall have a written policy and procedure on the supervision of PRTF staff that includes the following: a1. A medical director shall provide the following to an RN, clinical director or and APP. i) One hour of face-to-face supervision every month. ii) Thirty minutes of direct observation of the provision of services every 6 months.	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.)	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 DON.	

5330.41	Supervision of Staff	a. A PRTF shall have a written policy and procedure on the supervision of PRTF staff that includes the following: a2 (ii) 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 6 months. Each occurrence of direct observation of services shall be for at least 30 minutes.	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.	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.
5330.41	Supervision of Staff	a. A PRTF shall have a written policy and procedure on the supervision of PRTF staff that includes the following: § 5330.41 (a) (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 2 hours of supervision, 1 hour shall be face-to-face. (ii) One hour of direct observation of the provision of services every 6 months. Each occurrence of direct observation of services shall be for at least 30 minutes.	The program director should provide this level of supervision to the mental health worker supervisor rather than the Clinical Director. The Clinical Director and/or designee can provide trainings on clinically related topics but skill based supervision should remain with the program director.	It is the position this agency that the supervision of the mental health workers remains with program director.

5330.42	Staff Requirements	a. Staff working in a PRTF shall be 21 years of age or older.	This change in regulation excludes individuals over 18 who may be furthering education in a clinically related field. PRTF's have often been identified as entry level in the behavioral health workforce. This regulation limits the ability to build pathways from high school to higher education and inhibits the ability for individuals with associate's degrees or 60+ credit hours, or even bachelor's degrees to gain the experience qualifications for community based positions that require 1 year+ of prior experience working with children. (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.	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 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, there could be an exception for students enrolled in clinical field work, or higher education in a clinical field.

5330.42	Staff Requirements	b. At least 2 PRTF staff persons who are trained in the use of manual restraints shall be present and available at the PRTF at all times.	-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 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. - PRTF's that are individually licensed units with a census of 12 or below that are co-located 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	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 2 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.

			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.	

5330.42	Staff Requirements	During the PRTF's awake hours, the following requirements must be met: (c) (2)(d)(2). PRTF staff providing supervision shall always be within auditory and visual range of children, youth or young adults.	Oftentimes clients will utilize personal time outs 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 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.	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.

5330.42	Staff Requirements	During the PRTF's awake hours, the following requirements must be met: (c) (3) A mental health professional shall be present at the PRTF.	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.	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.
5330.42	Staff Requirements	During the PRTF's awake hours, the following requirements must be met: (e) (2). When 12 or more children youth or young adults are present at the PRTF at least one supervisory staff person shall be physically present at the PRTF for every 12 children, youth or young adults.	A facility that has 3 separately licensed units (8, 10, and 10 clients) per this regulation would be required to have a 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 costly addition, it is unlikely that programs will be able to recruit the additional supervisory level staff necessary to meet this regulation.	Clarification is needed as to whether each licensed unit will require a supervisor if census is less than 12, or of due to the units being co-located 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.

5330.45	Clinical Director	(a) A PRTF shall have a clinical director.	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 1 year of experience in treating children, youth or young adults with behavioral health needs.	In a time when there are significant nursing shortages it is unrealistic to require that nurses have at least 1 year 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 PRTF's at a recruiting disadvantage. (See 49 Pa Code 21.7 Temporary Practice Permits for reference).	Remove the 1 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 required to provide the nurse with additional training.
5330.48	Mental Health Professional	(d) The mental health professional's caseload may not exceed eight children, youth or young adults.	While it is preferred to maintain a 1:8 therapist 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.	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 needs of the children, youth, and young adults in care".

5330.48	Mental Health Professional	(e)(2)(4)(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.	There has been much confusion related to the terminology "clinical or mental health direct service practicum" as evidenced by the implementation of this language in other licensed behavioral health program regulations.	The agency suggests that the term "practicum" be replaced with "clinical field work" to not unnecessarily eliminate qualified applicants from being able to apply.

5330.50	Mental Health Worker	(b) The mental health worker shall have a high school diploma or the equivalent of a high school diploma and at least 1 year of experience working with children, youth or young adults.	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. Consideration should also be given to persons and family members with lived experience. 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 PRTF's 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 regulations requires. Our agency provides trained mentors who	Remove the 1 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 DSP's (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, there could be an exception for students enrolled in clinical field work, or higher education in a clinical field.

			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, that is only projected to exacerbate over the next 5 years (particularly in rural 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.	

5330.40	Additional Staff Positions	(4) The LPN shall be onsite at a PRTF whenever an RN is not onsite at the PRTF.	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 PRTF's will not have the ability to recruit LPN's to provide the coverage as identified in this regulation due to current and ongoing workforce shortages.	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.
5330.50	Additional Staff Positions	(5) The LPN shall have at least 1 year of experience working with children, youth or young adults.	Given the current workforce shortages in all levels of nursing in will be impossible for PRTF programs to effectively recruit LPN's with this level of experience. Hospital systems and inpatient units are not required to hire only LPN's with 1+ year of experience. Requiring PRTF providers to do so puts these agencies at an unfair disadvantage, with an inability to competitively recruit LPN's compared to all other disciplines that use this level of staff.	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.

5330.50	Additional Staff Positions	(7)(iii) The mental worker supervisor shall have the following: At least 3 years' 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.	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 2-3 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 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.	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 (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, and 9 credit hours in a related human services field.

5330.51	Initial staff training	(c) Except as required by subsection (d), PRTF staff shall complete at least 30 hours of training in the following areas within 120 days of their date of hire and 5330.3 Definitions- Staff- Individuals employed by a PRTF on a full-time or part time basis. Staff includes contracted staff, temporary staff, volunteers and interns.	Volunteers and interns who are not providing care or supervision within the PRTF should not be required to complete this level of training.	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).	Volunteers and interns who are not providing care or supervision within the PRTF should not be required to complete this level of training.	PRTF workers not working with clients must have annual training on fire safety, blood-borne pathogens, first aid, CPR, the agency's trauma-informed model, harassment training, and cultural competency.

5330.71	Communication System	(b) A PRTF shall have communication equipment, such as a hand-held two-way radio, to allow PRTF staff to contact other PRTF staff for assistance in an emergency safety situation.	Please clarify if this regulation requires PRTF's to have radios available to all staff on shift, or if those can be shared per unit.	Clarification needed.
5330.77	First Aid Supplies	(c) A first aid kit shall contain the following items: (10) Opioid overdose reversal medication.	Some PRTF providers have experienced barriers by licensing related to the manner in which opioid reversal medication is ordered and stored. It has been indicated that this medication, in order to be on site in facilities, must be ordered for each youth in care due to the individual prescription and medication storage requirements. While this agency has not experienced this issue and does keep this on site, this is not the case for other providers.	Please ensure that there is an approved process for ordering and storing this medication that does not required it to be ordered for each youth in care.
5330.83	Bathrooms	(g) The following toiletry items must be provided for each child, youth or young adult: 1) towels and washcloths 2)Toothpaste 3) Toothbrush 4)Comb or hairbrush 5)Shampoo 6)Soap 7)Feminine hygiene products, if needed 8)Toilet Paper 9)Deodorant, if needed 10)Body lotion (if needed)	Proposed regulation 1330.38 identified these items as non-allowable. Since they are required items to be provided by the PRTF, they should be considered in the allowable costs, and therefore included in rate determination.	Please revise the 1330.38 to include hygiene items as allowable costs.

5330.91	Unobstructed Egress	(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).	This proposed regulation is more restrictive than International Building Code § 1008.1.9.7 (relating to delayed egress locks), which allows for exception where approved, a delay of not more than 30 seconds. In units with egress doors to the outside located on the living units, decreasing from 30 to 15 seconds delayed egress could expose youth in care to higher risk of elopement and potential life threatening outcomes. Many community based programs are located near main highways, bodies of water, etc. Those facilities that have asked for and received approval for 30 second delayed egress due to such barriers should remain able to provide this level of safety.	Consider revising to the standards set forth in International Building Code § 1008.1.9.7 (relating to delayed egress locks) that allow exceptions to the 15 second requirement.
5330.94	Evacuation Procedures	A PRTF shall have written emergency evacuation procedures that include PRTF staff responsibilities, means of transportation and designated meeting areas.	This regulation requires that PRTF providers maintain evacuation procedures that include a plan for transportation. 5330.151 requires at least 1 staff person be present for every 3 children during transportation, and that the driver does not count in the supervision ratio. This regulation will result in all units needing to be staffed at a 1:3 ratio at all times in order to accommodate transportation during emergency events. In addition, it will required providers, who typically use 10 passenger vehicles (which under this regulation will only be able to accommodate 6 residents and need 3 staff), to purchase additional vehicles in order to meet this regulation.	Consider revising to increase the staff: client ratio during transportation or provide and exception during events that require activation of the emergency plan.

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 3 days from the date the initial medical assessment was completed.	It will be challenging for PRTF's to meet this regulation, particularly when admission occurs at times when the psychiatrist might not be available within 3 days. In addition, this regulation is more stringent than scope of practice of those disciplines indicated. In PA, an RN may perform health assessments, diagnose and treat patients responses to diagnosed health problems (RN's may not perform medical diagnosis). Similarly, CRNP's, when acting in collaboration with a physician, may perform comprehensive assessments of patients and establish medical diagnoses. There are no minimum standards for physician signature indicated with the CRNP scope of practice. Physician assistant scope of practice requires that physician countersignature be obtained within 10 days during the PA's first 12 months of licensure or change in specialty and/or 6 months under the supervision of the approved physician. As per the medical practice act of 1985 (10/7/21 revision) Section 3d1. Patient record review: (3-5), (5)"The board may not require, by order, regulation or any other method, countersignature requirements of patient records completed by a physician assistant that exceed the requirements specified under this subsection". Given the shortages of available psychiatric providers and the proposed new regulations related to use of physician time, any mandated documentation review by a physician that is not required by regulation is not practical.	Consider changing the timeframe for physician signature/review of the initial medical assessment to 10 days following the assessment when completed by a physician assistant as set forth in the medical practice act of 1985, or when completed by a registered nurse.

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 or APP shall be complete within 15 days of the child's, youth's or young adult's admission to a PRTF.	Please note that PRTF providers in rural areas have significant challenges in currently meeting this regulation due to lack of availability of primary care providers who accept Medical Assistance.	Consider revising to, " a medical examination by a physician or APP shall be completed within 30 days of the child's youth's or young adult's admission to a PRTF, or documentation present in the medical record that includes the PRTF's outreach attempts to secure such examination". Alternatively, allow PA, CRNP, and MD/DO in the PRTF to complete such EPSDT examination and ensure that associated expenses are considered allowable costs.
5330.115	Dental Care	(b) A child, youth or young adult shall have a dental examination and teeth cleaning within 30 days after admission to a PRTF.	Please note that PRTF providers in rural areas have significant challenges in currently meeting this regulation due to lack of availability of dental providers who accept Medical Assistance and or certain Private insurance.	Consider revising to: " A child, youth or young adult shall have a dental examination and teeth cleaning within 60 days after admission to a PRTF, or documentation present in the medical record that includes the PRTF's outreach attempts to secure such examination". Alternatively, allow providers to contract directly with dental offices for services and ensure that associated expenses are considered allowable costs.
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.	This proposed regulation does not take into consideration the contributions that persons with lived experience such as advocates or peers, or DSP's can contribute to the treatment planning process.	Consider revising to: "A treatment team leader shall ensure that when a specific intervention is identified in the Treatment plan, that those staff implementing those modalities will have the appropriate training, lived experience or certification".

5330.141	Treatment planning requirements	(d) PRTF staff shall maintain a communication log for each child, youth or young adult that includes daily notes about the child's, youth's, or young adult's behaviors and observations about the child, youth or young adult that can be used by the treatment team in the treatment planning process.	Typically PRTF's document such information in the E HR. This regulation encourages staff and providers to document at a high level outside of the electronic health record, which is inappropriate. This regulation will force providers to maintain such documentation outside of an electronic format in a manner that is not readily accessible to all staff without being physically present at the program. Detailed documentation such as this poses a privacy/security risk when stored outside of the E HR.	Consider eliminating this proposed regulation.

5330.145	Treatment Services	(c) The following must be provided in accordance with the child's youth's or young adults treatment objectives: (1) Individual therapy with the child's, youth's or young adult's treatment team leader must be provided for at least 1 hour each month. (2) Individual therapy with the mental health professional at least 2 hours each week, (3) Group therapy at least 3 hours each week, (4) Family therapy at least 1 hour each week, (5) psychoeducation group at least 3 hours each week.	This regulation provides that at a minimum, each individual in care will be required to receive 10.25 hours of therapy per week while in the PRTF, or approximately 1.5 hours per day/7 days a week. Most youth attend school for at least 4-6 hours per weekday, Monday through Friday and/or participate in extended school year activities during the summer months, returning to facilities between 3pm-4pm daily. When therapy occurs during the school day for individuals with an IEP, those instructional hours must be completed at a later time, either at the facility or at the school. Most facilities have established bedtimes between 7:30pm-9pm during week days. Youth engage in homework, mealtimes, scheduled activity, telephone calls/visits with family and support systems, activities of daily living, hygiene activities, and self-care activities from the time they arrive home from school until bedtime. Mandating 10.25 hours of therapy weekly will affect the times that youth have to engage in these other activities that are necessary to the treatment process. This mandating of clinical contact also assumes that all youth are at the same level within the treatment process and excludes those who may be close to discharge and as such have progressed in the treatment process. It forces overreliance on the support of the institution and fails to effectively transition youth to a less intensive level of care, where this level of clinical support may not be	Consider revising, "Clinical interventions and therapy must be provided in accordance with the child's, youth's, or young adult's treatment objectives at a frequency, intensity and duration that promotes participation in the treatment process, and attainment of treatment goals."

			available. Frequency, intensity and duration of any intervention is best determined by the individual's treatment team based on the individual's needs.	

5330.145	Treatment Services	(e) Individual and group therapy and psychoeducational groups must be in person and may not be provided through two-way audio and video transmission.	This regulation supersedes bulletin OMHSAS-22-02, which indicates that for high intensity services such as residential facilities, "Providers and practitioners should carefully consider the clinical appropriateness of telehealth delivery for such services". Given the current and projected ongoing workforce issues it may be necessary for PRTF's to utilize telehealth for the delivery of these services, particularly since the proposed regulations dramatically increase the therapy requirements. Providers should be able to determine the manner in which these services are provided, as based on the clinical need of the youth in care.	Consider revising to include the implementation of telehealth for PRTF for individual and group therapy and psychotherapy, as clinically indicated.
5330.145	Treatment Services	(f)Family therapy may be provided in person or through secure, real-time, two-way audio and video transmission that meets the technology and privacy standards required by the Health Insurance Portability and Accountability Act of 1996.	This regulation supersedes bulletin OMHSAS-22-02, which indicates that for high intensity services such as residential facilities, "Providers and practitioners should carefully consider the clinical appropriateness of telehealth delivery for such services." In addition, this bulletin allows for audio only service when the individual served does not have access to video capability..." While in person or video transmitted therapy is ideal, some families can only engage in audio only based therapy. Many rural communities are lacking in broadband access and families may not have access to internet/Wi-Fi within their homes, or even the cellular based mobile data access to support video transmission. Many of the family members of the individuals in care do not have video transmission capabilities. Without the ability	Consider revising to include the use of audio only during family therapy sessions.

			to use audio only sessions in these circumstances, families will either need to travel to the facility for in person sessions, or the facility will need to travel to family homes. This will be an expensive undertaking for families and poor use of sparse resources for facilities.	

5330.151	Transportation	(b) A driver of a vehicle may not be counted toward the supervision ratio requirements specified in subsection (d). (c)A driver of a vehicle and at least one PRTF staff person shall be present in the vehicle when a child, youth, or young adult is being transported, (d) there shall be at least one PRTF staff person present for every three children, youth or young adults being transported	PRTF programs need to ensure that there are adequate staff available to implement emergency evacuation procedures as per 5330.94 and will need to staff to ensure adequate transportation is available in an emergency event. While it may seem that an on call system could be implemented in such cases, it is unrealistic to expect that PRTF programs will be able to utilize such a system on a daily basis, with multiple staff ensuring their availability. Agencies typically transport individuals using 10 passenger vehicles, with most facilities having 2 vehicles (the second often being a 5 passenger SUV) available for transportation purposes. This regulation requires that for a 10 passenger vehicle there can be no more 6 youth and 3 staff, one of whom is a driver. A 5 passenger vehicle can therefor only carry 3 youth and 2 staff. Programs with 10 or more youth will need to purchase additional vehicles (at a range of $45,000-$70,000 depending on the type and size of vehicle needed) in order to ensure safe evacuation. Such programs will need to staff at least 5 staff at all times to accommodate this regulation. Under the proposed regulation, this would mean a ratio of 1:2 at all times in order to ensure that emergency evacuation plans can be executed when needed. This regulation will be costly to execute and negates the proposed ratio identified in 5330.42(c) (1) and 5330.42 (d) (1).	Consider eliminating this proposed regulation.

5330.182	Ordering a manual restraint	(i) An order for a manual restraint and the application of a manual restraint may not exceed 30 minutes. (h) A manual restraint must end when the earliest of the following occurs: (1) The order for manual restraint expires, (2) The manual restraint has been applied for 30 minutes, (3) When the child, youth or young adult no longer poses an imminent danger of physical harm to self or others.	Facilities ensure that staff engage in extensive training that encourages non-physical interventions and de-escalation techniques (Ukeru, Safe Crisis Management). In all circumstances, manual restraint is used a last resort to prevent imminent risk of harm to self or others. This regulation is more restrictive than 42 CFR § 483.358 and OMHSAS 53-01-01. Physicians within this agency have already determined that restraints will be ordered for no longer than one hour regardless of age. Decreasing this to 30 minutes will result in additional unnecessary administrative and financial burden. Restraints are traumatic to all involved, including other youth in the facility. Severe acts of aggression toward peers often result in restraint. Some individuals in care are physically more developed or can become assaultive toward others. When acting out, these individuals can induce a trauma response to other youth in care, which will only exacerbate should the staff need to attempt a release while the individual is still agitated if unable to contact a physician or APP within 30 minutes following the initial order. In such a circumstance, PRTF programs may need to attempt to release a potentially dangerous individual prematurely, risking harm to both the individual and others involved in the restraint. In addition, hospitals who have more resources to ensure safety (can use mechanical and chemical restraint and seclusion), are not required to	Consider revising the regulation to meet the standards set forth in 42 CFR § 483.358 and OMHSAS 53-01-01 and indicate that the ordering practitioner must be updated when the restraint exceeds 1 hour in all cases.

			meet this restrictive regulation. There is no evidence that such a regulation will promote safety or will minimize trauma to the youth involved.	

5330.185	Application of a manual restraint	(c) At least one PRTF staff person who has completed the required manual restraint training who is not involved in applying a manual restraint shall be physically present throughout the use of a manual restraint to continually assess the physical and psychological well-being of the child, youth or young adult and to oversee that the manual restraint is being applied correctly.	This agency uses Safe Crisis Management, which includes training in implementing single person restraints, and monitoring for signs of positional asphyxiation and excited delirium. While the proposed regulation may be an ideal scenario, there are challenges with executing such a regulation. Staff who may not be able to complete the required annual training due to physical disabilities or injuries will be excluded from monitoring during such events. 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. This regulation negates the ratio provided in (c) (1) At least one mental health worker or a PRTF staff person who meets the	Consider eliminating this proposed regulation.

			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 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. PRTF's that are individually licensed units with a census of 12 or below that are co-located 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. There may also be scenarios (such as elopement or when the second staff becomes injured during an emergency safety event) when two staff may not be in the immediate area and it is necessary for staff to intervene to ensure safety. Such a regulation will force providers to use more caution when considering the admission of acutely aggressive individuals and will greatly affect the availability of care for these more challenging youth.	

5330.185	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:	This regulation is more restrictive than 42 CFR § 483.358 and OMHSS 53-01-01. This regulation creates an additional barrier for providers, especially those in rural areas. The current regulations provides a one hour timeframe for completion of this assessment following initiation of restraint. Due to limited staff resources (MD/DO, APP, and RN) in these communities, it is not uncommon for individuals to need to travel from other locations, particularly when incidents occur on evenings/overnights. Given the current and projected shortages of Registered Nurses it is unlikely that facilities will be able to effectively recruit the level of nursing positions required throughout these regulations, and needed to staff an RN on at all times. 5330.47(a) provides that "A PRTF shall have an RN who is either onsite or available at all times when not onsite", allowing for the use of an RN on call system when an RN is not at the facility. Per 5330.50 (4) The LPN shall be onsite at a PRTF whenever and RN is not onsite at the PRTF. PRTF's will only be able to consider for hire those RN's who reside within a 15-20 mile radius of the facility, in order to ensure adequate RN response time for assessment following manual restraint, when an LPN rather than and RN is assigned to the shift.	Maintain that assessment following manual restraint must be completed within 1 hour of initiation of the manual restraint.

5330.185	Application of a manual restraint	(k) A PRTF shall notify the child's, youth's or young adult's parent, legal guardian or caregiver of the manual restraint within 1 hour after the manual restraint has ended.	It is not uncommon for individuals involved in manual restraint to continue to need extensive staff support following the event. There are frequent times when the staff involved in the event require assessment at the emergency department due to injury. While parents/guardians/caregivers should be notified of the event, this notification may need to be prioritized less than ensuring care of the individuals involved in the event, and providing support to the other individuals in care on the unit. Notification within 1 hour of the event creates an unnecessary administrative burden and does not support trauma informed de-escalation and debriefing of such an event.	Consider revising to: "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 no longer than 24 hours after the manual restraint has ended".
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.	At this agency, this level of debriefing with the child is completed by the RN during the assessment following manual restraint. A mental health professional, per these proposed regulations, will also be required to be present during all awake hours. The RN and/or mental health professional should suffice as such representatives. Additionally, requiring involvement of the youth's caregiver/legal guardian/parent in this debriefing is more restrictive that Federal Regulation. Legal guardians of dependent/delinquent youth may not be available on weekends/Holidays for such debriefing.	Consider revising to: "Within two business days following the use of a manual restraint…"

5330.188	Debriefing	(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:	Further clarification is needed as to "supervisory and administrative staff" specifically using the terminology outlined in the proposed PRTF regulations, Treatment Team Leader, Medical Director, Clinical Director, Program Director, etc. Depending on the role, these individuals may not be available for review within 24 hours. While debriefing is critical to trauma informed care and can be beneficial to reducing restraint, there is an administrative burden associated with reviewing these situations within a 24 hour timeframe.	Consider revising to: "Within two business days following the use of a manual restraint…"
5330.221	Quality Assurance	(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 (iii) Assessment of delivered services outcomes and if treatment plan goals have been completed.	As part of the JCAHO certification process, providers are required to have robust quality assurance programs that assess those areas identified in this regulation. Summation of this information into one report annually creates an administrative burden and brings no value to the process other than ease of review for licensing entities. Additionally, requiring that the report include the assessment of delivered services outcomes and if treatment plan goals have been completed will result in the need for additional clinical staff hours dedicated solely to this level of chart review and or extensive modification to the E HR to obtain reports that can validate this. Both scenarios are costly to implement and are a poor use of scarce resources.	Eliminate the need for an annual report of services.

5330.221	Quality Assurance	(a) A PRTF shall establish and implement a written quality assurance plan that meets the following (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.	Updating letters of agreement annually is excessive and leads to additional administrative activities for the PRTF. Providers should be able to work together to arrange for standing letters of agreement with provisions that include updating when there are significant changes that would critically affect the agreement.	Clarify that multi-year letters of agreement are acceptable when there are provisions to address when updates are required within the agreement.

The Regulatory Analysis Form submitted to the IRRC contains detail related to the annual costs associated with the key staffing included in the proposed regulations. These costs appear to be salary related costs only and do not consider the associated benefits and taxes that providers will be accountable for. (typically 34%). Journey Health System/Beacon Light Behavioral Health System completed a market analysis upon release of these proposed regulations. Per recent market data, the true costs (assuming that the market does not change) of salaries for these positions are significantly more than were presented to the IRRC.

Role	Regulatory assumption	Market Job Title Match	Bradford, PA	Warren, PA	Kittanning, PA
Psychiatrist	$289,300	Entry Level Psychiatrist	$293,822	$291,559	$290,219
Psychiatrist	$289,300	Senior Level Psychiatrist	$334,520	$332,737	$332,004
Registered Nurse	$66,500	Registered Nurse (RN)	$89,624	$88,666	$91,586
Registered Nurse	$66,500	Entry Level RN	$75,708	$75,012	$78,311
Mental Health Professional	$51,500	Mental Health Counselor Master's	$51,792	$51,853	$54,484
Mental Health Professional	$51,500	Mental Health Therapist Licensed	$57,901	$57,999	$60,919
Mental Health Professional	$51,500	Licensed Clinical Social Worker (LCSW)	$81,234	$81,414	$84,865
Licensed practical nurse	$47,100	Licensed Practical Nurse (LPN)	$54,865	$54,057	$57,436
Licensed practical nurse	$47,100	Entry Level LPN	$46,693	$45,954	$48,857
Nurse Practitioner (CRNP)	$120,555	Certified Nurse Practitioner (CRNP)	$125,634	$124,181	$126,038
Physician Assistant	$110,000	Physician Assistant (PA)	$129,161	$127,656	$129,393
Physician Assistant	$110,000	Entry Level PA	$111,936	$110,638	$112,833