Regulatory Analysis Form

(Completed by Promulgating Agency)

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INDEPENDENT REGULATORY REVIEW COMMISSION

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Independent Regulatory Review Commission

October 1, 2025

(1) Agency
Department of Human Services

(2) Agency Number: 14-
Identification Number: 557

IRRC Number: 3460

(3) PA Code Cite: 55 Pa. Code Chapter 5250

(4) Short Title:

Licensure of Crisis Intervention Services

(5) Agency Contacts (List Telephone Number and Email Address):

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(6) Type of Rulemaking (check applicable box):

- ☒ Proposed Regulation
- ☐ Final Regulation
- ☐ Final Omitted Regulation
- ☐ Emergency Certification Regulation;
- ☐ Certification by the Governor
- ☐ Certification by the Attorney General

(7) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

The purpose of this proposed rulemaking is to add Chapter 5250 to Title 55 of the Pennsylvania Code to codify standards that a licensee must meet to provide emergency behavioral health crisis intervention services (crisis intervention services). Specifically, this new chapter applies to providers licensed by the Department to provide crisis intervention services under the following modalities: crisis call centers; mobile crisis team services; medical mobile crisis team services; emergency behavioral health crisis walk-in center services; and crisis stabilization unit services.

The proposed regulation also establishes new requirements related to physical site, emergency planning, quality monitoring, security personnel, staffing qualifications, medication storage, lab testing and training. Crisis intervention services are immediate, crisis-oriented services designed to amend or resolve precipitating stress. The services are provided to adults, children, youth, and their families. The services provide emergency responses to crisis situations which threaten the well-being of the individual or others. Crisis intervention services include intervention, assessment, counseling, screening, and disposition of services.

(8) State the statutory authority for the regulation. Include specific statutory citation.

Sections 105 and 112 of the Mental Health Procedures Act (50 P. S. §§ 7105, 7112), section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)), and sections 911 and 1021 of the Human Services Code (62 P.S. §§ 911 and 1021).

(9) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case, or regulation as well as any deadlines for action.

No Federal or State statute, regulation court order, or court decision mandates the proposed rulemaking.

(10) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

The proposed regulation is needed to codify the standards for the licensure of crisis intervention providers to protect the health and safety of individuals who access crisis intervention services by adopting minimum requirements for physical site, operation, staffing, and training. By codifying minimum training standards and requiring staff training in trauma-informed care, de-escalation techniques, and suicide risk assessment procedures, the proposed rulemaking benefits approximately 50,000 Medical Assistance recipients receiving crisis intervention services annually. The proposed regulation will also benefit the 70 crisis intervention service licensees by providing clear and consistent standards for licensure or approval of all modalities of crisis intervention services. The proposed regulation considers the broad variety in the size and capacity of crisis intervention service facilities.

The proposed rulemaking will benefit children, youth, and adults who receive emergency behavioral health services via any of the licensed modalities of crisis intervention services by establishing minimum requirements that specifically address the health, safety, and behavioral health needs of children, youth and adults who receive crisis intervention services. The proposed rulemaking benefits individuals of all ages who receive behavioral health treatment in a crisis stabilization unit by adding requirements for minimum standards for treatment services, building, equipment, operation, emergencies, and fire safety. The proposed rulemaking also establishes staff qualifications, roles, responsibilities, and training that are intended to result in behavioral health services being delivered by qualified staff, which will result in children, youth or young adults receiving services that meet their behavioral health needs when they are at their most vulnerable. Children, youth, or adults will further benefit from the proposed operational requirements under the proposed rulemaking. The Department reviewed national behavioral health crisis care guidelines established by Substance Abuse and Mental Health Services Administration (SAMHSA) in developing the proposed requirements. *See* (SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf)

For FY 20-21, a total of 149,281 Medical Assistance payment claims/encounters were processed for the delivery of crisis intervention services. Of that number, the distinct recipient count is 47,762 Medical Assistance recipients. The numbers for encounters and recipient counts include MA beneficiaries only. Providers of crisis services, however, are not limited to just MA only. The total number of claims/encounters shows that there were individuals who received multiple crisis intervention services throughout the year. Please also note, however, that the number of individuals who received crisis intervention services is likely greater than this Medical Assistance claim/encounter number due to the likelihood of private pay and commercial claims.

(11) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulations.

This proposed regulation is not more stringent than Federal standards. There are no federal standards applicable to crisis intervention services.

(12) How does this regulation compare with those of the other states? How will this affect Pennsylvania's ability to compete with other states?

The Department reviewed regulatory standards for crisis intervention services issued by Delaware, Maryland, New Jersey, New York, Ohio, and other states, as further provided below. The proposed rulemaking is similar to these other state's requirements for facility sites.

Delaware:
Delaware provides a continuum of crisis intervention services. These services are located throughout the state in crisis intervention service centers, community mental health centers, a recovery response center, and emergency rooms. Crisis intervention service staff are available 24 hours a day to assist people 18 years and older with severe personal, family, or marital problems. Delaware has sets of standards for alcohol and drug providers, and for mental health group homes. Delaware's Title 16 Chapter 6002 (relating to credentialing mental health screeners and payment for voluntary admissions) defines "crisis experience in a mental health setting" as "direct experience providing acute crisis services to people with mental health disorders in settings that include, but are not limited to, psychiatric assessment centers, hospital emergency rooms, crisis walk in settings, admission departments of psychiatric or general service hospitals, mobile crisis departments, drop in centers and certain settings found in the Department of Corrections."

Although it appears there are no formal crisis intervention service regulations in place, the requirements for group homes share some similarities with Pennsylvania's proposed rulemaking. Delaware's Title 16 Chapter 3305 (relating to group homes for persons with mental illness) defines "group home" as a residence to provide mental health treatment, rehabilitation and housing, staffed substantially full-time when residents are present for between three (3) and ten (10) adults with primary diagnosis of psychiatric disabilities." The chapter requires policies and procedures which involve the services of a crisis intervention service in the event of psychiatric emergencies, maintaining an emergency preparedness plan which includes prompt methods for acquiring the assistance of crisis intervention services, requiring the offering of a full range of services including outreach and crisis response, designating a clinician to coordinate the provision of emergency services and hospital liaison services when a resident is in crisis, and posting emergency crisis intervention services information near telephones.

Delaware has not promulgated regulatory standards for specific modalities of crisis intervention services (such as crisis call centers, mobile crisis team services, etc.). Further, for Delaware's group homes for persons with mental illness Delaware has not adopted established SAMHSA standards as defined in its "National Guidelines for Behavioral Health Crisis Care Toolkit." However, Delaware's group homes for persons with mental illness are similar to this proposed rulemaking in that they require crisis policies and procedures, emergency preparedness plans, coordination of services, and posting emergency phone numbers. However, Pennsylvania's proposed rulemaking is more robust, establishing and codifying standards that are in accordance with SAMHSA's guidelines.

Maryland:
Maryland regulates Residential Crisis Services (RCS) for individuals with a primary mental health diagnosis under Title 10, Chapter (relating to community mental health programs- residential crisis services). These services provide short-term mental health treatment and support services in a structured environment for individuals who require 24-hour supervision due to a psychiatric crisis; and are designed to prevent a psychiatric inpatient admission, shorten the length of inpatient stay, effectively use general hospital emergency departments; and provide an alternative to psychiatric inpatient admission. Under Maryland's regulations, residential crisis services mean intensive mental health and support services that are provided to a child or an adult with mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual's ability to function in the community, and are designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay or reduce the pressure on general hospital emergency departments. Maryland's regulations address program models, as well as eligibility, referral, screening, and admission to residential crisis services. In addition, the regulations set standards for treatment planning, evaluations, and required staff. For instance, Maryland RCS facilities must complete an Individual Treatment Plan (ITP) within 24 hours of placement in the program; this aligns with Pennsylvania's proposed rulemaking. However, Maryland's staff qualifications are vaguer than Pennsylvania's proposed rulemaking. In Maryland, the program director shall employ a sufficient number of direct service providers who as determined by the program, have sufficient qualifications and experience to carry out the duties of the position; and before providing services, have training applicable to the service. A specific educational level and experience is not required in Maryland's regulations. In addition, the regulations do not address the physical site premises, fire safety, or emergency planning as Pennsylvania's proposed rulemaking does.

New Jersey:
New Jersey offers licensure standards for County Psychiatric Facilities, Licensed Community Residences for Adults with Mental Illnesses, Community Support Services for Adults with Serious Mental Illnesses, Outpatient Service Standards, Partial Care Service Standards, and Short-Term Care Facility Standards. It appears there are no formal crisis intervention service regulations in place; however, Licensed Community Residences for Adults with Mental Illnesses share some similarities with Pennsylvania's proposed rulemaking.

Under New Jersey's Title 10, Chapter 37A (relating to Licensed Community Residences for Adults with Mental Illnesses) "crisis intervention" is defined as "face-to-face, short-term interventions with a consumer who is experiencing increased distress and/or an active state of crisis. Crisis intervention also includes developing and implementing the consumer's crisis contingency plan and/or advance directive for mental health care." Under this chapter, Licensed Community Residences for Adults with Mental Illnesses include supervised housing, including group homes that provide various services at distinct levels, apartments, family care homes and shared supportive housing residences, in which three or more consumers reside in a residence that may or may not be owned by a provider agency. The chapter includes requirements for physical site, such as water, bathrooms, sanitation, lighting, ventilation, heating/cooling, maintenance, kitchen, and fire safety/drills. New Jersey's physical site standards for Licensed Community Residences for Adults with Mental Illnesses are similar to Pennsylvania's proposed rulemaking, such as requiring valid Certificates of Occupancy under the Construction Code or Certificate of Inspection under the Fire Code, regulating water supply, trash removal, lighting, ventilation, heating/cooling, fire drills, and establishing standards and ratios for bathroom amenities.

New Jersey's chapter also includes requirements for written policies and procedures, service agreements and assessments, clinical records, quality management, and staff training. These requirements are similar to Pennsylvania's proposed rulemaking. New Jersey does not have promulgated regulations for specific modalities of crisis intervention services (such as crisis call centers, mobile crisis team services, etc.). Finally, New Jersey's chapter requires the provider to "employ a sufficient number of staff to offer and provide all required services to consumers, based upon the numbers of consumers served, the level of functioning and needs of the consumers, the types of residences utilized, and the geographical distribution of residences. The provider shall maintain the staffing pattern approved by the Division and reflected in the purchase of service contract. In addition, staff shall be appropriately licensed, and all staff shall have credentials as appropriate to their functional job descriptions and be hired in compliance with all applicable laws regarding criminal record background checks and substance use testing. These requirements are vague compared to Pennsylvania's proposed rulemaking, which includes a robust staff qualifications section.

New York:
Title 14 of the New York Codes, Rules, and Regulations (CRR) governs mental health services generally. 14 CRR XIII provides regulations specific to the Office of Mental Health. Additionally, a proposed rulemaking has been adopted, adding Part 600 to 14 CRR, pertaining to crisis stabilization centers. The proposed crisis stabilization center regulations in Part 600 largely follow SAMHSA best practices, and thus mostly align with Pennsylvania's proposed rulemaking. However, New York's staffing requirements differ from Pennsylvania's, with fewer general requirements for staff but more specific staffing qualifications (specifically, New York's proposed regulation requires a multi-disciplinary team consisting of at least one peer; whereas, under this proposed rulemaking teams may include peers but are not required). There are no specific regulations pertaining to the other specific modalities.

Ohio:
Ohio's crisis hotline regulations (Rule 5122-29-08) are similar to Pennsylvania's proposed rulemaking. Services are required to be offered 24/7/365, including suicide prevention measures, and offer crisis referrals when needed. Training requirements for staff are less prescriptive but similar to those in Pennsylvania's proposed rulemaking. For example, general staffing requirements for Ohio can be found in Rule 5122-29-30 and are likewise similar to Pennsylvania's proposed rulemaking. In Ohio, individuals are eligible to provide and supervise within their professional scope of practice those services certified by the Ohio department of mental health and addiction services and licensed, certified or registered individuals must comply with current, applicable scope of practice, supervisory, and ethical requirements identified by appropriate licensing, certifying or registering bodies. Ohio's "crisis intervention service" regulations in Rule 5122-29-10 correlate with Pennsylvania's walk-in center regulations in the proposed rulemaking but are more general than Pennsylvania's. Mobile crisis regulations in Ohio are limited to the mobile response and stabilization service under Rule 5122-29-14, which is specifically for individuals under age 21. However, Ohio does not regulate mobile crisis services for individuals 21 years of age or older.

The proposed rulemaking will not put the Commonwealth at a competitive disadvantage. The licensing regulations were developed to be in line with national best practices. Further, funding from the federal government related to the implementation of crisis services requires adherence to the standards outlined in the department's proposed regulations.

(13) Will the regulation affect any other regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

The proposed regulation will not affect existing or proposed regulations of the Department or another state agency.

(14) Describe the communications with and solicitation of input from the public, any advisory council/group, small businesses and groups representing small businesses in the development and drafting of the regulation. List the specific persons and/or groups who were involved. ("Small business" is defined in Section 3 of the Regulatory Review Act, Act 76 of 2012.)

The Department convened a series of stakeholder workgroup sessions to ensure that all affected individuals and organizations had the opportunity to provide input into the proposed rulemaking. There were 63 total members in the workgroup. The kick-off meeting was conducted on March 2, 2020, and was followed by a series of 6 whole-day meetings attended through an on-line connection by interested stakeholders. The workgroup held online meetings on March 10, 2021, March 24, 2021, April 14, 2021, May 5, 2021, May 26, 2021, and August 11, 2021, to provide recommendations for the proposed regulation.

To assure participation by those with both interest and expertise on given topics, workgroup members were provided with copies of updated drafts of the proposed annex prior to each workgroup meeting. The workgroup consisted of individuals and family members with lived experience, county mental health/intellectual disability (MH/ID) staff, representatives of behavioral health managed care organizations, provider organizations, advocacy groups, the Mental Health Planning Council (MHPC), and staff from the department, the Department of Health, the Pennsylvania Insurance Department and the Department of Drug and Alcohol Programs. In addition, a total of 13 licensed providers, representing all modalities of crisis intervention service treatment within the scope of this chapter, participated in the workgroup.

The following organizations were represented in the workgroup: Rehabilitation and Community Providers Association (RCPA), Pennsylvania Mental Health Consumers Association (PMHCA), Mental Health Partnerships, Pennsylvania Association of Community Health Centers (PACHC), Behavioral Health Alliance of Rural Pennsylvania (BHARP), Family Resource Network, PA Parent and Family Alliance, Keystone National Alliance on Mental Illness (NAMI), and The Mental Health Association in Pennsylvania (MHAPA).

The following providers were represented in the workgroup: Access Services, Center for Community Resources, Elwyn, Montgomery County MH/MR Emergency Service, Northeast Counseling Services, Service Access & Management Inc., Somerset Crisis Intervention, SPHS Care Center, TrueNorth Wellness Services, UPMC Western Behavioral Health at Safe Harbor, and Valley Creek Crisis Center.

(15) Identify the types and number of persons, businesses, small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012) and organizations which will be affected by the regulation. How are they affected?

The proposed regulation will affect all licensed crisis intervention service providers. There are currently 70 licenses issued to provide crisis interventions services. Of the 70 crisis intervention service licenses issued, four are for-profit businesses.

Of the four for-profit businesses, none provided crisis call center services. Crisis call centers provide 24/7/365 confidential support services such as behavioral health counseling, consultation, information and referral services to individuals in suicidal crisis or emotional distress requiring emergency behavioral health intervention.

Three for-profit businesses provided crisis walk-in center services. Crisis walk-in center services provide short-term crisis (up to 23 hours) receiving and limited stabilization services to any individual in a safe, recovery-oriented environment for emergency behavioral health care.

No for-profit businesses provided medical mobile crisis team services. Medical mobile crisis team services provide community-based emergency behavioral health intervention via two-person teams to an individual in crisis or emotional distress 24/7/365, wherever the individual happens to be while experiencing a behavioral health crisis, including place of residence, work, or in the community. Medical mobile crisis team services differ from mobile crisis team services in that there is consultation with a crisis intervention services licensed medical professional for medical back-up, and these teams are authorized to administer medication. The medical mobile crisis team service is typically utilized in situations where it is known or anticipated that medication will be required.

Finally, two for-profit businesses provided stabilization unit services. The crisis stabilization unit service is available 24/7/365, and is an intensive, short-term stabilization service (up to 7 days) for individuals experiencing a behavioral health emergency.

It should be noted that some of the for-profit businesses are licensed to provide multiple modalities of crisis intervention services.

Section 3 of the Regulatory Review Act (71 P.S. § 745.3) includes the following definition of "small business:" "As defined in accordance with the size standards described by the United States Small Business Administration's Small Business Size Regulations under 13 CFR Ch. 1 Part 121 (relating to Small Business Size Regulations) or its successor regulation."

Of the 70 crisis intervention service provider agencies, 20 of the provider agencies are for-profit entities, with the remaining 50 provider agencies being non-profit entities. Based upon review of the Department's paid claims data for fiscal year 2021, nine of the 70 crisis intervention service provider agencies received Medical Assistance reimbursement in excess of the North American Industry Classification System (NAICS) standards for a small business per the definition of "small business" found in 13 CFR § 121.201. The NAICS small business size standard for crisis intervention service providers is $16.5M in annual receipts reported on the small business's Internal Revenue Service tax return form.

The remaining 41 of the 50 non-profit crisis intervention service provider agencies received a combined $207 million in Medical Assistance payment for services. Therefore, based only upon the Department's paid claims data, 41 of the 50 non-profit crisis intervention service facilities may be considered small businesses.

For the 20 for-profit crisis intervention service provider agencies, the Department does not have access to information on the total revenue generated by each for-profit crisis intervention service that is reported on its Internal Revenue Service tax return form.

Crisis intervention service providers will be affected by the codification of licensing standards as proposed. Both individuals and the community will benefit from the requirements for emergency preparedness that assure individual safety during declared all-hazards emergency situations. Individuals will benefit from the minimum health and safety requirements, including those for the crisis intervention service facility, and treatment planning and delivery.

Because the proposed rulemaking provides minimum health and safety licensure standards, the proposed regulation will affect all providers of crisis intervention services, including small businesses, equally.

(16) List the persons, groups or entities, including small businesses that will be required to comply with the regulation. Approximate the number that will be required to comply.

The proposed regulation will affect all licensed crisis intervention service providers, including small businesses. There are 70 licenses issued to provide crisis intervention services in the Commonwealth. Of that number, there are 41 that may be considered small businesses. Due to minimum health and safety standards, all crisis intervention service providers must comply with the regulation to maintain their license to provide crisis intervention services in the Commonwealth.

(17) Identify the financial, economic and social impact of the regulation on individuals, small businesses, businesses and labor communities and other public and private organizations. Evaluate the benefits expected as a result of the regulation.

It is anticipated that implementation of the proposed rulemaking may result in increased costs for providers as a result of the proposed staffing requirements, which will vary based upon modality of crisis intervention services provided and the size of the facility. Specifically, the proposed rulemaking requires mobile crisis team services to be delivered in teams of at least two individuals. Current practice across most of the state allows for mobile crisis intervention services to be delivered by one person. This shift aligns the state with national best practices in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care Toolkit (https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf) (pp. 37) and provides for an increase in Medicaid payment from the federal government.

In addition, the proposed rulemaking establishes qualifications for a new staff position titled a crisis intervention service licensed behavioral health professional. The staffing qualifications proposed allow for a staff member to advance into positions as they acquire both education and experience. The proposed staffing regulations may help to retain staff as it provides for staff with the potential to advance within the provider's organization.

Current standards require 24/7 availability of crisis call centers; the proposed rulemaking establishes that all modalities of crisis intervention services be available 24/7/365. This will result in increased costs to some providers as not all providers currently offer crisis intervention services 24/7/365.

Finally, the proposed rulemaking acknowledges security personnel. Providers will need to address whether or how they use security contractors or security staff, including the training and qualifications for security contractors or security staff. They may choose to have security of the premises, including having written protocols for security emergencies.

Crisis intervention service providers will benefit from the provision of licensing standards in the proposed rulemaking. The benefits of clarity and standardization are significant and will increase consistency in the licensing process and reduce the number of violations and related appeals, resulting in potential savings in both time and money for providers' administrative effort to resolve compliance issues.

The codification of minimum licensure standards also provides basic health and safety standards for individuals receiving services. The proposed regulation also provides clear and consistent standards for licensure or approval of all modalities of crisis intervention services within the scope of this chapter.

There is no social impact of the regulation on small businesses, businesses and labor communities and other public and private organizations.

(18) Explain how the benefits of the regulation outweigh any cost and adverse effects.

The proposed rulemaking codifies the minimum standards for licensure of crisis intervention services. For those facilities that are currently licensed or approved by the Department, current applicable codified regulations are limited to 55 Pa. Code Chapter 20 (related to licensure or approval of facilities and agencies), and 55 Pa. Code Chapter 5100 (relating to mental health procedures). These regulations are limited, and do not provide specific standards for physical site, fire safety, and emergency preparedness.

The proposed regulation will help to ensure minimum health and safety standards are met for individuals receiving crisis intervention services. The proposed regulation addresses physical site, fire safety, and emergency preparedness, which meet national standards and staffing.

The proposed rulemaking is needed to provide necessary oversight to protect the health and safety of individuals who access crisis intervention services by adopting minimum requirements for building, equipment, operation, staffing, and training. The proposed rulemaking provides clear and consistent standards for licensure or approval of all modalities of crisis intervention services within the scope of this chapter. The proposed rulemaking considers the broad variety in the size and capacity of crisis intervention service facilities.

(19) Provide a specific estimate of the costs and/or savings to the **regulated community** associated with compliance, including any legal, accounting or consulting procedures that may be required. Explain how the dollar estimates were derived.

The overall fiscal impact for each crisis intervention service provider will vary and depends upon the services provided, the current organizational structure, and current qualification, supervision, and training requirements.

It is anticipated that emergency behavioral health walk-in center service providers will incur costs to implement blood and urine lab testing. Providers have a choice in how blood and urine lab testing is processed; providers can process the tests onsite if they are equipped and approved to do so, or the provider may utilize lab testing through a contract with an agency outside the provider. Processing lab testing onsite will likely cost the provider more than contracting with an outside agency, due to staffing and licensure requirements, unless the provider has existing licensure and capacity to process laboratory tests. Costs for contracting would vary from provider to provider based on a number of variables such as whether the provider had existing relationships with entities capable of processing lab testing, the volume of lab testing needed, and local differences in the costs of such services. The Department is hoping to gather additional feedback from the regulated community about the cost of contracting for lab services. Due to the variance in the costs of contracting for lab testing services across providers, fiscal estimates were derived assuming that all providers will utilize in-house lab testing. This methodology reflects the highest possible cost of the lab testing requirement. With additional detail from the regulated community regarding the cost of contracting for lab services, the Department anticipates this number will change in the final-form version of this document.

Per Department of Health (DOH), providing onsite lab testing requires four specific management and staff positions at the provider agency (estimated salaries in parenthesis): laboratory director ($120,640.00), clinical consultant ($89,755.00), technical consultant ($116,498.00), and testing personnel ($45,760.00). DOH and BLS.gov salary information was not available for the specific titles required for Clinical Laboratory Improvement Amendments (CLIA) certification, so Pennsylvania-specific data from ZipRecruiter as of February 2024 was used to estimate salaries for each position. The total estimated staffing costs were derived assuming each of the required management positions (Laboratory Director, Clinical Consultant, Technical Consultant) and one lab technician position at all 47 licensed walk-in providers.

In addition, providers conducting onsite lab testing will need to obtain the appropriate licensure from DOH. Licensure entails an application fee of $100 as well as a CLIA fee of $248. These one-time fees are assumed for all 47 licensed walk-in providers and factored into costs a single time in 2026-27 ($16,000).

As previously mentioned, the total costs for each provider will vary depending on whether the provider chooses to process lab testing onsite or contract those services out. If all providers opted to process lab testing onsite, the cost would be approximately $17,515,000 per year due to staffing requirements. However, as many providers will likely contract out lab testing, the cost will likely be significantly lower.

To the extent that crisis intervention service providers incur costs due to the regulations, these costs will be considered when the Department determines future behavioral health managed care organization capitation rates and the fee schedule for the behavioral health Fee-for-Service program. Once the county has exhausted all other insurance and coverage methods for payment (i.e., Medicaid, commercial insurance, etc.) and

completed a liability assessment, the county mental health programs can use their base funding as the last payor of a service. In other words, an increase to county base funding and updating the fee schedule rates may be proposed in the Governor's budget which would ultimately need approval by the General Assembly. This would result in no fiscal impact to the regulated community.

(20) Provide a specific estimate of the costs and/or savings to the **local governments** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

Absent additional county mental health base funding from the General Assembly, the proposed rulemaking may result in an annual cost to local governments of approximately $35,006,000. The Department is hoping to gather additional feedback about the cost of contracting for lab services. Due to the variance in the costs of contracting for lab testing services across providers, fiscal estimates were derived assuming that all providers will utilize in-house lab testing. This methodology reflects the highest possible cost of the lab testing requirement. With additional details from the regulated community regarding the cost of contracting for lab services, the Department anticipates this number will change as reflected in the final-form regulation. An increase to county base funds to support county implementation of this regulatory package may be proposed in the Governor's budget. However, it will ultimately require approval by the General Assembly.

The local government fiscal impact of the crisis regulation was estimated using results from the 988 Crisis Services Capacity survey sent to county administrators in 2021. In the survey, counties were asked to estimate the annual recurring cost of alignment with the updated Substance Abuse and Mental Health Services Administration (SAMHSA) crisis service guidelines. Responses were compiled and calculated to determine an estimate of the increase in annual budget for non-Medicaid crisis services. The estimate is a statewide cost that adjusted individual county responses where there were outliers and filled in projected expenses for those counties that did not complete the survey. The SAMHSA guidelines, from which these regulations were modeled, were used at the time as a proxy for the crisis regulations as the regulations were still under development.

Based on the information submitted by the counties in response to the survey, the anticipated impact for both MA and non-MA expenditures for the survey respondents was $58,000,000 in total. The county survey respondents represented a population of 8,400,000 people. In order to determine a per capita increase, the total cost for the survey respondents was divided by the represented population. This equates to a $7 per capita increase which was then multiplied by 40%, the proportion of expenses submitted in the survey that were reported as non-MA. This resulted in a non-MA per capita increase of $2.80. This was multiplied by the total number of non-MA individuals in the Commonwealth (10,000,000), for an impact to local governments of $28M.

Counties were not required to submit budget drivers in the survey but did submit budget increase estimates for two categories of crisis services. For the county submissions that were used in the estimated development, 33% of the total budget increase was related to mobile crisis services, and 67% of the increase was related to crisis recovery and stabilization services.

In addition to the survey costs, costs of providing or contracting for laboratory testing required in the regulations were added to the costs from the survey. The Department assumed that approximately 40% of the total laboratory costs would be non-MA costs. This will result in an ongoing annual cost of

approximately $7,006,000 based on the assumption that all providers will utilize in-house lab testing as discussed in Question 19. The amount would cover the costs of a Laboratory Director, Clinical Consultant, Technical Consultant, and Testing Personnel. The cost in the first year of implementation would also include one-time certification fee requirements associated with laboratory testing for 47 Licensed Walk-in Centers (approximately $6,000 = $7,012,000 for the first year of implementation).

Once the county has exhausted all other insurance and coverage methods for payment (i.e., Medicaid, commercial insurance, etc.) and completed a liability assessment, the county mental health programs can use their base funding as the last payor of a service.

As previously mentioned, an increase to the county base funds may be included in the Governor's budget which would ultimately require approval by the General Assembly. For this reason, the ongoing annual local government costs of $35,006,000 ($35,012,000 for the first year of implementation) will be reflected in the state government costs in question 23.

No new legal, accounting or consulting procedures are required for local governments.

(21) Provide a specific estimate of the costs and/or savings to the **state government** associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

<u>MA Impact</u>
The proposed rulemaking will result in an annual cost to the MA program of approximately $32,909,000 ($11,906,000 in State funds). Approximately $100,000 can be attributed to the Behavioral Health (BH) Fee-for-Service program, with the BH HealthChoices program accounting for the rest. The Fee-for-Service rates will be updated to reflect these cost increases. Additionally, it is anticipated that the MA BH HealthChoices program capitation rates will be increased to reflect the revisions to the Fee Schedule rates. Due to the costs of the service increasing from these regulations, MA rates will need to be increased in both the Fee-for-Service and Behavioral Health Managed Care programs to ensure that providers are able to sustain operations.

The Department worked with its contracted actuaries to determine a range of fee schedule rates that would be required to meet the requirements of crisis services under the updated regulation. The actuaries developed a range of applicable wages using the Bureau of Labor Statistics' Occupational Employment and Wage Statistics survey specific to Pennsylvania. Additionally, the actuaries reviewed the regulations to understand the requirements and expectations for provider licensure and staffing for each service category. Please note that in compliance with federal regulations, room and board expenses were excluded from the development of the rates.

The updated rates were then compared to the rates historically paid by Pennsylvania BH Managed Care Organization (MCO) and Medicaid Fee-for-Service Medicaid crisis fees to determine the fiscal impact to State Government. The Department calculated the fiscal impact of the regulation by comparing calendar year (CY) 2019 encounter data service unit costs to the updated rates. In cases where the historical unit costs were higher, no increase or decrease cost was assumed. Additionally, alternative payment arrangements (APAs) for telephone and mobile crisis services in the BH HealthChoices program were also reviewed as their dollars are not captured in the encounter data. For the crisis APAs, a percentage increase

that was equivalent to the increase in the revised rates was assumed. Costs related to increases in utilization that may occur due to provider expansion were not considered in the fiscal analysis, only costs related to the changes in service requirements due to the regulations were included.

The estimates consider a six-month ramp up period after which, a directed payment is expected to be implemented for these services, pending Federal approval by the Centers for Medicare and Medicaid Services. The proposed rulemaking will result in an additional cost to the MA program of $16,455,000 ($5,621,000 in State funds) during the fiscal year in which it is promulgated.

It is anticipated that Fee Schedule rates in the MA program will be increased for Mobile Crisis for updated service requirements including expanded hours and community responses and additional required staffing for mobile crisis which will result in an annual cost to the MA program of approximately $9,100,000 ($3,109,000 in State funds). The proposed rulemaking requires mobile crisis team services to be delivered in teams of at least two individuals. Current practice across most of the state allows for mobile crisis intervention services to be delivered by one person. Additionally, Mobile Crisis providers will be required to deliver services in the community. The proposed rulemaking would also result in expanded hours for Mobile Crisis, which will necessitate additional staffing for mobile crisis providers.

In addition, it is anticipated that the Walk-in Crisis Fee Schedule rate in the MA program will be increased to cover the MA portion of the anticipated laboratory costs discussed in question 19. This represents an annual cost to the MA program of approximately $10,509,000 ($3,590,000 in State Funds) based on the assumption that all providers will utilize in-house lab testing as discussed in question 19. As previously mentioned, the Department is seeking comments regarding the cost of contracting out for lab testing. With additional details from the regulated community regarding the cost of contracting for lab services, the Department anticipates this number will change in the final-form version of the regulation. The amount would cover the costs of a Laboratory Director, Clinical Consultant, Technical Consultant, Testing Personnel and certification fee requirements associated with laboratory testing for 47 Licensed Walk-in Centers. These costs would be paid for by billing the anticipated increased MA program Fee Schedule rate to the Department.

In addition, it is anticipated that the Crisis Residential, Walk-in Crisis, Telephone Crisis, Mobile Crisis and Medical Mobile Crisis rates in the MA program will be increased for the costs of wage inflation which will result in an annual cost to the MA program of approximately $7,400,000 ($2,528,000 in State Funds). Walk-in Crisis providers will be required to have a licensed medical professional present. The anticipated Fee Schedule increase would also account for necessary wage rates that would need to be paid by providers to ensure providers are able to hire staff to meet the requirements of the regulations. Additionally, the proposed rulemaking establishes that all modalities of crisis intervention services be available 24/7/365. Current standards only require Telephone Crisis to operate 24/7/365. Bureau of Labor Statistics data from 2020 was used for the staff salary assumptions and was trended forward at a rate of 4% for each year.

Lastly, it is anticipated that the Crisis Residential, Walk-in Crisis, Telephone Crisis, Mobile Crisis and Medical Mobile Crisis rates in the MA program will be increased for other additional costs in the regulations which will result in an annual cost to the MA program of approximately $5,900,000 ($2,015,000 in State Funds). This is comprised of braided funding impacts and the differences between the assumptions used in the development of the updated rates and current provider practices in the State. Due to limitations in the available data for both braided funding and current provider practices in the State, the exact impact of each of those drivers is not estimated. Current grant funding will expire in 2027 which will

result in increased costs to all other payors; these anticipated rate increases aim to ensure providers receive enough funding to deliver services in full compliance with these regulations beyond 2027.

Additional Complement

Lastly, the Department will need to hire four additional Human Services Program Representative 1 staff positions, one Crisis Coordinator, one Fiscal Management Specialist 2, one Human Services Analyst Supervisor and two Human Services Analysts in order to carry out the work associated with these licensing regulations. It is anticipated that these added positions will result in an additional annual cost of approximately $1,170,000 ($608,000 in State funds) in FY 26-27 and $1,163,000 ($595,000 in State funds) in FY 27-28 and beyond. In FY 26-27 $5,000 in operational costs are assumed for each new staff member and $3,000 in operational costs are assumed for the following years.

Summary of Impact

In summary, there are a few impacts to the state resulting from this regulatory package. First, the MA program will see an annualized state cost of $11,242,000. Beginning in FY 26-27 there is a state cost of $608,000 for nine new staff, which grows to $595,000 in FY 27-28 and beyond. Lastly, assuming the General Assembly provides additional county mental health base funding, there is an additional state impact of $35,006,000 which supports non-MA populations to receive crisis intervention services. This last item is described in more detail in question 20. With additional details from the regulated community, the Department expects the fiscal impact to change in the final-form version of the regulation.

No new legal, accounting or consulting procedures will be required as a result of the proposed rulemaking.

(22) For each of the groups and entities identified in items (19)-(21) above, submit a statement of legal, accounting or consulting procedures, and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

Of the paperwork requirements listed below, the development of emergency preparedness plans is a new requirement. The proposed licensing regulations include the following paperwork requirements for crisis intervention service providers:

- Emergency preparedness plans
- Individual case records and recordkeeping
- Medication records
- Provider policies and procedures
- Quality management plans
- Service description
- Staff training plans

However, most of these paperwork requirements are existing requirements. The proposed rulemaking establishes that the crisis intervention service provider must develop written policies and procedures for the implementation of the emergency preparedness plan and must review and update policies and procedures annually. The proposed licensing regulations will require crisis intervention service providers to have an emergency preparedness plan that includes a documented premises-based and community-based risk assessment process. The plan must include strategies to address various emergency events identified in the risk assessment.

In addition, the proposed regulation is codifying the requirement for policies, procedures, quality management plans, service descriptions and staff training plans. The proposed regulations include a section related to recordkeeping and case records. The proposed regulation requires provider policies and procedures, including written protocols for each crisis intervention service which shall state the policy and guidelines for responding to specific situations, including threats of harm to self or others and other common or anticipated crisis situations.

The proposed licensing regulations also require crisis intervention service providers to participate in quality monitoring activities such as establishing and implementing a quality management plan that monitors, evaluates, and initiates activities to improve the quality and effectiveness of administrative and crisis intervention services and to also generate quality, utilization and performance reports quarterly. There are federal benchmarks specific to the delivery of crisis service that previously did not exist. Providers will need to track far more detail than previously collected, specific to the timeliness of services delivered, engagement of service modalities, and the outcome of services delivered.

The proposed regulation further requires crisis intervention service providers to submit a service description prior to licensure. In addition, crisis intervention service providers will be required to have written staff training plans that address training needs related to each specific job duties that are designed to improve the delivery of services by increasing staff members' skill set. As noted above, emergency preparedness plans are a new requirement under the proposed regulation, although some providers may already have these in place due to being part of an integrated health system. Tracking client engagement will require greater specificity and attention to timeframes for service delivery. There will be new data mechanisms required to meet these expectations; however, the Commonwealth intends to support the creation and availability of tracking platforms.

The proposed regulations do not require any legal, accounting or consulting procedures.

(22a) Are forms required for implementation of the regulation?

The Department currently requires all crisis intervention service providers seeking licensure to complete a licensing application, which can be found by accessing the Department's web site, or by contacting the Department and requesting the form. The link to the Department's web site for a licensing application is provided below.

(22b) If forms are required for implementation of the regulation, **attach copies of the forms here.** If your agency uses electronic forms, provide links to each form or a detailed description of the information required to be reported. **Failure to attach forms, provide links, or provide a detailed description of the information to be reported will constitute a faulty delivery of the regulation.**

The licensing application form, and other information relating to licensing, is available at the following link: https://www.dhs.pa.gov/providers/Clearances-and-Licensing/Pages/App-for-License.aspx.

(23) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year 2024-2025	FY +1 Year 2025-2026	FY +2 Year 2026-2027	FY +3 Year 2027-2028	FY +4 Year 2028-2029	FY +5 Year 2029-2030
SAVINGS:	**$**	**$**	**$**	**$**	**$**	**$**
Regulated Community	0	0	0	0	0	0
Local Government	0	0	0	0	0	0
State Government	0	0	0	0	0	0
Total Savings	0	0	0	0	0	0
COSTS:						
Regulated Community	$0	$0	$0	$0	$0	$0
Local Government	$0	$0	$0	$0	$0	$0
State Government	$0	$ 5,621,000	$46,862,000	$46,843,000	$46,843,000	$46,843,000
Total Costs	0	0	0	0	0	0
REVENUE LOSSES:						
Regulated Community	0	0	0	0	0	0
Local Government	0	0	0	0	0	0
State Government	$0	$0	$0	$0	$0	$0
Total Revenue Losses	0	0	0	0	0	0

*Note: The cost to the regulated community and local government are displayed as $0 because the Governor's budget will possibly include increases to MA/County Base funding. If the General Assembly provides the additional funding, the state will bear the increased cost.

(23a) Provide the past three-year expenditure history for programs affected by the regulation.

Program	FY -3 2021-2022	FY -2 2022-2023	FY -1 2023-2024	Current FY 2024-2025
Mental Health (base dollars)	$822,470,000	$866,093,000	$885,567,000	$956,535,000
MA Capitation	$4,557,295,000	$3,418,498,000	$3,594,065,000	$3,606,799,000
MA Fee-for-Service	$644,059,000	$589,137,000	$697,354,000	$648,977,000

General Government Operations	$120,570,000	$120,016,000	$128,196,000	$136,587,000

(24) For any regulation that may have an adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), provide an economic impact statement that includes the following:

(a) An identification and estimate of the number of small businesses subject to the regulation.

- As noted in response to question 15, there are 41 crisis intervention service providers enrolled in the Medical Assistance program that may be considered small businesses that are subject to this regulation. Based upon a review of the Department's paid claims data for crisis intervention services for fiscal year 2020-2021, four for-profit crisis intervention service providers received $1,727,037.09 in Department funds, meeting the definition of "small business" in 13 CFR § 121.201. However, the Department does not have access to information on the total revenue generated by each for-profit provider of crisis intervention services and can only base its estimate on the Department's paid claims data. (See the Department's answer to Question 15 for more details.)

(b) The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed regulation, including the type of professional skills necessary for preparation of the report or record.

- The proposed regulation requires crisis intervention service providers to participate in quality monitoring activities and to report data results for quality, utilization and performance measures. In addition, crisis intervention service providers will be required to have written staff training plans that address training needs related to specific job functions and are designed to improve the skills of staff to ensure that quality crisis intervention services are provided. Additionally, crisis intervention service providers will be required by the proposed regulations to have a written emergency preparedness plan. The remaining paperwork and recordkeeping requirements included in the proposed regulations will be greater than the current expectations, but the additional burden will be mitigated by processes created by the Commonwealth. This includes the requirements for individual case records, and what the records are composed of, as well as recordkeeping requirements for the provider's agency records. Recordkeeping also includes medication records, and a service description which addresses the specific services the provider offers. The overall fiscal impact for each crisis intervention service provider will vary and depends upon the organizational structure including policies and procedures, and current training requirements.

(c) A statement of probable effect on impacted small businesses.

- Due to these being minimum health and safety requirements, the proposed regulation affects all businesses equally, including the 41 crisis intervention service agencies that may be considered small businesses. Although there may be some costs associated with complying with the proposed regulation's staffing requirements, these expenses are likely

to be minimal and offset due to the recognition of various types of experience, which will allow additional individuals to qualify for more staffing positions and provide additional options for crisis intervention service providers to hire and retain qualified staff.

(d) A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

- There are no less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. The stated purpose of the regulations, to ensure minimum standards for the health and safety of individuals receiving crisis intervention services, can only be achieved through promulgating and enforcing regulations.

(25) List any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, the elderly, small businesses, and farmers.

This proposed regulation applies to providers who offer crisis intervention services to individuals from all age groups and ethnicities. There are no provisions specifically developed for minorities, elderly, small businesses or farmers. Providers of all modalities of crisis intervention services have the option to designate special populations to be served when submitting the facility service description.

(26) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

The proposed regulation proposes to codify the minimum standards for the issuance of licenses to provide crisis intervention services in this Commonwealth. Minimum health and safety licensure standards for crisis intervention service facilities ensure safe, consistent and adequate treatment for individuals receiving crisis intervention services. As minimum health and safety standards, the proposed regulations are the least burdensome acceptable alternative to meet this need. The proposed regulations were drafted in consultation with providers and clinicians, as well as individuals with lived experience and other subject matter experts. This was the expert opinion of providers and clinicians, as well as individuals with lived experience and other subject matter experts that these would be the minimum standards.

(27) In conducting a regulatory flexibility analysis, explain whether regulatory methods were considered that will minimize any adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), including:

a) The establishment of less stringent compliance or reporting requirements for small businesses;

- The proposed regulations include the minimum standards to ensure the safety of individuals receiving crisis intervention services and the delivery of quality services. Therefore, exempting small businesses from specific provisions or establishing less stringent compliance or reporting requirements within the regulations was not considered due to health and safety.

b) The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;

- The proposed regulations include the minimum standards to ensure the safety of individuals receiving crisis intervention services and the delivery of quality services. Therefore, exempting small businesses from specific provisions or establishing less stringent schedules or deadlines for compliance or reporting requirements within the regulations was not considered due to health and safety.

c) The consolidation or simplification of compliance or reporting requirements for small businesses;

- The proposed regulations include the minimum standards to ensure the safety of individuals receiving crisis intervention services and the delivery of quality services. Therefore, exempting small businesses from specific provisions or the consolidation or simplification of compliance or reporting requirements within the regulations was not considered due to health and safety.

d) The establishment of performance standards for small businesses to replace design or operational standards required in the regulation; and

- The proposed regulations include the minimum standards to ensure the safety of individuals receiving crisis intervention services and the delivery of quality services. Therefore, exempting small businesses from specific provisions or establishing performance standards for small businesses to replace standards required within the regulations was not considered due to health and safety.

e) The exemption of small businesses from all or any part of the requirements contained in the regulation.

- The proposed regulations include the minimum standards to ensure the safety of individuals receiving crisis intervention services and the delivery of quality services. Therefore, exempting small businesses from all or any part of the requirements within the regulations was not considered due to health and safety.

(28) If data is the basis for this regulation, please provide a description of the data, explain in detail how the data was obtained, and how it meets the acceptability standard for empirical, replicable and testable data that is supported by documentation, statistics, reports, studies or research. Please submit data or supporting materials with the regulatory package. If the material exceeds 50 pages, please provide it in a searchable electronic format or provide a list of citations and internet links that, where possible, can be accessed in a searchable format in lieu of the actual material. If other data was considered but not used, please explain why that data was determined not to be acceptable.

Data was not the basis for this regulation. However, the department did review surrounding states' requirements and researched best practices.

Crisis intervention service regulations published by Delaware, Maryland, New Jersey, New York, and Ohio were reviewed to inform the staffing requirements for crisis intervention services, including staff responsibilities and qualifications, crisis service requirements, service planning process and time frames, and recordkeeping requirements prior to drafting the new proposed chapters. This information was obtained by researching each state's website for copies of applicable regulations. The regulations can be accessed at:

Delaware:

- Delaware provides a continuum of Crisis Intervention Services. These services are located throughout the state in Crisis Intervention Service Centers, Community Mental Health Centers, the Recovery Response Center, and Emergency Rooms. Crisis Intervention Service (CIS) staff are available 24 hours a day to assist people, 18 years and older, with severe personal, family, or marital problems. The Division has sets of standards for alcohol and drug providers, and for mental health group homes; it appears as though there are no formal crisis intervention service regulations in place.
- https://dhss.delaware.gov/dhss/dsamh/regs.html
- https://dhss.delaware.gov/dhss/dsamh/files/grouphomestandards.pdf

Maryland:

- Maryland regulates Residential Crisis Services (RCS) for individuals with a primary mental health diagnosis. These provide short-term mental health treatment and support services in a structured environment for individuals who require 24-hour supervision due to a psychiatric crisis; and are designed to prevent a psychiatric inpatient admission, shorten the length of inpatient stay, effectively use general hospital emergency departments; and provide an alternative to psychiatric inpatient admission.
- https://dhs.maryland.gov/documents/Licensing-and-Monitoring/Maryland%20Law%20Articles/RCC/COMAR%2010.21.26%20Community%20Mental%20Health%20Programs%20-%20Residential%20Crisis%20Services.pdf

New Jersey:

- New Jersey offers licensure standards for County Psychiatric Facilities, Licensed Community Residences for Adults with Mental Illnesses, Community Support Services for Adults with Serious Mental Illnesses, Outpatient Service Standards, Partial Care Service Standards, and Short-Term Care Facility Standards. It appears as though there are no formal crisis intervention service regulations in place.
- https://www.state.nj.us/humanservices/providers/rulefees/regs/

- https://www.state.nj.us/humanservices/providers/rulefees/regs/rulesfiles/NJAC%2010_37A%20LICENSED%20COMMUNITY%20RESIDENCES%20FOR%20ADULTS%20WITH%20MENTAL%20ILLNESSES.PDF

New York:
The Office of Mental Health (OMH) has filed a Notice of Proposed Rulemaking creating a new Part 600 to implement Article 36 of the Mental Hygiene Law by establishing standards for Crisis Stabilization Centers which provide a full range of psychiatric and substance use services within a defined geographic area. The notice of revised rulemaking was published in issue #10 of the State Register dated March 9, 2022. The public comment period ended on April 23, 2022, and the regulations were adopted on June 13, 2022 (N.Y. Comp. Codes R. & Regs. Tit. 14 § 600).

- https://dos.ny.gov/system/files/documents/2021/08/081821.pdf
- https://omh.ny.gov/omhweb/policy_and_regulations/#proposed
- https://omh.ny.gov/omhweb/policy_and_regulations/proposed/omh600revised.pdf

Ohio:

- Crisis intervention service requirements are promulgated under Chapter 5122-29 (relating to requirements and procedures for behavioral health services) of the Ohio Administrative Code.
- https://codes.ohio.gov/ohio-administrative-code/rule-5122-29-10

In addition to the review of other states' regulations, research was gathered to review the most recent prevalence estimates of mental illness, the national cost impact of untreated mental illness, crisis services treatment outcomes and recovery from mental illness. Research was accessed via internet search. Information cited was provided in reports from national entities such as the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services, the Center for Disease Control (CDC), the World Health Organization (WHO), the National Institute of Mental Health (NIMH) and the National Alliance on Mental Illness (NAMI). The research utilized can be accessed at:

SAMHSA:

- SAMHSA National Guidelines for Behavioral Health Crisis Care Guidance – https://library.samhsa.gov/product/national-behavioral-health-crisis-care-guidance/pep24-01-037.
- SAMHSA Suicide Prevention resources – https://www.samhsa.gov/find-help/suicide-prevention
- SAMHSA 2013 National Survey on Drug Use and Health: Summary of National Findings - http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

CDC:

- CDC Healthy People 2020 – https://www.cdc.gov/nchs/healthy_people/hp2020.htm
- CDC Suicide Prevention resources – https://www.cdc.gov/suicide/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fsuicide%2Findex.html

WHO:

- WHO Mental Health Action Plan 2013-2020 - http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf?ua=1

NIMH:

- NIMH Suicide Prevention resources - https://www.nimh.nih.gov/health/topics/suicide-prevention

NAMI:

- NAMI Mental Health in Pennsylvania State Fact Sheet - https://www.nami.org/NAMI/media/NAMIMedia/StateFactSheets/PennsylvaniaStateFactSheet.pdf
- NAMI Mental Health by the Numbers - http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

(29) Include a schedule for review of the regulation including:

A. The length of the public comment period: 30 days after publication of the proposed regulation.

B. The date or dates on which any public meetings or hearings will be held:

No public meetings or hearings will be held.

C. The expected date of delivery of the final-form regulation:

Spring 2026

D. The expected effective date of the final-form regulation:

180 days after publication in the *Pennsylvania Bulletin*.

E. The expected date by which compliance with the final-form regulation will be required:

180 days after publication in the *Pennsylvania Bulletin.*

F. The expected date by which required permits, licenses or other approvals must be obtained:

180 days after publication in the *Pennsylvania Bulletin*.

(30) Describe the plan developed for evaluating the continuing effectiveness of the regulations after its implementation.

The Department will review the regulations on an ongoing basis to ensure compliance with Federal and State law and to assess the appropriateness and effectiveness of the regulation. The Department will monitor the impact of this regulation through annual licensing inspections and utilization management reviews of crisis intervention service providers. Existing facilities will be inspected for compliance with the new chapter during their annual renewal inspection. In addition, the Department will meet with stakeholder organizations, OMHSAS Planning Council, provider organizations and individuals receiving crisis intervention services on an ongoing basis. The Department will research and address any issues identified as needed.

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

RECEIVED

Independent Regulatory Review Commission

October 1, 2025

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General

By: Amy M Elliott (Digitally signed by Amy M Elliott Date: 2025.09.24 09:13:40 -04'00')

(Deputy Attorney General)

Date of Approval

☐ **Check if applicable Copy not approved. Objections attached.**

Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:

DEPARTMENT OF HUMAN SERVICES

(Agency)

LEGAL COUNSEL: _____

DOCUMENT/FISCAL NOTE NO. 14-557

DATE OF ADOPTION: _____

BY: _____

TITLE: SECRETARY OF HUMAN SERVICES

(Executive Officer, Chairman or Secretary)

Copy below is hereby approved as to form and legality. Executive or Independent Agencies.

BY: _____

5/30/2025

Date of Approval

(Deputy General Counsel)
(Chief Counsel, Independent Agency)
(Strike inapplicable title)

☐ **Check if applicable. No Attorney General approval or objection within 30 days after submission.**

NOTICE OF PROPOSED RULEMAKING

DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

[55 Pa. Code Chapter 5250. Crisis Intervention Services]

Licensure of Crisis Intervention Services

Statutory Authority

Notice is hereby given that the Department of Human Services (Department) under the authority of sections 105 and 112 of the Mental Health Procedures Act (50 P.S. §§ 7105, 7112), section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)), and sections 911 and 1021 of the Human Services Code (62 P.S. §§ 911 and 1021), intends to adopt the regulation set forth in Annex A.

Section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)) requires the Department to consult with the Advisory Committee for Mental Health and Intellectual Disability when developing regulations relating to the provision of mental health and intellectual disability services. Because the Advisory Committee is no longer active, the Department consulted with the Mental Health Planning Council in the development of this proposed rulemaking. The Mental Health Planning Council advises the Department on issues related to mental health, substance abuse, behavioral health disorders, and cross-system disability and participated in the stakeholder workgroup in reviewing this proposed rulemaking.

Purpose of Rulemaking

The purpose of the proposed rulemaking is to codify the minimum standards for the issuance of licenses to provide emergency behavioral health crisis intervention services (crisis intervention services) in this Commonwealth in alignment with national best practices for crisis services. The proposed rulemaking also establishes new requirements related to service modalities that include facility requirements, quality monitoring, staffing qualifications, services provided and training.

The proposed rulemaking is needed to codify the necessary oversight of health and safety protections for individuals who access behavioral health services in a crisis situation. The proposed rulemaking codifies the minimum requirements for building, equipment, operation, staffing, and training for entities providing these services. The proposed rulemaking provides clear and consistent standards for licensure or approval of all modalities of crisis intervention services within the scope of the proposed rulemaking.

Background

The effective delivery of crisis intervention services to individuals with acute behavioral health concerns is one of the most important functions of Pennsylvania's behavioral health system. Effective delivery of crisis services ensures that individuals with acute mental health conditions have immediate access to mental health services. The equivalent to emergency physical health services, crisis intervention services are immediate services designed to de-escalate individuals experiencing suicidal crisis or emotional distress due to acute stress while identifying appropriate intervention and treatment services to further lessen an individual's level of distress. Crisis intervention services are provided to individuals across the lifespan. Crisis intervention services include de-escalation, assessment, peer support, counseling, screening, prescribing of medication, and connection to appropriate ongoing services. Crisis intervention services are an emergency response to behavioral health crisis situations that threaten the well-being of an individual.

In Pennsylvania, there are currently five types of licensed crisis intervention services, including Crisis Call Center Services, Mobile Crisis Team Services, Medical Mobile Crisis Team Services, Emergency Behavioral Health Crisis Walk-In Center Services, and Crisis Stabilization Unit Services. Pennsylvania has a decentralized system that uses Federal, State, and county braided funding and is managed at the county level. Crisis intervention services are provided to

all individuals who need the service regardless of funding resources or established connections to the behavioral health service delivery system.

The current county-based service delivery system lacks uniform standards and consistency, resulting in potential quality-of-care concerns and varying availability and access to the different modalities of crisis intervention services across all 67 counties. These inconsistencies create challenges for individuals when accessing crisis intervention services across county borders and for behavioral health professionals when coordinating care for individuals who live in different counties.

To aid in the overall readability and application of this chapter, the proposed rulemaking includes provisions applicable to specific modalities of crisis intervention services within the scope of the chapter, which include Crisis Call Center Services, Mobile Crisis Team Services, Medical Mobile Crisis Team Services, Emergency Behavioral Health Crisis Walk-In Center Services, and Crisis Stabilization Unit Services, unless specifically noted otherwise.

Requirements

Proposed Chapter 5250 (relating to crisis intervention services) identifies and codifies the minimum program and operational standards for a provider to obtain a license to provide one or more crisis intervention services. The following is a summary of the major provisions of the proposed rulemaking.

Chapter 5250. Crisis Intervention Services.

General Provisions (§§ 5250.1 - 5250.8). These provisions of the proposed rulemaking apply to all licensed crisis intervention service providers. Section 5250.2 (relating to applicability) also specifies the following five modalities of crisis intervention services under this chapter: Crisis Call Center Services, Mobile Crisis Team Services, Medical Mobile Crisis Team

Services, Emergency Behavioral Health Crisis Walk-In Center Services, and Crisis Stabilization Unit services. As provided under Section 5250.3 (relating to purpose), the purpose of the proposed rulemaking is to protect the health, safety, and well-being of individuals who receive crisis intervention services. In addition, the proposed rulemaking defines various terms used in the chapter and lists applicable laws to crisis intervention services, to which licensed providers must comply.

The proposed rulemaking requires all providers that provide crisis intervention services to obtain a license from the Department before providing services. Under the proposed rulemaking, a crisis intervention service provider may be licensed for one or more crisis intervention services, including Crisis Call Center Services, Mobile Crisis Team Services, Medical Mobile Crisis Team Services, Emergency Behavioral Health Crisis Walk-In Center Services, and Crisis Stabilization Unit Services. The crisis intervention service provider must post the current license in a conspicuous and public place within the facility or agency and must also grant access to the Department and to community advocates, consistent with current licensing practices.

General Requirements (§§ 5250.11 - 5250.16). These proposed provisions also apply to all licensed crisis intervention service providers. The proposed rulemaking requires a written fire safety approval from the Department of Labor and Industry, the Department of Health, or the appropriate local building authority, prior to issuance of a license. This proposed provision helps ensure the building is appropriately constructed to serve individuals. This is an existing requirement under 55 Pa. Code § 20.35 (relating to fire safety approval). The proposed rulemaking also maintains the existing requirement for a crisis intervention service provider to comply with statutes and regulations relating to the confidentiality of records.

The proposed rulemaking also provides a waiver provision. Under the proposed rulemaking, the Department may grant a waiver of a specific requirement if the following circumstances are met: there is no significant jeopardy to an individual receiving crisis intervention services; there is an alternative for providing an equivalent level of health, safety and well-being protection of an individual receiving crisis intervention services; the benefit of waiving the regulation outweighs any risk to the health, safety and well-being of an individual receiving crisis intervention services; and the waiver does not violate other applicable Federal or State statutes or regulations. Also, the proposed rulemaking does not permit the scope, definitions, purpose, or applicability of the chapter to be waived.

The proposed rulemaking establishes a requirement for a quality management plan, which focuses on monitoring, evaluating, and initiating activities to improve the quality and effectiveness of administrative and crisis intervention services. Some of the proposed requirements of the plan include staffing, licensing, and regulatory reviews; reviews of interviews and meeting minutes; and quality, utilization, and performance measures. The proposed rulemaking establishes that a crisis intervention service provider is required to prepare an annual quality report, which includes an analysis of the findings of the annual quality review, identification of the actions to address annual review findings, and quality, utilization, and performance measures as identified by the Department. The proposed rulemaking also provides that the quality management plan be reviewed and updated annually to ensure that all information is current. Having a quality management plan ensures that the provider has a tool for identifying and addressing deficits in the delivery of services and management of crisis intervention services. Crisis intervention service providers may already utilize these documents and processes; however, some updating may be necessary to ensure compliance with this proposed provision.

The proposed rulemaking also codifies and standardizes a requirement for crisis intervention service facilities to produce and maintain a service description approved by the Department through the licensing process. The proposed regulation enumerates items that must be included in the service description. Current crisis intervention service providers should already have service descriptions; however, some service providers may need to update their service descriptions under the proposed requirements.

Finally, the proposed rulemaking requires that individuals have the right to file a complaint in accordance with § 5100.54, Article VII, Grievance and Appeal Procedures (relating to the manual of rights for persons in treatment). Under the proposed rulemaking, the crisis intervention service provider must have a written policy and procedure for receiving, reviewing, and responding to complaints; and have a process for ensuring adherence to the policy. In addition, the proposed rulemaking provides standards for investigating and resolving the complaint. Under the proposed rulemaking, an individual receiving services shall be given a copy of the complaint and final decision, and a copy shall be filed in the individual's record. Finally, if the complaint remains unresolved, the crisis intervention service provider is required to follow the appeal procedures under § 5100.54, Article VII, Grievance and Appeal Procedures.

Individual Rights (§§ 5250.21 - 5250.24). The proposed rulemaking codifies the rights of individuals receiving crisis intervention services. The proposed rulemaking affirms the right to refuse medication or placement in crisis intervention services or terminate services without prejudice to other mental health services or future services. In addition, consistent with state law, a youth or the youth's parent may consent to the youth receiving crisis intervention services. The proposed rulemaking also establishes the requirement that parents, legal guardians, or caregivers must be notified prior to intervention if the individual is a child or youth. The proposed

rulemaking also contains assurances of non-discrimination, confidentiality, and individual rights. The proposed rulemaking also cross-references specific patient rights under §§ 5100.51 - 5100.55 (relating to patient rights).

Staffing (§§ 5250.31 - 5250.35). The proposed rulemaking codifies the minimum staffing requirements for crisis intervention service providers and includes the minimum qualifications for those who provide crisis intervention services.

For the crisis intervention service licensed medical professional, the qualifications are similar to current practice, with the addition of a licensed physician's assistant with 1 year of behavioral health service experience in diagnosis, evaluation, and treatment of behavioral health conditions.

The crisis intervention service licensed behavioral health professional is a new position under the proposed rulemaking and includes any of the following licensed professions: bachelor social worker, social worker, clinical social worker, professional counselor, associate professional counselor, marriage and family therapist, associate marriage and family therapist, and psychologist. The proposed rulemaking aligns with current practice for the crisis intervention service behavioral health professional.

The proposed qualifications for a crisis intervention service crisis worker align with current practice. The only difference is the obsoletion of a consumer or family member who has 1 year of experience as an advocate or leader in a consumer or family group and has a high school diploma or equivalency.

The proposed rulemaking also adds the requirements for a certified peer professional who has a certification in good standing from a state-approved training entity (e.g., the Pennsylvania Certification Board) to deliver peer support services to individuals and/or families impacted by mental illness and/or substance use disorders.

Finally, volunteers need to meet one of the staff qualifications as defined in the proposed rulemaking, and interns in accredited training programs in various mental health disciplines may participate in providing crisis intervention services when under the direct supervision of a crisis intervention service behavioral health professional. This proposed shift aligns with national best practices. The proposed staffing qualifications were designed so a staff member may qualify for each position as the staff member gains education and experience. By taking this graduated approach, staff may be retained more easily, and there is an opportunity for growth within a provider's organization.

The proposed rulemaking codifies that crisis intervention service providers must complete criminal history background checks for all staff and volunteers. In addition, under the proposed rulemaking, all crisis intervention service providers must develop and consistently implement written policies and procedures regarding personnel decisions based on the results of criminal history checks. This proposed requirement helps to protect the health, safety, and well-being of all individuals receiving crisis intervention services.

The proposed rulemaking codifies essential training and certification requirements in first aid, obstructed airway techniques, and Cardio Pulmonary Resuscitation (CPR). Consistent with current training requirements in first aid and certification in obstructed airway techniques, CPR training must be provided by an individual certified as a trainer by a hospital or other recognized health care organization. The proposed rulemaking also provides that crisis intervention service staff be trained and maintain certification in the administration of Naloxone or other appropriate medications used to reverse a substance overdose. Consistent with current training in the administration of Naloxone and other appropriate medications used to reverse a substance overdose, training must be provided by an individual certified as a trainer by a hospital or other recognized health care organization. This proposed requirement will help to protect the health,

safety, and well-being of all individuals receiving crisis intervention services, as any working staff member will be properly trained and can respond in the event of an emergency.

The proposed rulemaking proposes the requirement that within the first 10 scheduled working days, all crisis intervention service crisis staff, interns, and volunteers shall have an initial orientation lasting at minimum 4 hours, that includes de-escalation techniques, suicide risk assessment procedures, trauma-informed care, or other trainings as published in a notice in the *Pennsylvania Bulletin*. In addition, the proposed rulemaking proposes the requirement that within the initial 4 scheduled working weeks, all crisis intervention service crisis staff, interns, and volunteers shall have 8 hours of training in various enumerated topics. This initial training will help staff transition into their roles and set the standard for delivering services. The proposed rulemaking also proposes to require all crisis intervention service staff, interns, and volunteers have a minimum of 12 hours of annual training including, but not limited to, emergency preparedness and universal precautions, policy and procedure review which is specific to the intern, volunteer, or crisis intervention service staff person's position, and the general topics enumerated under the prior provision. To the extent this training has not already occurred, current staff members will need to complete these training requirements upon the effective date of the regulation, which is proposed to be 180 days after promulgation of the final-form rulemaking. However, the proposed rulemaking clarifies that staff are not required to repeat completed initial training if the training was completed within the past year as a crisis intervention staff member, intern or volunteer, with written verification. This allows staff who have received the initial training and changed jobs to begin providing crisis intervention services immediately.

Utilizing an electronic learning management system, the Commonwealth will provide modules on all required topics online and at no additional cost. This free resource brings crisis

intervention service staff into compliance with the proposed rulemaking with no financial burden to provider entities, other than the time it takes a staff person to successfully complete the training.

Staff training plans are proposed as a new requirement under the proposed rulemaking to ensure that staff providing crisis intervention services have the knowledge and skills to deliver crisis intervention services. The proposed rulemaking establishes that written training plans must be developed for each type of crisis intervention service provided. The written staff training plan must include training aimed at improving the knowledge and skills of staff persons in carrying out job responsibilities and specify training for each staff classification that must be completed before a staff member may provide crisis intervention services. This helps to ensure that staff will be properly trained before providing crisis intervention services. In addition, the staff training plan must establish ongoing training requirements for staff members and have a primary objective that enables staff persons to identify a crisis and provide crisis intervention services to adults, youth, and children in an age-appropriate and culturally competent manner. Ongoing training requirements help to ensure that staff develop the proper skills and knowledge over time to meet the demands of their role in providing crisis intervention services. The proposed rulemaking also provides that the staff training plan be approved by the county administrator and be reviewed and updated at least annually Finally, the crisis intervention service provider must keep documentation of compliance with the staff training plan.

Physical Site (§§ 5250.41 - 5250.48). The proposed rulemaking codifies new standards for the physical site of facilities where crisis intervention services are provided. Currently, there are no physical site standards aside from safety standards for elevators inspections and permits. For the safety of individuals receiving services, the proposed rulemaking establishes that crisis

intervention service providers must have a policy that addresses the use of locks, the use of security personnel, the use of external law enforcement, and key access control.

In addition, stairways, hallways, doorways, passageways, and egress routes from rooms and from the building shall be unobstructed and lighted, and interior and exterior stairways must have securely fastened handrails and non-skid surfaces or non-skid devices. Establishing physical site standards, such as these, will help to ensure that individuals receiving services remain safe while ambulating within the facility and may also evacuate quickly in the event of an emergency while receiving services at the facility. Finally, for those crisis intervention service providers that have elevators in the facility, they must obtain a certificate of operation from the Department of Labor and Industry or the appropriate local building authority. The standard to have elevators properly inspected and permitted by the Department of Labor and Industry is not a new requirement.

The proposed rulemaking takes into account that there may be individuals receiving services who may use tobacco by establishing minimum standards for their safety while remaining in compliance with other laws relating to smoking indoors. The proposed rulemaking establishes requirements for smoking, including not allowing smoking indoors. A crisis intervention service provider must comply with The Clean Indoor Air Act (35 Pa.C.S. Ch. 637), by having signage prominently posted and properly maintained at every entrance to the premises. For crisis intervention service providers who permit smoking outside, written fire safety policies and procedures must be developed and implemented that include proper safeguards inside and outside of the crisis intervention premises to prevent fire hazards. Providers who permit smoking outdoors must limit smoking to designated smoking areas. Under the proposed rulemaking, the policy and procedures must address the use of fireproof receptacles and ashtrays, fire-resistant furniture, fire extinguishers in the smoking areas, and fire extinguishing procedures. While

smoking outside is permitted, the proposed rulemaking establishes that crisis intervention service providers must have policies that incorporate tobacco-free recovery principles into overall service objectives and provide individuals with access to resources that support tobacco-free recovery. This provision takes into account that while there may be individuals who use tobacco, there may be interest from individuals in quitting that practice. During the stakeholder workgroup sessions, the workgroup members were split on the issue of allowing smoking. The proposed rulemaking as drafted was found to be acceptable by all members of the stakeholder workgroup sessions.

The proposed rulemaking also establishes requirements for the building exterior and grounds of the crisis intervention service facility. The proposed rulemaking is intended to help preserve the safety of individuals receiving services, staff members who work on the premises, and the general public who may come into contact with the premises. Proposed requirements include maintaining structures on the grounds, as well as keeping the grounds of the premises clean, safe, sanitary, and in good repair at all times. In addition, a requirement is also included for the exterior of the building and the building grounds or yard free of hazards, and for exterior exits, stairs and walkways designated for emergency exit routes to be lighted at night. Finally, the proposed rulemaking provides the requirement that trash be stored in noncombustible, covered containers that prevents the penetration of insects and rodents.

The proposed rulemaking also provides requirements for exit signs in a crisis intervention service facility. This includes requirements for the location and visibility of exit signs, as well as the exit signage letter font size. Also included is the requirement that doors, passageways, or stairways that are not exits be marked as such. Large facilities have more doors that could be mistaken as exits. Labeling exits helps individuals receiving services, staff, and visitors escape during a fire or other emergency. In addition, labeling exits so they can be read properly is

important as people need to be able to understand how to exit the premises. It is likely that current licensed providers already have these measures in place, as these are Labor and Industry building standards.

The proposed rulemaking also provides requirements for items such as telephone numbers for the nearest hospital, police department, fire department, ambulance, and poison control center, patient rights, a list of local and state advocacy organizations and contact information, information about the local county Mental Health/Intellectual or Developmental Disability (MH/IDD) program and Single County Authority contact information, all licenses issued to the crisis intervention service provider, and the certificate of occupancy to be posted in the crisis intervention service facility. Posting the required information allows for easy access to critical information by staff and laypersons during an emergency.

The proposed rulemaking also proposes requirements for emergency preparedness and fire safety in crisis intervention service facilities. For emergency preparedness, this includes a requirement for an emergency plan that includes a documented premises-based and community-based risk assessment, utilizing an all-hazards approach. The emergency plan must include strategies to address emergency events identified in the risk assessment, as well as a communication plan. Crisis intervention service providers that are part of an integrated health system must demonstrate the capability to implement the integrated emergency plan. Additionally, the proposed rulemaking establishes that the crisis intervention service provider must develop written policies and procedures for the implementation of the disaster plan and must review and update policies and procedures annually. Having an established written emergency preparedness plan helps to ensure that individuals receive crisis intervention services in a safe manner. It also ensures that providers are prepared to respond to localized and general emergencies.

For fire safety, the proposed rulemaking establishes the requirement that all fire safety systems must be inspected and approved annually by a certified fire inspector. Approved fire safety systems help to ensure that the devices will function properly in the event of a fire. In addition, the proposed rulemaking requires the crisis intervention service provider to post either exit diagrams or lighted signs, or both, throughout the premises to designate escape routes. Emergency evacuation diagrams help individuals receiving services, staff, and visitors escape in the event of a fire or other emergency. Manual fire alarm systems and portable fire extinguishers must also be immediately accessible to all staff on duty. Easily accessible fire extinguishers offer staff and individuals the chance to extinguish a fire before it spreads. Having fire safety systems in place ultimately helps to ensure that individuals receive crisis intervention services in a safe manner.

Finally, the proposed rulemaking provides the requirement for fire drills to occur. Under the proposed rulemaking, for all modalities of crisis intervention services, an unannounced fire drill must be held at least once every 2 months. Unannounced fire drills ensure that staff and individuals will be prepared to evacuate without hesitation in the event of a real fire. The proposed rulemaking provides that alternate exit routes must be used during fire drills. Varying the location of the fire and the exit routes used ensures that staff and individuals are prepared to respond to different fire scenarios. The proposed rulemaking also provides that fire drills must be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present, and not routinely held at times when individual attendance is low. Staggering fire drill dates and times ensures that staff and individuals are prepared to respond to different fire scenarios, and that staff on all shifts are properly trained in evacuation procedures. The proposed rulemaking also provides that individuals must evacuate to a designated meeting place away from the building or within the fire-safe area during each fire

drill. Designated meeting places and communication systems ensure that individuals are accounted for during actual fires to ensure total evacuation and prevent death or injury from wandering. The proposed rulemaking also provides that a fire alarm or smoke detector shall be set off during each fire drill, and that elevators may not be used during a fire drill or a fire. Sounding the alarm simulates what would happen in an actual fire, and elevators may be inoperative during fires, causing people to become trapped in the building. In addition, under the proposed rulemaking crisis stabilization units are required to have a fire drill during sleeping hours once every 6 months. It is critical to practice response and evacuation while individuals are asleep since an individual's response time and actions when waking from sleep are reduced, and because most fire deaths occur during sleeping hours. Lastly, the proposed rulemaking proposes that a written fire drill record must be maintained. The written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of individuals in the facility at the time of the drill, the number of individuals evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative. Recording fire drill information helps facilities ensure compliance with all of the regulations relating to fire drills, and to identify and correct problems with evacuation.

Responsibilities (§§ 5250.51 - 5250.54). The proposed rulemaking codifies the responsibilities of licensed crisis intervention service providers. This includes responsibilities such as compliance with the new chapter, submitting reports, and the establishment of a written protocol for each crisis intervention service which shall state the policy and guidelines for responding to specific situations, including threats of harm to self or others and other common or anticipated crisis situations. Comprehensive written protocols clarify exactly what the provider will and will not do in specific situations, which limits confusion about the provider's responsibilities in the event of a situation. This is a current practice for licensed providers, so

these policies and guidelines should already be in place. The proposed rulemaking also proposes the requirement for written protocol to address services to children, youth, special populations, and family members. The written protocols must also address substance use, misuse, and overdose, including the use of Naloxone or other appropriate medications used to reverse a substance overdose. These are issues which are frequently encountered in crisis intervention service facilities. The written protocol must additionally address notification to family members of children, youth and adults, and must address procedures which will provide continuity of care for individuals and monitor outcomes. Under the proposed rulemaking, the written protocol must be reviewed and approved annually by a team of individuals that represents the multi-disciplinary team membership and provider quality and administration. Finally, the written protocol must ensure interpretive services including sign language interpretation are available, and language services are offered to individuals with limited English proficiency. A written protocol is also needed for the storage and administration of drugs which has been approved by a physician and reviewed annually.

In addition, the proposed rulemaking proposes that crisis intervention service providers maintain and make available a current list of community resources for individuals and their family members, as well as notify individuals and family members of their rights. Providing a list of community resources empowers individuals and family members in crisis to seek assistance with mental health needs and other issues that can be addressed through community resources; it also may help to increase the chance that individuals and family members may use the information to seek assistance. The proposed rulemaking also proposes to require crisis intervention service providers to establish and maintain relationships with community resource providers to ensure accessibility for substance use, misuse, and substance use disorder services and to establish letters of agreement for substance use, misuse, and substance use disorder

services. Finally, the proposed rulemaking proposes a requirement that if a crisis intervention service provider also provides other behavioral health services, the provider shall allow freedom of choice, that the provider should disclose that services could also be provided by another provider if desired, and that the provider makes available a listing of behavioral health treatment, rehabilitation, and support services available within a reasonable proximity to an individual's home where needed services could be obtained and if desired, the crisis intervention services staff shall assist the individual in accessing those services. This proposed provision encourages choice in the use of providers.

The proposed rulemaking codifies requirements for recordkeeping, case records, and record retention. The proposed rulemaking also proposes requirements for disposal of records. For recordkeeping, the department proposes the mandatory copies of licensing and staffing documentation be kept in a provider's records and requirements for record maintenance. These proposed requirements include that the records be permanent, legible, dated, and signed by the staff person providing the service. These proposed provisions help ensure that information stored in the record is detailed, accurate, and unaltered. In addition, the proposed rulemaking provides that the records show the dates of service, the time of the beginning and end of each service, and that the records be organized and maintained according to a uniform format so that information is readily located. Finally, the records must be reviewed annually for quality by a crisis intervention service licensed medical professional, crisis intervention service licensed behavioral health professional, or crisis intervention service behavioral health professional.

The proposed rulemaking also codifies requirements for individual case records. Under the proposed rulemaking, records for each crisis intervention service must be specifically identified and may be integrated with the individual's other service records which are maintained by the provider. Integration of an individual's files was developed for ease of recordkeeping for

providers. In addition, the proposed rulemaking codifies requirements for the content of case records, and standards for entries in an individual's case record. This provision is in line with current case record practice.

Finally, the proposed rulemaking provides that except as otherwise provided by law, a crisis intervention service provider is to maintain records for a minimum of 4 years following discharge or until any audit or litigation is resolved. This is consistent with other departmental practice; e.g., § 1101.51(e) (relating to ongoing responsibilities of providers). In addition, the proposed rulemaking requires that records generally be retained and disposed of in a manner consistent with applicable law.

Crisis Call Center Services (§§ 5250.61 - 5250.62). The proposed rulemaking lists the specific requirements for the different modalities of crisis intervention services offered under this new chapter. Under these provisions, the proposed rulemaking includes additional requirements specific to each crisis call center services. The proposed rulemaking also includes proposed requirements for the staffing, operation, and services delivered through crisis call centers.

The proposed rulemaking codifies requirements for crisis call center services. Under the proposed rulemaking, crisis call center services are to provide confidential support services to individuals or third-party callers in suicidal crisis or emotional distress requiring emergency behavioral health intervention. Under the proposed rulemaking, crisis call center services are to operate 24 hours a day, 7 days a week, 365 days a year to deliver telephonic, text, or chat crisis intervention services. The proposed rulemaking further provides that a crisis call center is to provide behavioral health counseling, consultation, information and referral services for individuals who exhibit substance use disorder, disturbed thought, behavior, mood or problems with social relationships. In addition, the proposed rulemaking provides that a crisis call center shall provide services to callers who seek assistance on behalf of another individual (third-party

callers). Finally, under the proposed rulemaking, a crisis call center must employ a minimum of one crisis intervention service licensed behavioral health professional per shift. The proposed rulemaking is consistent with the current service description practice for providing crisis call center services; however, texting and chat services have been added to the proposed rulemaking as these services are now available to individuals in need.

The proposed rulemaking also codifies the responsibilities of crisis call center service providers. Under the proposed rulemaking, the department proposes to require a crisis call center provider to maintain a written plan that is developed in collaboration with the mental health county administrator and the Single County Authority. This plan is to detail how services are provided, in that telephone calls are answered by a member of the crisis staff and not by a recording or other mechanical device. This is consistent with current practice. In addition, the written plan must address collaboration with other services, such as services to aging and older adults, intellectual and developmental disability services, and substance use, misuse, and substance use disorder. It is important that collaboration with other services is addressed, as many individuals in crisis often have other factors affecting their behavior. It is possible that some individuals receiving crisis services may require services from multiple providers with different specialties. The proposed rulemaking also provides that a written policy must also be in place, which identifies specific requirements for how crisis call center services will be delivered. Providers must also ensure that the operational requirements as established by the proposed rulemaking are followed. The department reviewed the Substance Abuse and Mental Health Services Administration's (SAMHSA) national guidelines for crisis care in establishing these operational requirements. SAMHSA's National Behavioral Health Crisis Care Guidance can be found here: https://library.samhsa.gov/product/national-behavioral-health-crisis-care-guidance/pep24-01-037. Finally, the proposed rulemaking proposes staffing and supervision

requirements for crisis call centers, such as supervision of services, individual supervision by a crisis intervention service behavioral health professional, and the provision of services by crisis intervention service behavioral health professionals and crisis intervention service crisis workers.

Mobile Crisis Team Services (§§ 5250.71 - 5250.72). Under these provisions, the proposed rulemaking includes additional requirements specific to mobile crisis team services. The proposed rulemaking includes requirements for the staffing, operation, and services delivered through mobile crisis team services.

The proposed rulemaking codifies requirements for mobile crisis team services. Under the proposed rulemaking, the department proposes to require mobile crisis team services to operate 24 hours a day, 7 days a week, 365 days a year and provide community-based emergency behavioral health intervention to an individual in suicidal crisis or emotional distress. Under the proposed rulemaking, mobile crisis team services are to be delivered by any combination of crisis intervention service licensed behavioral health professionals, crisis intervention service behavioral health professionals, and crisis intervention service crisis workers. A crisis intervention service medical professional or a crisis intervention service licensed behavioral health professional may participate in the mobile crisis team via tele-behavioral health.

Under the proposed rulemaking, a one-person team is permitted to respond to a setting where a person who meets the requirements of one of the following is already present at the location and will remain engaged in the crisis situation until it is resolved: is a crisis intervention service licensed behavioral health professional; is a crisis intervention service behavioral health professional; is a crisis intervention service crisis worker; or is a crisis intervention service medical professional. Additionally, the proposed rulemaking requires that these mobile services be deployed by 988 or county lines. The proposed rulemaking also provides that mobile crisis team services include the following services: de-escalation, suicide risk assessment, service

needs assessment, motivational interviewing, supportive engagement, the development of a service plan, ensuring the crisis is resolved or an individual is connected to the next level of service, and referral and follow-up, including referrals for assessment and treatment for substance use disorder. The proposed rulemaking also proposes to require that mobile crisis team services provide linkages with other services and referrals as a mechanism for diversion from emergency department services and the criminal justice system. Behavioral health crisis services play a vital role in diverting individuals experiencing behavioral health crises from unnecessary emergency department visits and involvement with the criminal justice system. Emergency departments are often ill-equipped to handle mental health crises effectively. Individuals may experience longer wait times and a lack of specialized care in emergency departments. Also, by diverting individuals from jail and into mental health care, these services can potentially reduce recidivism and improve mental health outcomes. Mobile crisis team services should also ensure they are familiar with local crisis resources and the required intake process for emergency behavioral health walk-in centers and crisis stabilization programs. Under the proposed rulemaking, mobile crisis teams must develop agreements to guide the interaction between law enforcement officers and mobile crisis providers in responding to behavioral health crisis calls. The proposed rulemaking differs from current practice, as it requires the mobile crisis team services to be delivered in teams, and not by an individual. The proposed rulemaking aligns with SAMHSA national guidelines for crisis care (SAMHSA's National Behavioral Health Crisis Care Guidance) for two-person mobile crisis teams. The requirement is also present so that mobile teams are able to safely respond to individuals in community-based locations.

The proposed rulemaking also codifies the responsibilities of mobile crisis team service providers. Responsibilities include written plans developed in collaboration with the mental health county administrator and the Single County Authority, a description of service

availability, as well as the organizational structure of the program. This is consistent with current practice. In addition, the written plan must address how collaboration includes the following populations, but are not limited to aging and older adults, individuals with intellectual and developmental disabilities, and individuals with substance use, misuse, and substance use disorder. It is important that collaboration with other services is addressed, as many individuals in crisis often have additional factors affecting their behavior. It is possible that some individuals receiving crisis services may require services from multiple providers with different specialties. The proposed rulemaking also proposes that a written policy must also be in place, which identifies specific requirements for how mobile crisis team services will be delivered. Operational requirements are established in the proposed rulemaking and include the SAMHSA national guidelines for crisis care. Finally, the proposed rulemaking for mobile crisis team services establishes staffing and supervision requirements, such as crisis intervention service providers having a licensed behavioral health professional supervise the provision of mobile crisis team services.

Medical Mobile Crisis Team Services (§§ 5250.81 - 5250.82). Under these provisions, the proposed rulemaking includes additional requirements specific to medical mobile crisis team services.

The proposed rulemaking codifies requirements for medical mobile crisis team services, including requirements for the staffing, operation, and services delivered through medical mobile crisis team services. Under the proposed rulemaking, medical mobile crisis team services shall be contacted in situations where it is known or anticipated that medication will be required. The proposed rulemaking provides that medical mobile crisis team services are to be provided in the community directly to an individual experiencing a behavioral health crisis and shall supplement rather than be a substitute for mobile crisis team services. Finally, the proposed rulemaking

establishes the staff qualifications and types of services delivered by medical mobile crisis teams. The proposed rulemaking aligns with current practice.

The proposed rulemaking also codifies the responsibilities of medical mobile crisis team service providers. Under the proposed rulemaking, responsibilities include items such as a written plan developed in collaboration with the mental health county administrator and the Single County Authority, a description of service availability, as well as the organizational structure of the program. This is consistent with current practice. In addition, the department proposes that the written plan address how collaboration includes the following populations: aging and older adults; individuals with intellectual and developmental disabilities; and individuals with substance use, misuse, and substance use disorder. A written policy must also be in place, which identifies specific requirements for how medical mobile crisis team services will be delivered. Policies must include information, such as how the medical mobile crisis team service provider operates 24 hours a day, 7 days a week, 365 days a year; responding without law enforcement or emergency medical services accompaniment unless special circumstances warrant inclusion; referring outpatient follow-up appointments, as authorized by the individual; availability of a crisis intervention services licensed medical professional for consultation as needed 24 hours a day, 7 days a week, 365 days a year; supervision of staff during all hours of operations for timely consultation in determining the most appropriate intervention for individuals who may be at imminent risk of an emergency or life-threatening incident; and how the medical mobile crisis team service provider uses, administers, and stores medications. The proposed rulemaking for medical mobile crisis team services establishes staffing and supervision requirements, such as supervision of services and individual supervision must be carried out by a crisis intervention service licensed medical professional or crisis intervention service licensed behavioral health professional. Finally, the department proposes that medical mobile crisis team

services must be provided in teams by at least one crisis intervention service licensed medical professional who can administer medications, and any of the following: crisis intervention service licensed behavioral health professionals, crisis intervention service behavioral health professionals, and crisis intervention service crisis workers. The proposed rulemaking aligns with current practice.

Emergency Behavioral Health Crisis Walk-In Center Services (§§ 5250.91 - 5250.100). Under these provisions, the proposed rulemaking includes additional requirements specific to emergency behavioral health crisis walk-in center services.

The proposed rulemaking codifies requirements for emergency behavioral health crisis walk-in center services, including requirements for the staffing, operation, and services delivered through emergency behavioral health crisis walk-in center services. Under the proposed rulemaking, emergency behavioral health crisis walk-in centers are to provide short-term crisis interventions and limited stabilization services to an individual in a safe, recovery-oriented environment for emergency behavioral health care. The department proposes to require emergency behavioral health crisis walk-in centers to have continuous access, at the center or via tele-behavioral health access, to a physician for the purpose of completing the required process outlined in Section 302 of the Mental Health Procedures Act. Should the physician conduct the examination via tele-behavioral health, the proposed rulemaking proposes to require an advanced practice professional to be present at the facility and engaged in the assessment process. Under the proposed rulemaking, emergency behavioral health crisis walk-in centers are required to accept all walk-ins, which is a new requirement. This requirement is similar to the national guidelines for crisis care established by SAMHSA, which encourage a no-wrong-door access to mental health and substance use care. Finally, the proposed rulemaking codifies the types of clinical and medical services delivered by emergency behavioral health crisis walk-in center

staff. These include the following services: medical and behavioral health assessments; medication, when deemed medically necessary; stabilization within 23 hours and referral to appropriate level of care; peer support services, and evaluation and follow-up, including referrals for assessment and treatment for substance use disorder, as appropriate.

The proposed rulemaking also codifies the responsibilities of emergency behavioral health crisis walk-in center service providers. Responsibilities under the proposed rulemaking include items such as a written plan developed in collaboration with the mental health county administrator and the Single County Authority, detailing how services are provided, as well as the organizational structure of the program. This is consistent with current practice. In addition, the written plan must address how collaboration includes the following populations, but are not limited to aging and older adults, individuals with intellectual and developmental disabilities, and individuals' substance use, misuse, and substance use disorder. A written policy must also be in place, which identifies specific requirements for how emergency behavioral health crisis walk-in center services will be delivered. Operational requirements are established in the proposed rulemaking and include the SAMHSA national guidelines for crisis care. In addition, the proposed rulemaking establishes staffing and supervision requirements, such as supervision of services must be carried out by a crisis intervention service licensed medical professional, and that emergency behavioral health crisis walk-in center services must be provided by crisis intervention service licensed medical professionals, crisis intervention service licensed behavioral health professionals, crisis intervention service behavioral health professionals, and crisis intervention services crisis workers which includes certified peer specialists. Under the proposed rulemaking, the department proposes to require emergency behavioral health crisis walk-in centers to have professionals onsite, at all times, whose scope of practice permits diagnosing, prescribing, and administering medication. In addition, the proposed rulemaking

proposes two new requirements of licensed emergency behavioral health crisis walk-in center service providers - allowing intake without requiring medical clearance and providing capacity to accept all referrals and maintain a no-rejection policy for individuals. The proposed rulemaking meets SAMHSA's national guidelines for crisis care regarding prior authorization or medical clearances and the proposed requirement for a no-rejection policy.

The proposed rulemaking is also consistent with the SAMHSA guidelines for behavioral health crisis intervention services. Effective delivery of crisis intervention services ensures the treatment needs of individuals with acute mental health conditions have immediate access to mental health services.

Premises requirements (§ 5250.93). The proposed rulemaking codifies requirements for the premises of an emergency behavioral health crisis walk-in center. This includes the requirement for anti-ligature devices to eliminate points where a cord, rope, or other items that can be looped or tied to a fixture to create a point of ligature. In addition, the proposed rulemaking includes the requirement to protect heat sources from individuals receiving services in an emergency behavioral health crisis walk-in center. Both of these are new requirements; current practice does not address the physical site of a facility which provides emergency behavioral health crisis walk-in center services. Anti-ligature devices help to minimize self-harm and suicide by hanging or strangulation. In addition, anti-ligature devices help to provide a sense of independence while receiving care, as staff are less reluctant to leave individuals receiving services on their own due to the risk of damage, self-harm, and suicide. During the stakeholder workgroup sessions, many of the providers acknowledged that anti-ligature devices were already being used in their facilities. Finally, having established standards regarding exposed heat sources helps to minimize the risk that individuals will suffer burns by coming into contact with exposed heat sources.

First aid (§ 5250.94). The proposed rulemaking provides the requirement for first aid kits, including a list of medical items needing to be in the kit, and the requirement that first aid kits are stored in a location that is easily accessible to all staff of the emergency behavioral health crisis walk-in center. In addition, the proposed rulemaking establishes the requirement for crisis intervention service providers to establish a policy which will ensure that the contents of the first aid kit have not expired and are in good working order. The requirement for a first aid kit in an emergency behavioral health crisis walk-in center is a new requirement. The proposed rulemaking helps to ensure that essential items for basic emergency medical care are present in case of an emergency, as well as allows staff to quickly retrieve the first aid kit in the event that an individual is injured. Having a well-stocked first aid kit accessible by all staff members increases the odds that an individual needing first aid may receive the emergency care they need in a timely manner.

Cameras (§ 5250.95). The proposed rulemaking provides the proposed requirements for emergency behavioral health crisis walk-in centers which use video cameras. The proposed requirements include the notification of use of cameras, a written policy and procedure for the security, retention and destruction of recorded material and the use of cameras to ensure privacy in designated spaces. In addition, audio monitoring is prohibited. This proposed requirement regarding the use of cameras is a new requirement. Establishing requirements for the use of video cameras helps to ensure that video recording devices are used properly, records are securely destroyed, and individual privacy is maintained.

Restraint and seclusion (§ 5250.96). The proposed rulemaking provides requirements for emergency behavioral health crisis walk-in centers to maintain a seclusion room. Under the proposed rulemaking, an emergency behavioral health crisis walk-in center service provider shall meet the restraint and seclusion requirements under 42 CFR 483.358 (relating to orders for the

use of restraint or seclusion) regardless of the age of the individual being served. The Department is proposing to mirror the Federal standards for the use of restraint and seclusion in emergency behavioral health crisis walk-in centers.

Medication administration (§ 5250.97). The proposed rulemaking provides requirements for medication administration in an emergency behavioral health crisis walk-in center. Under the proposed rulemaking, if medication is prescribed or dispensed by the facility, the requirements of applicable Federal and State drug statutes and regulations must be met. This requirement is already applicable for psychiatric outpatient clinics under Chapter 5200 (relating to psychiatric outpatient clinics) and partial hospitalization facilities under Chapter 5210 (relating to partial hospitalization). This proposed requirement ensures that medication administration practices safeguard individuals receiving services. In addition, the proposed rulemaking provides that if prescription medication is administered by the emergency behavioral health crisis walk-in center, it must be administered in accordance with the practitioner's scope of practice. This requirement helps to ensure that individuals have their medications administered by trained licensed professionals whose scope of practice permits them to administer medications. The proposed rulemaking for the medication administration section also establishes that prescription medication may be administered through an automated medication system if specific parameters are met. In addition, the department proposes to require a written program for quality assurance of the automated medication system. This requires monitoring of the automated medication system and establishing mechanisms and procedures to test the accuracy of the automated medication system at least every 6 months and whenever any upgrade or change is made to the system. These parameters are in accordance with 49 Pa. Code § 27.204 (relating to automated medication systems). This is a new requirement, as automated medication systems are a recent

addition to the medical world. Automated medication systems help to streamline medication management, reduce medication errors, and enhance patient safety.

Storage and disposal of medications and medical supplies (§ 5250.98). The proposed rulemaking provides new requirements for storing and disposing of medications and medical supplies in an emergency behavioral health crisis walk-in center. Under the proposed rulemaking, prescription medications, over-the-counter medications, and syringes must be kept in an area or container that is locked, including prescription medications, over-the-counter medications, and syringes that are stored in a refrigerator. The proposed rulemaking helps to safeguard medications (including those that are refrigerated) and syringes from contamination, spillage, theft, or misuse of the medications. The proposed rulemaking also provides that prescription medications and over-the-counter medications must be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light and in accordance with the manufacturer's instructions. Putting this requirement in place helps to ensure that medications will be stored in a manner that prevents damage or loss. Finally, for prescription medications and over-the-counter medications that are discontinued, expired or for individuals who are no longer receiving crisis services in the facility, the department proposes that the medications be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. This helps to ensure the emergency behavioral health crisis walk-in center properly destroys medications to prevent abuse.

Medication records (§ 5250.99). The proposed rulemaking provides requirements for the use of medication records in an emergency behavioral health crisis walk-in center, including the content of a medication record for each individual for whom medications are administered. The intent of the proposed rulemaking is to ensure that staff persons will be able to track all medications an individual receives and that medications are administered as prescribed. Under

the proposed rulemaking, the information in the medication record should be recorded at the time the medication is administered, including medication administered pro re nata (as needed). The new requirement ensures Medication Administration Record (MAR) accuracy by minimizing the chances of documentation mistakes if an individual refuses a medication. In addition, the proposed rulemaking provides that if an individual refuses to take prescribed medication, the refusal shall be documented in the individual's record and on the medication record. The proposed rulemaking helps preserve the safety of individuals and protects the emergency behavioral health crisis walk-in center if the refusal of medication can lead to health complications.

Requirements for stock medications and blood or urine lab testing (§ 5250.100). The proposed rulemaking provides that emergency behavioral health crisis walk-in centers have a current license from the Department of Health's Board of Examiners or the Department of State's State Board of Pharmacy and a Drug Enforcement Agency (DEA) registration and shall prescribe and dispense stock medication as needed. Emergency behavioral health crisis walk-in centers must meet the requirements under 42 CFR § 493.1101 (relating to standard: facilities) for blood or urine lab testing. The Department is proposing to use Federal standards for blood or urine lab testing in emergency behavioral health crisis walk-in centers. Emergency behavioral health crisis walk-in centers must secure blood or urine lab results to diagnose and prescribe behavioral health medications within a 12-hour timeframe. This is due to the short-term nature of walk-in center services. When processing blood or urine lab testing, emergency behavioral health crisis walk-in centers may conduct it onsite if appropriately certified and licensed or may contract with an outside agency that is appropriately certified and licensed. For those who do contract with an outside agency that is appropriately certified and licensed to perform blood or urine lab testing, it must have the following: a copy of the outside agency's CLIA certificate, and

a list of diagnostic procedures that the outside agency's laboratory is CLIA-certified to perform with the corresponding Healthcare Common Procedure Coding System (HCPCS) codes (the standardized coding system used in the United States to report medical procedures, supplies, and services on health insurance claims). This is in accordance with 28 Pa. Code § 709.32 (relating to medication control). This is a new requirement. Emergency behavioral health crisis walk-in centers should have the ability to have stock medications onsite and to do lab testing. These two critical services are pertinent to providing services in emergency behavioral health crisis walk-in centers.

The Department is also asking for commentators' specific opinions and suggestions regarding stock medications and lab testing. As this is a new requirement, the Department is interested in hearing from commentators about how it would affect licensed providers of crisis intervention services.

Crisis Stabilization Unit Services (§§ 5250.101 - 5250.129). Under these provisions, the proposed rulemaking includes additional requirements specific to crisis stabilization unit services.

The proposed rulemaking codifies requirements for crisis stabilization unit services, including requirements for staffing, the operation, and services delivered through crisis stabilization unit services. Under the proposed rulemaking, crisis stabilization unit services are to be provided 24 hours a day, 7 days a week, 365 days a year. The department proposes to require crisis stabilization units to offer intensive, short-term stabilization services for individuals experiencing a behavioral health emergency and provide for continuous supervision for individuals in crisis. Under the proposed rulemaking, crisis stabilization units offer a temporary place for individuals to stay for relief from a stressful environment, or for ongoing stabilization, or until other arrangements are made. Crisis stabilization unit services must be accessed through

a licensed crisis intervention service professional. The proposed requirement for a crisis stabilization unit to provide services 24 hours a day, 7 days a week, 365 days a year is a new standard. This 24/7 standard is consistent with SAMHSA's national guidelines for crisis care (SAMHSA's National Behavioral Health Crisis Care Guidance).

The proposed rulemaking also codifies the responsibilities of crisis stabilization unit service providers. Under the proposed rulemaking, responsibilities include items such as a written plan developed in collaboration with the mental health county administrator and the Single County Authority, detailing how services are provided, an organizational chart, and maintaining a list of referral sources approved by the county administrator. This is consistent with current practice. In addition, the written plan must address how collaboration includes the following populations: aging and older adults, those with intellectual and developmental disabilities, and individuals with substance use, misuse, and substance use disorder. The proposed rulemaking also includes the requirement for crisis stabilization unit service providers to offer individuals the opportunity to create or revise a mental health advance directive. Under the proposed rulemaking, crisis stabilization unit service providers are required to have policies which address how the crisis stabilization unit service provider handles security, including training and qualifications for security contractors or security staff, if applicable; how the crisis stabilization unit service provider will ensure security of the premises, including written protocols for security emergencies; how the crisis stabilization unit service provider will screen for suicide risk and completion of comprehensive suicide risk assessments and planning, if applicable; and how the crisis stabilization unit service provider will screen for violence risk and completion of comprehensive violence risk assessments and planning, if applicable. The proposed rulemaking also provides that crisis stabilization unit services include the following services: intake; examination and evaluation completed within 24 hours, including when a

medical examination and diagnoses are completed for an individual who stays in the unit for more than 24 hours; room and board; counseling, peer support and other services intended to support stabilization; recreational activities; connection and referral through county mental health case management service providers; and administration of medication. These services are typically provided in currently licensed crisis stabilization units.

Under the proposed rulemaking, the maximum stay in a crisis stabilization unit is 168 hours. An additional stay of up to 48 hours may be authorized if recommended by a crisis intervention service licensed medical professional or crisis intervention service licensed behavioral health professional. Finally, the proposed rulemaking provides the organizational requirements in a crisis stabilization unit. These operational requirements are consistent with SAMHSA's national guidelines for crisis care. Specifically, the proposed operational standard to not require medical clearance prior to intake is a SAMHSA national guideline for crisis care. This proposed prohibition changes what is currently in place. Under current practice, crisis stabilization unit providers must ensure that an individual has a medical clearance prior to placement in the facility. It was identified by the stakeholder workgroup that the issue of medical clearances has been historically problematic. Further, the stakeholder workgroup acknowledged that what constitutes a medical clearance varies from hospital to hospital. In addition, medical clearances can often be a barrier to an individual receiving services when experiencing a behavioral health emergency. Based on this feedback, the Department aligned this provision with SAMHSA's national guidelines.

Peer-run crisis stabilization unit services (§ 5250.103). The proposed rulemaking provides requirements specific to peer-run crisis stabilization units, including having sufficient staff to carry out the functions of the facility and the requirement to provide peer support and crisis stabilization services. In addition, the proposed rulemaking provides that the maximum

stay in a peer-run crisis stabilization unit is 168 hours; an additional stay of up to 48 hours can be authorized by a crisis intervention service licensed medical professional or crisis intervention service licensed behavioral health professional. This is consistent with current practice. Under the proposed rulemaking, the peer-run crisis stabilization unit must have access to clinical consultation as needed by peer support staff. The proposed rulemaking also establishes that peer-run crisis stabilization units have a minimum of two staff at all times, with one staff person to four individuals served ratio. The two minimum staff must be a crisis intervention service crisis worker holding certification in peer support. The proposed rulemaking provides certain exemptions for peer-run crisis stabilization unit or crisis respite facilities, such as recordkeeping items, board, food, counseling, medication administration, and staffing.

Maximum capacity (§ 5250.104). The proposed rulemaking includes the requirement that the maximum capacity specified on the license may not be exceeded without approval. The maximum capacity is the total number of individuals who are permitted to receive crisis intervention services on the premises at any time. The proposed rulemaking establishes that capacity is also limited to 16 beds. This is an increase from current practice, which allows crisis stabilization units to serve no more than 8 individuals. During the stakeholder workgroup sessions, there were discussions regarding increases in beds for crisis stabilization unit services, acknowledging the need to keep capacity on the smaller side. The amount of 16 beds was a capacity that the stakeholder workgroup felt allowed for more services to be delivered, while not compromising care and delivery of crisis stabilization unit services to individuals in need. In addition, the maximum capacity of 16 beds also aligns with the Institution for Mental Diseases (IMD) exclusion, which limits Medical Assistance (MA) funding.

Staffing policy (§ 5250.105). The proposed rulemaking establishes a written policy that ensures staffing meets the program's service volume needs and has a minimum of two staff members on duty at all times for every eight individuals served. This new requirement helps ensure that sufficient staff hours are provided to meet the needs of the individuals receiving services.

Staffing (§ 5250.106). The proposed rulemaking provides that at least one staff person shall be awake on duty at all times when individuals are present in the crisis stabilization unit. This new standard helps to ensure that staff persons are prepared to respond to the needs of individuals at all times.

Additional staffing based on the needs of the individuals (§ 5250.107). The proposed rulemaking provides that crisis stabilization unit service providers shall provide staff to meet the needs of individuals as specified in the individual's assessments and support plans. Also, additional staffing may be needed as necessary to protect the health, safety and well-being of the individuals receiving crisis stabilization unit services. This new standard helps to ensure that there are sufficient staff persons on duty who are prepared to respond to the needs of individuals at all times.

Premises requirements (§ 5250.108). The proposed rulemaking includes requirements for the premises of a crisis stabilization unit. For crisis stabilization units, the premises must be appropriate for the purpose for which it is used. The proposed rulemaking includes the requirement for separate units and programs for crisis intervention providers who serve both adults and individuals under 18 years of age. This is consistent with current practice. Lastly, crisis stabilization units must be equipped with anti-ligature devices to eliminate points where a cord, rope, or other items can be looped or tied to a fixture to create a point of ligature. Current

practice does not address the physical site of a crisis stabilization unit. Anti-ligature devices help to minimize self-harm and suicide by hanging or strangulation. In addition, anti-ligature devices help to provide a sense of independence while receiving care, as staff are less reluctant to leave individuals receiving services on their own due to the risk of damage, self-harm, and suicide. During the stakeholder workgroup sessions, many of the providers acknowledged that anti-ligature devices were already being used in their facilities.

Bedrooms (§ 5250.109). The proposed rulemaking provides requirements for bedrooms in crisis stabilization units; there are currently no standards for the bedrooms in crisis stabilization units. First, bedrooms should be designed to hold one or two individuals. Second, bedroom items such as a place to store clothing and personal items, a bed that is clean and in good repair, and a window with a source of natural light that has drapes, shades, curtains, blinds, shutters, or other devices that provide privacy must be provided. In addition, ventilation by operable windows or mechanical ventilation must be present in each bedroom. Mattresses must be fire retardant and have a moisture barrier that is permanent and can be easily cleaned. Fire retardant mattresses minimize the risk of fire and injury in the event of a fire. Bunk beds and other raised beds that require individuals to climb steps or ladders to get into or out of bed are prohibited. This helps to ensure that individuals may not suffer a fall or other injury from climbing steps to get into or out of bed. Lastly, the proposed regulation includes requirements for direct access to a corridor or external exit, bedrooms as a means of egress, and entrances to internal stairways or basements. These proposed requirements are consistent with other similar Departmental regulations (such as 55 Pa. Code Chapters 2600, 2800, and 3800), which have standards for bedrooms within a licensed facility.

Bathrooms (§ 5250.110). The proposed rulemaking establishes requirements for bathrooms in crisis stabilization units; there are currently no standards for bathrooms in crisis stabilization units. Bathrooms must have fixtures in place such as at least one functioning flush toilet for every six or fewer individuals, at least one sink and wall mirror for every six or fewer individuals, and at least one bathtub or shower for every 10 or fewer individuals. During the stakeholder workgroup sessions, it was determined that the ratios as specified in the draft proposed rulemaking were acceptable and that many providers already met the proposed standard. Bathtubs and showers must have slip-resistant surfaces. This helps to prevent injurious falls while bathing. The proposed rulemaking also establishes requirements for ventilation, privacy, and toiletry items such as toilet paper and a dispenser with soap and either individual paper towels or a mechanical dryer in each bathroom. Individual paper towels and mechanical dryers help to prevent the spread of disease. For ventilation, good air circulation throughout the crisis stabilization unit clears dust from the air. Dust exacerbates medical conditions like asthma and may be the source of allergies for individuals receiving services.

Dining area (§ 5250.111). The proposed rulemaking provides requirements for dining areas in crisis stabilization units, which must have a separate dining room area and be equipped with tables and chairs of the appropriate size for the population served and be able to accommodate the maximum number of individuals scheduled for meals at any one time. A dining room that accommodates many individuals at once promotes community and ensures that individuals may sit while dining. In addition, serving items must be provided and be in good repair. This requirement helps to maintain sanitary conditions and reduces the risk of individual injury or illness. Chipped, cracked serving items can also harbor harmful bacteria. The proposed rulemaking establishes new standards for the dining areas of a crisis stabilization unit; there are currently no standards in place.

Lounge and visiting areas (§ 5250.112). The proposed rulemaking provides requirements for lounge and visiting areas in crisis stabilization units; there are currently no standards for these areas in crisis stabilization units. Under the proposed rulemaking, visiting space for individuals in treatment must be provided, including at least one furnished lounge area for individuals which contains tables, chairs, and lighting. Lounge and visiting areas create a comforting atmosphere and foster community interaction and must be furnished to meet the needs of individuals and their guests.

Counseling rooms (§ 5250.113). The proposed rulemaking establishes requirements for counseling rooms in crisis stabilization units, which must maintain space for both individual and group counseling sessions and have room walls that extend from the floor to the ceiling to provide for privacy. There are currently no standards in place for counseling rooms. The proposed rulemaking helps to ensure that counseling rooms are private and meet the needs of individuals receiving services in a crisis stabilization unit.

First aid (§ 5250.114). The proposed rulemaking provides the requirement for first aid kits, including a list of medical items needing to be in the kit, and the requirement that first aid kits are stored in a location that is easily accessible to all staff of the crisis stabilization unit. In addition, the proposed rulemaking establishes the requirement for crisis intervention service providers to establish a policy which will ensure that the contents of the first aid kit have not expired and are in good working order. The requirement for a first aid kit in a crisis stabilization unit is a new requirement. The proposed rulemaking helps to ensure that essential items for basic emergency medical care are present in case of an emergency, as well as allows staff to quickly retrieve the first aid kit in the event that an individual is injured. Having a well-stocked first aid

kit accessible by all staff members increases the odds that an individual needing first aid may receive the emergency care they need in a timely manner.

Laundry and linens (§ 5250.115). The proposed rulemaking provides requirements for crisis stabilization units to maintain access to an onsite laundry area or have an agreement with an external contracted provider for laundering linens. Providers must maintain laundry equipment and supplies onsite for the individuals to wash and dry personal clothing at no cost to the individual. This requirement also includes the laundry supply needed, as well as implementing procedures that ensure that individuals' clothing items are not lost or misplaced during laundering or cleaning. The proposed rulemaking helps to ensure that individuals are provided clean laundry sufficient to maintain sanitary conditions. Finally, the proposed rulemaking establishes cleaning and maintenance standards for the clothes dryers' ventilation ductwork. By establishing cleaning and maintenance standards for the clothes dryers' ventilation ductwork, the proposed rulemaking attempts to help reduce the chance of fire in the crisis stabilization unit.

Housekeeping and maintenance (§ 5250.116). The proposed rulemaking provides housekeeping and maintenance requirements for the premises of the crisis stabilization unit. The proposed rulemaking establishes new requirements; there are currently no housekeeping and maintenance standards for crisis stabilization units. The proposed rulemaking establishes that crisis stabilization units be free of hazards, implement safety precautions immediately when a hazard occurs, and have a policy in place for remediation. A crisis stabilization unit which is free of hazards helps to maintain sanitary conditions and minimizes the risk that individuals will suffer an injury while receiving services. Under the proposed rulemaking, crisis stabilization units must also use appropriate vector control measures to keep the premises free of insects, bed

bugs, rodents, and other pests, and must store cleaning equipment, chemicals and supplies in a locked location separate from consumables. Storing cleaning equipment, chemicals, and supplies in a locked location separate from consumables helps to greatly minimize the risk of illness, food contamination, or death from improperly stored poisonous materials. Locked cleaning equipment, chemicals and supplies also help to protect individuals who are unable to safely use or avoid poisonous materials from illness, injury, or death related to misuse of accessible poisonous materials.

Furnishings, equipment, and supplies (§ 5250.117). The proposed rulemaking provides requirements for furnishings, such as maintaining a 3-day supply of culturally-appropriate personal care items for use by individuals and maintaining a supply of information in various formats on mental illness, recovery, and treatment methods for the use of individuals in crisis stabilization units. The proposed rulemaking helps to ensure that individuals have necessary personal hygiene items, as well as information available regarding mental illness, recovery, and treatment methods. The information provided in various formats helps to educate and empower individuals receiving services about behavioral health issues and what services or treatments may be available. Finally, the proposed rulemaking establishes crisis stabilization units be equipped with furnishings that are clean, in good repair, and are appropriate for the needs of the population served. The proposed rulemaking helps to ensure that furnishings are safe and meet the needs of individuals receiving services in crisis stabilization units.

Water (§ 5250.118). The proposed rulemaking includes requirements for water in crisis stabilization units. Under the proposed rulemaking, hot and cold water under pressure must be in each bathroom and laundry area of the crisis stabilization unit, and it may not exceed 120°F. This is a new standard which will help to ensure that the crisis stabilization unit's water supply is

sufficient to meet individuals' needs for hygiene and comfort, as well as protect individuals from accidental scalding. For crisis stabilization units that are not connected to a public water system, they will need to obtain a permit through the Department of Environmental Protection (DEP) in accordance with the Safe Drinking Water Act (35 P.S. §§ 721.1—721.17). This is not a new requirement; licensed facilities are currently required to obtain a permit from DEP when they are not connected to public water systems. This proposed rulemaking ensures that water in a crisis stabilization unit with a private water source is safe for use.

Sewage and sanitation (§ 5250.119). The proposed rulemaking includes requirements for sewage and sanitation. For crisis stabilization units that are not connected to a public sewer system, they will need to obtain written sanitation approval for the sewage system by the sewage enforcement official of the municipality in which the premises is located. The proposed rulemaking helps to ensure that the sewage system is properly designed and installed so as to minimize the spread of disease and damage to the environment or to the crisis stabilization unit. In addition, the proposed rulemaking includes a list of sanitary conditions which must be maintained by the crisis stabilization unit. This includes the use of universal precautions, no evidence of insect or rodent infestation, the removal of trash from the premises, and keeping trash in covered receptacles that prevent the penetration of insects and rodents. This requirement is established to help minimize the risk of illness, rodent and insect infestation, and helps to provide dignified living conditions for individuals while they are receiving services in the crisis stabilization unit. In addition, covered trash receptacles prevent the spread of disease through exposure to body fluids, and the risk of insect and rodent infestation due to open food containers is also minimized.

Temperature and heat sources (§ 5250.120). The proposed rulemaking establishes requirements for temperature and heat sources, which is new as there are currently no standards regarding temperature and heat sources for crisis stabilization units. Under the proposed rulemaking, crisis stabilization units must have systems in place for heating and cooling ventilation, mechanical ventilation, and must maintain an indoor temperature between 70°F - 80°F. The proposed rulemaking attempts to reduce the likelihood that individuals with special medical needs will be medically compromised by temperature extremes. In addition, the requirement also helps to maintain an environment that is comfortable for all individuals and reduces the likelihood that individuals with special medical needs will be medically compromised by temperature extremes. In addition, exterior doors and windows of the crisis stabilization unit must be screened, heat sources must be equipped with protective guards or insulation, and the furnace or heat source must be cleaned annually by a professional company. The proposed rulemaking ensures that windows are in good repair and may prevent injury to individuals, and that having screens in place lowers the risk of insect or rodent infestation. Finally, the proposed rulemaking establishes requirements for heat sources, to help minimize the risk that individuals will suffer burns by coming into contact with exposed heat sources, and to ensure that the crisis stabilization unit's furnace or heat source will produce heat and that individuals are protected from carbon monoxide poisoning. Heaters that are not permanently mounted or installed are prohibited. This is due to safety reasons to prevent fires.

Cameras (§ 5250.121). The proposed rulemaking establishes requirements for crisis stabilization units that use video cameras. The proposed rulemaking establishes requirements for the notification of use, the policy and procedure for the security, retention and destruction of recorded and transmitted recorded camera images, and the angle of video monitoring and recording equipment in relation to individual privacy. In addition, audio monitoring is

prohibited. The proposed rulemaking for crisis stabilization units that employ cameras is a new requirement. Establishing requirements for the use of video cameras helps to ensure that video recording devices are used properly, records are securely destroyed, and that individual privacy is maintained.

Emergency preparedness plan (§ 5250.122). The proposed rulemaking establishes a new requirement that crisis stabilization units have an emergency plan that includes strategies to address emergency events identified in the risk assessment. The proposed rulemaking helps to ensure that the crisis stabilization unit is prepared to respond to localized and general emergencies. The emergency plan must also address the availability of consumables, staff, transportation, first aid supplies, and personal protective equipment in the event of an emergency. Written policies and procedures must address items such as a system to track the location of on-duty staff and sheltered individuals in the care of the crisis intervention services provider during and after the emergency, documentation of the name and location of a receiving provider or location if relocation is necessary, and a means to safely shelter in place. The proposed rulemaking also requires that the policies and procedures include a system of medical documentation that preserves the individual's information, protects confidentiality, and secures and maintains the availability of records, the use of volunteers, the development of arrangements with other facilities, and roles of the crisis intervention service provider in the provision of care to individuals at an alternate care site identified by emergency management officials.

Fire safety (§ 5250.123). The proposed rulemaking provides a new requirement that crisis stabilization units conduct fire drills at least quarterly on every shift for staff, and under varied conditions. Conducting fire drills helps to ensure that individuals and staff will be prepared to evacuate without hesitation in the event of a real fire. In addition, the proposed rulemaking

establishes the new requirement that crisis stabilization units must maintain a written fire drill report that includes the following: date of the fire drill, time of day of the fire drill, length of time from start to completion of the fire drill, the exit route used, number of participating staff, number of participating individuals, and the number of individuals who did not evacuate, the reason for non-participation in the drill, problems encountered, and whether the smoke alarm was operative. Recording fire drill information helps crisis stabilization units to ensure compliance with all of the regulations relating to fire drills, and to identify and correct problems with evacuation. This information could also help a crisis stabilization unit to refine its fire safety practices and improve future responses to emergency events.

Nutrition (§ 5250.124). The proposed rulemaking provides new requirements for nutrition in crisis stabilization units, as there are currently no nutrition standards for crisis stabilization units. Under the proposed rulemaking, meals must be offered that meet the recommended dietary allowances established by the United States Department of Agriculture (USDA). The recommended dietary allowances established by the USDA are intended to reflect the best scientific judgment on nutrient allowances for the maintenance of good health and to serve as the basis for evaluating the adequacy of diets of groups of individuals. The proposed rulemaking also provides the requirement for at least three nutritionally well-balanced meals to be offered daily, and that an individual's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner, or dietitian shall be met. An individual's body requires a constant input of energy and nutrients at least three times a day for proper nutrition; the proposed rulemaking helps to meet this need. In addition, dietary alternatives shall be available for an individual who has special health needs or religious beliefs regarding dietary restrictions. The proposed rulemaking also establishes the requirements that drinking water must be available to individuals at all times, and that there may not be more than

15 hours between the evening meal and the first meal of the next day. There also may not be more than 6 hours between breakfast and lunch and between lunch and dinner.

Individual service plans (§ 5250.125). Currently, there is no standard for developing individual service plans in a crisis stabilization unit. The proposed rulemaking establishes that an individual service plan is required for each individual within 24 hours of initiation of crisis intervention services. Having an individual service plan in place helps to ensure that each individual's needs are met, and that accountability for meeting those needs is firmly established. The individual service plan must be signed and dated and be developed in collaboration with the individual receiving crisis intervention services. Having an individual participate in the development of the individual service plan helps to provide crucial detailed information about the specific individual which can assist the crisis stabilization unit in developing a specific plan as to how it will meet the needs of the individual. The proposed rulemaking also provides that the individual service plan must contain specific goals, objectives, and interventions to address the identified crisis intervention service needs with definable and measurable outcomes. This will ensure that services are designed for each individual's specific needs. The proposed rulemaking establishes that individual service plan updates must be based upon the assessment, diagnosis, and input from the crisis intervention service team and the individual receiving services. Finally, the proposed rulemaking includes requirements for the individual service plan to be reviewed and updated as needed, to be kept in the individual's record, and that crisis intervention services be provided in accordance with the identified goals in the individual service plan and any updates.

Medication administration (§ 5250.126). The proposed rulemaking provides requirements for medication administration in a crisis stabilization unit. Requirements are

established that if medication is prescribed or dispensed by the facility, the requirements of applicable Federal and State drug statutes and regulations must be met. This requirement is already applicable for psychiatric outpatient clinics under Chapter 5200 (relating to psychiatric outpatient clinics), and partial hospitalization facilities under Chapter 5210 (relating to partial hospitalization). Establishing this requirement ensures that medication administration practices safeguard individuals receiving services. In addition, the proposed rulemaking establishes that if prescription medication is administered by the crisis stabilization unit, it must be administered in accordance with the practitioner's scope of practice. This proposed requirement helps to ensure that individuals have their medications administered by trained licensed professionals whose scope of practice permits them to administer medications. The medication administration section also establishes that prescription medication may be administered through an automated medication system if specific parameters are met. In addition, a written program for quality assurance of the automated medication system is required. This requires monitoring of the automated medication system and establishing mechanisms and procedures to test the accuracy of the automated medication system at least every 6 months and whenever any upgrade or change is made to the system. These parameters are in accordance with 49 Pa. Code § 27.204 (relating to automated medication systems). This is a new requirement, as automated medication systems are a recent addition to the medical world. Automated medication systems help to streamline medication management, reduce medication errors, and enhance patient safety.

Storage and disposal of medications and medical supplies (§ 5250.127). The proposed rulemaking provides new requirements for storing and disposing medications and medical supplies in a crisis stabilization unit. Under the proposed rulemaking, prescription medications, over-the-counter medications, and syringes are to be kept in an area or container that is locked, including prescription medications, over-the-counter medications, and syringes that are stored in

a refrigerator. The proposed rulemaking safeguards medications (including those that are refrigerated) and syringes from contamination, spillage, theft, or misuse of the medications. In addition, only current prescriptions, over-the-counter medications, and sample medications for individuals receiving crisis services in the facility may be kept in the crisis stabilization unit. This ensures the crisis stabilization unit does not keep medications that are for individuals no longer receiving services or that have been discontinued. The proposed rulemaking also provides that prescription medications and over-the-counter medications must be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light and in accordance with the manufacturer's instructions. This proposed provision helps to ensure that medications will be stored in a manner that prevents damage or loss. Finally, for prescription medications and over-the-counter medications that are discontinued, expired, or for individuals who are no longer receiving crisis services in the facility, they must be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. This helps to ensure the crisis stabilization unit properly destroys medications to prevent abuse.

Medication records (§ 5250.128). The proposed rulemaking provides requirements for the use of medication records in a crisis stabilization unit. Currently, the standard for crisis stabilization units that are authorized to administer medication is to maintain a written protocol for the storage and administration of medications, which has been approved by a physician and reviewed annually. The proposed rulemaking establishes the content of a medication record for each individual for whom medications are administered. The proposed rulemaking ensures that staff persons will be able to track all medications an individual receives and ensure all medications are administered as prescribed. Under the proposed rulemaking, the information in the medication record should be recorded at the time the medication is administered. The new requirement ensures Medication Administration Record (MAR) accuracy by minimizing the

chances of documentation mistakes if an individual refuses a medication. In addition, the proposed rulemaking establishes that if an individual refuses to take a prescribed medication, the refusal shall be documented in the individual's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber. The proposed rulemaking helps preserve the safety of individuals and protects the crisis stabilization unit if the refusal of medication can lead to health complications.

Records (§ 5250.129). The proposed rulemaking provides and lists the specific information that should be present in each individual's record, the specific emergency and contact information that must be in the individual's record, and the specific medical information that must be in the individual's record. While there are current case records practices, the proposed rulemaking provides new requirements which require emergency and contact information must be in the individual's record, and the specific medical information which must be in the individual's record.

Affected Individuals and Organizations

Individuals, including adults, youth and children who receive behavioral health crisis intervention services, will be affected by the proposed rulemaking, which codifies the minimum standards for building, equipment, operation, staffing, and training. The proposed regulation is needed to provide necessary oversight to protect the health and safety of individuals who access these services within the scope of this chapter. Benefits for individuals include a focus on health and safety minimum standards for crisis intervention services. The proposed rulemaking benefits approximately 50,000 individuals receiving crisis intervention services annually.

Current and new providers of crisis intervention services will be affected by the proposed rulemaking, which codifies clear, uniform standards for service provision and facility licensure. The proposed rulemaking requires all providers who offer crisis intervention services to be licensed by the Department before providing crisis intervention services in any of the modalities of crisis intervention services within the scope of this chapter. As of June 5, 2023, there were 70 licenses issued to provide crisis intervention service across this Commonwealth.

The Department convened a series of six stakeholder work group sessions from March 2021 to August 2021 to ensure that all affected individuals and organizations had the opportunity to provide input into the proposed rulemaking, to express concerns, and to participate in the regulatory process. The work group offered expertise on given topics and made suggestions for establishing minimum standards for licensure. The work group consisted of individuals and family members, county MH/ID staff, representatives of behavioral health managed care organizations, provider organizations such as the Rehabilitation and Community Providers Association (RCPA), advocacy groups such as Disability Rights Pennsylvania (DRP) and the Pennsylvania Mental Health Consumers Association (PMHCA), the Mental Health Planning Council (MHPC) and staff from the department, the Department of Health, the Pennsylvania Insurance Department and the Department of Drug and Alcohol Programs. In addition, a total of 13 licensed providers, representing all modalities of crisis intervention services within the scope of this chapter, participated in the workgroup. There were 63 members in total in the workgroup. The Department appreciates the work group members' expertise, time and commitment to the drafting process, and the helpful comments.

Accomplishments and Benefits

The proposed rulemaking codifies the minimum standards for licensure of crisis intervention service providers, including the five modalities of crisis intervention services: Crisis Call Center Services, Mobile Crisis Team Services, Medical Mobile Crisis Team Services, Emergency Behavioral Health Crisis Walk-In Center Services, and Crisis Stabilization Unit Services. Crisis intervention service providers will benefit from the codification of clear licensing standards in the proposed regulation. Further, these standards protect the health and safety of those receiving these services.

Fiscal Impact

It is anticipated that implementation of the proposed rulemaking will result in increased costs for providers as a result of the proposed staffing requirements, which will vary based on the modality of crisis intervention services provided and the size of the facility. Specifically, the proposed rulemaking requires mobile crisis team services to be delivered in teams of at least two individuals. Current practice across most of the state allows for mobile crisis intervention services to be delivered by one person. This shift will align the state with national best practices and provide for an increase in the MA reimbursement rate. Additionally, many counties do not have access to 24/7 continuously operating mobile crisis teams. The new required hours of operation will also affect mobile crisis service agencies that deliver mobile crisis intervention services with limited hours.

It is anticipated that emergency behavioral health walk-in center service providers will incur costs to implement blood and urine lab testing. Providers have a choice in how blood and urine lab testing is processed: providers may process the tests onsite if they are equipped and approved to do so; or providers may utilize lab testing through a contracted agency. Processing

the lab testing onsite will likely increase costs due to staffing requirements needed to process the lab testing. Under the Department of Health (DOH) regulations, providing onsite lab testing requires four staff positions at the provider agency. These positions include laboratory director, clinical consultant, technical consultant, and testing personnel. The salary for these positions ranges from $ 45,760 to $120,640 per year, depending on the staff level. In addition, providers will need to obtain the appropriate licensure from DOH to conduct lab testing. Providers will need to pay an application fee of $100, as well as a Clinical Laboratory Improvement Amendments (CLIA) fee of $248. These are one-time fees. The total costs for each provider will vary depending on whether the provider chooses to process lab testing onsite or contract for these services. If all providers opted to process lab testing onsite, the aggregate cost would be approximately $17.515 million per year due to staffing requirements. However, as many providers will likely contract for lab testing services, the financial impact is anticipated to be significantly lower.

Therefore, the overall fiscal impact for each crisis intervention service provider will vary and depend upon the services provided, the current organizational structure, and current qualification, supervision, and training requirements.

The proposed rulemaking will result in an annual cost to the MA program of approximately $32,909,000 ($11,906,000 in State funds). Both the Fee-For-Service rates and the Behavioral Health HealthChoices capitation rates will be increased to reflect the revisions to the fee schedule rates. The cost to the regulated community and local government is anticipated to be $0 because the Governor's budget will possibly include increases to MA/County Base funding. If the General Assembly provides the additional funding, the state will bear the increased cost.

In addition, the Department will need to hire four additional Human Services Program Representative 1 staff positions, one Crisis Coordinator, one Fiscal Management Specialist 2, one Human Services Analyst Supervisor and two Human Services Analysts in order to carry out the work associated with these licensing regulations. It is anticipated that these added positions will result in an additional annual cost of approximately $1,170,000 ($608,000 in State funds) in FY 26-27 and $1,163,000 ($595,000 in State funds) in FY 27-28 and beyond. In FY 26-27 $5,000 in operational costs are assumed for each new staff member and $3,000 in operational costs are assumed for the following years. However, the standardization, consistency, and minimum health and safety standards in the provision of services outweigh the anticipated costs of the codified licensure requirements.

Paperwork Requirements

The proposed rulemaking standardizes a requirement for crisis intervention service providers to produce and maintain a service description, written protocols for each crisis intervention service, quality management plan, complaint policy and procedures, staff training plan, medical records, individual safety policy and procedures, emergency preparedness plan, and fire safety policy and procedures that are approved by the Department through the licensing process. It is anticipated that most providers already maintain these documents; however, some updating to these documents may be necessary to assure compliance with this chapter. No new forms are required, and providers may elect to continue using existing forms and formats.

Effective Date

This proposed rulemaking will be effective 180 calendar days after final-form publication in the *Pennsylvania Bulletin.*

After the effective date, each currently licensed facility will be inspected for compliance with this chapter within the Department's established timeline for renewal of the currently held license 90 days prior to the expiration date of the current license. This graduated process avoids duplication of inspections, unnecessary extra paperwork, and offers providers adequate time to review and complete service descriptions and achieve compliance with staffing standards.

Public Comment

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed rulemaking to the Department at the following address: ***Tara Pride, PA3, Office of Mental Health and Substance Abuse Services (OMHSAS), Commonwealth Tower, 303 Walnut Street, 11th Floor, Harrisburg, PA. 17105 and RA-PWCRISISSRVSREGS@pa.gov***, within 30 calendar days after the date of publication of this proposed rulemaking in the ***Pennsylvania Bulletin***. Reference Regulation **No. #14-557** when submitting comments.

Persons with a disability who require an auxiliary aid or service may submit comments by using the Pennsylvania Hamilton Relay Service at 1-800-654-5984 (TDD users) or 1-800-654-5988 (voice users).

Regulatory Review Act

Under § 5(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on October 1, 2025, the Department submitted a copy of this proposed rulemaking to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Human Services and the Senate Committee on Health and Human Services. In addition to submitting the proposed rulemaking, the Department has provided the IRRC and the Committees with a copy of a

Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

Under § 5(g) of the Regulatory Review Act, if the IRRC has any comments, recommendations or objections to any portion of the proposed regulation, it may notify the Department and the Committees within 30 days after the close of the public comment period. Such notification shall specify the regulatory review criteria that have not been met. The Regulatory Review Act specifies detailed procedures for review by the Department, the General Assembly and the Governor, of any comments, recommendations or objections raised, prior to final publication of the regulation.

ANNEX A

TITLE 55. HUMAN SERVICES

PART VII. MENTAL HEALTH MANUAL

CHAPTER 5250. CRISIS INTERVENTION SERVICES

Subchapter A. GENERAL PROVISIONS

§ 5250.1. Scope.

This chapter establishes minimum standards for the licensing of crisis intervention service providers.

§ 5250.2. Applicability.

This chapter applies to providers licensed by the Department to provide crisis intervention services under the following modalities:

(a) Crisis call center services.

(b) Mobile crisis team services.

(c) Medical mobile crisis team services.

(d) Emergency behavioral health crisis walk-in center services.

(e) Crisis stabilization unit services.

§ 5250.3. Purpose.

(a) The purpose of this chapter is to protect the health, safety, and well-being of individuals who receive crisis intervention services through the formulation, application, and enforcement of minimum licensing requirements.

(b) The purpose of crisis intervention services is to offer immediate services designed to improve or resolve precipitating stress when an individual or family member experiences an

acute problem of disturbed thought, behavior, mood, or social relationships. The services provide emergency response to behavioral health crisis situations that threaten the well-being of the individual or others.

§ 5250.4. Definitions.

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

Adult – An individual who is 18 years of age or older.

All-hazards approach – An integrated, specific approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies, man-made emergencies, and natural disasters, which consider and address the location of the provider and the particular type of hazards most likely to occur in their areas.

Automated medication system – As defined in 49 Pa. Code § 27.1 (relating to definitions).

CLIA – Clinical Laboratories Improvement Amendments of 1988.

CPR - Cardio Pulmonary Resuscitation.

Caregiver – An individual with responsibility for the care and supervision of a child, youth, or adult. The term includes the biological or adoptive mother or father, legal guardian, or a responsible relative or caretaker for the child, youth, or adult.

Certified peer professional – An individual who holds certification in good standing from the state-approved certification entity to deliver peer support services to an individual, the individual's family, or both, who are impacted by mental illness, substance use disorder, or both.

Child – An individual under 14 years of age.

County administrator – The MH/IDD administrator who has jurisdiction in the geographic area of the county/joinder.

Crisis – An immediate stress-producing situation or condition that causes acute problems of disturbed thought, behavior, mood, or social relationships requiring emergency behavioral health intervention.

Crisis intervention service provider – An entity licensed by the Department that is responsible for the day-to-day operation and management of crisis intervention services.

Crisis intervention services — A service array that includes immediate, crisis-oriented services provided to an individual who exhibits an acute problem of disturbed thought, behavior, mood, or social relationships, and the individual's family. Crisis intervention services include screening, assessment, intervention, counseling, and disposition services. The five modalities of crisis intervention services under this chapter are crisis call center services, mobile crisis team services, medical mobile crisis team services, emergency behavioral health crisis walk-in center services, and crisis stabilization unit services.

Crisis intervention service staff – Individuals employed by or contracted through providers who, through education and experience, are qualified to oversee or directly provide crisis intervention services.

Department – The Department of Human Services of this Commonwealth.

Facility – A building or a part of a building in which a licensed crisis intervention service provider is located and renders service.

Family – The people that the individual identifies as family members, including but not limited to blood relatives, legal guardians, or other natural supports. The people identified as family may change over time.

First responders - First responder includes a firefighter, law enforcement officer, paramedic, emergency medical technician, or other individual (including an employee of a legally organized and recognized volunteer organization, whether compensated or not), who, in the course of their professional duties, responds to fire, medical, hazardous material, or other similar emergencies.

Imminent risk – An immediate threat of an individual causing substantial physical injury to self or others.

Individual – An adult, youth, or child who has requested or is receiving crisis intervention services.

Intern – A student or trainee with supervision who, with or without monetary compensation, works in crisis intervention services to gain work experience.

Joinder – Local authorities of any county who have joined with the local authorities of another county to establish a county mental health and intellectual disabilities program, subject to the provisions of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. §§ 4101 - 4704), or a drug and alcohol program pursuant to the Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. §§ 1690.101 – 1690.115).

LGBTQIA+ – Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, and Asexual/Aromantic and others.

License – A certificate of compliance issued by the Department permitting the delivery of crisis intervention services, at or from a given location, for a specific period of time, for a specified capacity, if applicable.

Medical clearance - The requirement to complete medical testing prior to intake.

Mental health advance directive – A mental health declaration or mental health power of attorney made in accordance with 20 Pa.C.S. Chapter 58 (relating to mental health care).

MH/IDD – Mental Health/Intellectual Developmental Disability.

Peer-run crisis stabilization unit – A form of crisis stabilization unit services for individuals in crisis that are primarily staffed by certified peer professionals, who are supervised by a crisis intervention service behavioral health professional. The term is also known as crisis respite.

Premises – The grounds and buildings on the same grounds used for providing crisis intervention services.

Seclusion – Defined in accordance with 42 CFR § 483.352 (relating to definitions).

Single County Authority – The agency designated by the local authorities in a county or joinder to plan, fund, and administer drug and alcohol activities in that county or joinder.

Special populations – Individuals with a serious mental illness or severe emotional disturbance who are homeless, elderly, hearing impaired, visually impaired, physically impaired, dually diagnosed (mental illness with substance use disorder or intellectual and developmental disabilities, or both), veterans, LGBTQIA+, Human Immunodeficiency Virus (HIV) positive, involved in the criminal justice system, members of racial or ethnic minority groups, or individuals with needs requiring coordination with other State agencies.

Universal precautions - Guidelines developed to prevent the transmission of bloodborne pathogens by treating all human blood and certain bodily fluids as potentially infectious, regardless of a patient's infection status.

Volunteer – An individual who, without monetary compensation, provides a direct care service.

Youth – An individual 14 years of age or older but under 18 years of age.

§ 5250.5. Applicable laws.

A crisis intervention service provider shall comply with:

(1) Chapter 20 (relating to licensure or approval of facilities and agencies).

(2) 62 P. S. §§ 901—1087 (relating to Articles IX and X of the Human Services Code).

(3) The applicable requirements under Chapter 5100 (relating to mental health procedures).

(4) The Mental Health Procedures Act (50 P.S. §§ 7101-7503).

(5) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. No. 104-191).

(6) Applicable Federal, State, and local laws, ordinances, and regulations.

§ 5250.6. Application and inspections.

A legal entity desiring to provide crisis intervention services shall file an application for a certificate of compliance with the Department in accordance with Articles IX and X of the Human Services Code, 55 Pa. Code Chapter 20 (relating to licensure or approval of facilities and agencies) and this chapter.

§ 5250.7. Licenses.

(a) A crisis intervention service provider may be licensed for one or more of the following crisis intervention services:

(1) Crisis call center services.

(2) Mobile crisis team services.

(3) Medical mobile crisis team services.

(4) Emergency behavioral health crisis walk-in center services.

(5) Crisis stabilization unit services.

(b) The crisis intervention service provider shall post the current license in a conspicuous and public place within the facility or agency.

§ 5250.8. Access to premises and records.

In addition to Department access required by 55 Pa. Code § 20.34 (relating to access) and 62 P.S. § 1016 (relating to right to enter and inspect), a crisis intervention service provider shall, upon request of an individual, grant access to a community advocate to interview the individual privately.

Subchapter B. GENERAL REQUIREMENTS

§ 5250.11. Fire safety approval.

(a) Prior to issuance of a license, the legal entity shall obtain written fire safety approval from the Department of Labor and Industry, the Department of Health, or the appropriate local building authority under the Pennsylvania Construction Code Act (35 P.S. §§ 7210.101—7210.1103), for the premises where the facility will be located.

(b) If the fire safety approval is withdrawn or restricted, the crisis intervention service provider shall immediately notify the Department orally and in writing within 48 hours of the withdrawal or restriction.

(c) If a building is structurally renovated or altered after the initial fire safety approval is issued, the crisis intervention service provider shall submit the new fire safety approval, or written certification that a new fire safety approval is not required, from the appropriate fire safety authority. This documentation shall be submitted to the Department within 15 days of the completion of the renovation or alteration.

(d) The Department may request additional fire safety inspections by the appropriate agency if the Department identifies potential fire safety violations during an inspection.

§ 5250.12. Confidentiality of records.

A crisis intervention service provider shall comply with the confidentiality requirements of the following statutes and regulations, where applicable:

(a) The Child Protective Services Law (23 Pa.C.S. §§ 6301—6388).

(b) The Adoption Act (23 Pa.C.S. §§ 2101—2938).

(c) The Mental Health Procedures Act (50 P.S. §§ 7101—7503).

(d) Section 602(d) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4602(d)).

(e) The Confidentiality of HIV-Related Information Act (35 P.S. §§ 7601 – 7612).

(f) The Adult Protective Services Law (35 P.S. §§ 10210.101—10210.704).

(g) The Older Adults Protective Services Act (35 P.S. §§ 10225.101 - 10225.5102).

(h) Chapters 3490 and 5100 (relating to protective services; and mental health procedures).

(i) Any other applicable confidentiality statutes and regulations.

§ 5250.13. Waivers.

(a) A crisis intervention service provider may submit a written request for a waiver in a manner and format as prescribed by the Department.

(b) The Department may grant a waiver of a specific provision of this chapter if the following conditions exist:

(1) There is no significant jeopardy to an individual receiving crisis intervention services.

(2) There is an alternative for providing an equivalent level of health, safety, and well-being protection to the individual receiving crisis intervention services.

(3) The benefit of waiving the provision outweighs any risk to the health, safety, and well-being of an individual receiving crisis intervention services.

(4) The waiver does not violate other applicable Federal or State statutes or regulations.

(c) The scope, definitions, purpose, or applicability of this chapter may not be waived.

§ 5250.14. Quality management.

(a) A crisis intervention service provider shall establish and implement a quality management plan that monitors, evaluates, and initiates activities to improve the quality and effectiveness of administrative and crisis intervention services.

(b) The quality management plan shall include the annual review of the following:

(1) Individual records.

(2) Staff member hiring, training, and other related staff development matters.

(3) Licensing or regulatory agency actions and plans of correction, if applicable.

(4) Interviews from both individuals served and staff persons regarding the quality of services, satisfaction, complaints, and investigations.

(5) Meeting minutes from internal committees or workgroups.

(c) A crisis intervention service provider shall prepare an annual quality report that includes the following:

(1) Analysis of the findings of the annual quality management plan required under subsection (b).

(2) Identification of the actions to address findings under the annual quality management plan.

(3) Quality, utilization, and performance measures in a manner and format as prescribed by the Department.

(d) A crisis intervention service provider shall review the quality management plan on an annual basis and update it as needed.

§ 5250.15. Service description.

(a) A crisis intervention service provider shall maintain a Department-approved written service description and update it any time a change is made.

(b) The service description shall include information on the following:

(1) Agency organization.

(2) Listing of all licenses held by the crisis intervention service provider.

(3) Agency mission.

(4) Advisory process.

(5) Quality improvement process.

(6) Funding sources.

(7) Population served.

(8) Licensed capacity for the maximum number of individuals served, if applicable.

(9) Criteria for admission.

(10) Criteria for denial of admission.

(11) Voluntary and involuntary treatment availability.

(12) Treatment philosophy and treatment methods available.

(13) Strategies to address racial inequities and bias.

(14) Visitation arrangements and coordination with families and other natural supports.

(15) Collaboration with other supports, if applicable.

(16) Discharge planning process.

(17) Availability of specialized services designed to serve special populations.

(18) Availability of trauma-informed care or trauma treatment, or both.

(19) Availability of a certified peer professional on a crisis team.

(20) Overview of staffing patterns, credentials, and training.

(21) Formal agreements/processes with local law enforcement, emergency medical services, and hospitals to ensure behavioral health professionals lead crisis response efforts where appropriate

§ 5250.16. Complaints.

(a) An individual has a right to file a complaint in accordance with 55 Pa. Code § 5100.54, Article VII, Grievance and Appeal Procedures (relating to manual of rights for persons in treatment).

(b) A crisis intervention service provider shall have a written policy and procedure for receiving, reviewing, and responding to complaints; and have a process for ensuring adherence to the policy.

(c) A crisis intervention service provider shall investigate a complaint, make every effort to resolve the complaint, and provide a written decision to the individual who filed the complaint within 48 hours of receiving the complaint.

(d) Complaints shall be investigated and decided by persons not directly involved in the circumstances leading to the grievance.

(e) The individual who filed the complaint shall be given a copy of the complaint and final decision and a copy shall be filed in the individual's record.

(f) If a complaint remains unresolved, the crisis intervention service provider shall comply with the appeal procedures under § 5100.54, Article VII, Grievance and Appeal Procedures (relating to manual of rights for persons in treatment).

Subchapter C. INDIVIDUAL RIGHTS

§ 5250.21. Individual participation.

(a) An individual has the right to refuse medication or placement in crisis intervention services or terminate service without prejudice to other parts of the treatment program and future services.

(b) A youth or parent may consent to crisis intervention services in accordance with Federal and State laws and regulations on obtaining consent to treatment.

§ 5250.22. Nondiscrimination.

A crisis intervention service provider may not discriminate against staff or individuals receiving services on the basis of race, color, disability, religious affiliation, ancestry, gender, gender identity or expression, sexual orientation, national origin or age, ethnic minority groups, and shall comply with all applicable State and Federal statutes and regulations, including Chapter 5100 (relating to mental health procedures) and section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. § 794), regarding nondiscrimination under Federal grants and programs on the basis of handicap or disability, and the Americans with Disabilities Act (42 U.S.C.A. §§ 12101-12213).

§ 5250.23. Specific rights.

(a) An individual is entitled to the rights enumerated under §§ 5100.51 - 5100.55.

(b) An individual shall be notified of specific individual rights under subsection (a) upon admission.

§ 5250.24. Confidentiality.

An individual receiving services is entitled to confidentiality of records and information under §§ 5100.31 - 5100.39 and other applicable Federal and State requirements.

Subchapter D. STAFFING

§ 5250.31. Minimum staffing credentials.

(a) A crisis intervention service licensed medical professional shall be at least one of the following:

(1) A licensed psychiatrist.

(2) A licensed physician with 1 year of behavioral health service experience in diagnosis, evaluation, and treatment of behavioral health conditions.

(3) A licensed certified registered nurse practitioner with 2 years of behavioral health service experience in diagnosis, evaluation, and treatment of behavioral health conditions.

(4) A licensed physician assistant with 2 years of behavioral health service experience in diagnosis, evaluation, and treatment of behavioral health conditions.

(b) A crisis intervention service licensed behavioral health professional shall be at least one of the following:

(1) A licensed bachelor social worker.

(2) A licensed social worker.

(3) A licensed clinical social worker.

(4) A licensed professional counselor.

(5) A licensed associate professional counselor.

(6) A licensed marriage and family therapist.

(7) A licensed associate marriage and family therapist.

(8) A licensed psychologist.

(c) A crisis intervention service behavioral health professional shall have at least one of the following:

(1) A master's degree in sociology, social work, psychology, activity therapies, counseling, education, nursing, or related fields and 3 years of behavioral health direct care experience.

(2) A bachelor's degree in sociology, social work, psychology, activity therapies, counseling, education, nursing, or related fields and 5 years of behavioral health direct care experience.

(3) A Pennsylvania license to be a registered nurse and 5 years of behavioral health direct care experience, with 2 of those years including experience as a supervisor.

(d) A crisis intervention service crisis worker shall act under the supervision of a crisis intervention service behavioral health professional and meet any of the following:

(1) Has a bachelor's degree with major coursework in sociology, social work, psychology, gerontology, nursing, counseling, or a related field.

(2) Has a bachelor's degree with major coursework in anthropology, political science, history, criminal justice, theology, education, or a related field and 2 years of behavioral health direct care experience.

(3) Is a licensed registered nurse.

(4) Has a high school diploma or equivalency and 12 semester credit hours in sociology, social welfare, psychology, gerontology, or other social science and 2 years of experience in public or private human services with one year of behavioral health direct care experience.

(5) Has a certification in good standing from the state-approved certification entity to deliver peer support services to individuals and/or families impacted by mental illness and/or substance use disorders.

(e) For any staffing positions requiring a college level degree, an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. (AICE) or the National Association of Credential Evaluation Services (NACES) will be accepted. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.

(f) A volunteer shall meet one of the staff qualifications under subsection (a), (b), (c), or (d).

(g) Interns in accredited training programs in various mental health or medical disciplines may participate in the provision of crisis intervention services when under the direct supervision of one of the following:

(1) A crisis intervention service behavioral health professional.

(2) A crisis intervention service licensed behavioral health professional.

(3) A crisis intervention service licensed medical professional.

§ 5250.32. Criminal history checks.

(a) A crisis intervention service provider shall complete clearances on staff and volunteers as required under the following:

(1) Child Protective Services Law (23 Pa.C.S. §§ 6301—6388).

(2) Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704).

(3) Older Adults Protective Services Act (35 P.S. §§ 10225.101 - 10225.5102).

(b) A crisis intervention service provider shall develop and consistently implement written policies and procedures regarding personnel decisions based on the results of criminal history checks under subsection (a).

§ 5250.33. Emergency first aid training.

(a) Crisis intervention service staff shall be trained and maintain certification in first aid, obstructed airway techniques and CPR.

(b) Crisis intervention service staff shall be trained and maintain certification in the administration of Naloxone or other appropriate medications used to reverse a substance overdose.

(c) Current training in first aid, certification in obstructed airway techniques and CPR shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

(d) Current training in the administration of Naloxone or other appropriate medications used to reverse a substance overdose shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

§ 5250.34. Staff training.

(a) Within the first 10 scheduled working days, crisis intervention service staff, interns, and volunteers shall have 4 hours of initial orientation, which includes the following:

(1) De-escalation techniques.

(2) Suicide risk assessment procedures.

(3) Trauma-informed care.

(4) Other trainings as published as a notice in the *Pennsylvania Bulletin*.

(b) Within the first 4 scheduled working weeks, all crisis intervention service staff, interns, and volunteers shall have 8 hours of training in any of the following topics, tailored to all populations:

(1) The crisis intervention service provider's policies and procedures.

(2) Emergency preparedness.

(3) Universal precautions.

(4) De-escalation techniques.

(5) Recovery principles.

(6) Trauma-informed care.

(7) Harm reduction.

(8) Special populations.

(9) Human development across the lifespan.

(10) Suicide risk assessment procedures.

(11) Substance use, misuse, and substance use disorder.

(12) Naloxone or other appropriate medications used to reverse a substance overdose.

(13) Intervention.

(14) Assessment.

(15) Counseling.

(16) Screening.

(17) Disposition services.

(18) Confidentiality and consent.

(19) Mental health advance directives.

(20) The Mental Health Procedures Act (50 P.S. §§ 7101 – 7503).

(21) This chapter.

(c) Crisis intervention service staff, interns, and volunteers shall have a minimum of 12 hours of annual training including, at a minimum, the following:

(1) Emergency preparedness and universal precautions.

(2) Policy and procedure review which is specific to the intern, volunteer, or crisis intervention service staff person's position.

(3) Training topics listed under subsection (b).

(d) The requirement for initial training under subsections (a) and (b)(3) - (21) does not apply if the crisis intervention service staff person, intern, or volunteer provides written verification of completion of the training under either of the following circumstances:

(1) If a crisis intervention service staff member, intern, or volunteer has completed the required initial training within the past year as a crisis intervention service staff member, intern, or volunteer at another crisis intervention service facility.

(2) If a crisis intervention service staff member, intern, or volunteer has completed the required initial training as a crisis intervention service staff member, intern or volunteer within one year prior to the effective date of this chapter.

§ 5250.35. Staff training plan.

(a) A crisis intervention service provider shall establish a written staff training plan for each crisis intervention service provided. The written staff training plan shall:

(1) Include training aimed at improving the knowledge and skills of crisis intervention service staff persons, interns, and volunteers in carrying out job responsibilities.

(2) Specify training for each staff classification that shall be completed before a staff member, intern, or volunteer may provide crisis intervention services.

(3) Establish ongoing training requirements for staff members, interns, and volunteers.

(4) Have a primary objective that enables staff persons, interns, and volunteers to identify a crisis and provide crisis intervention services to adults, youth, families, and children in an age-appropriate and culturally competent manner.

(5) Be approved by the county administrator for the county where the crisis intervention service is located and reviewed annually by the Department.

(6) Be updated at least annually, or more frequently if needed.

(b) A crisis intervention service provider shall keep documentation of compliance with the staff training plan.

Subchapter E. PHYSICAL SITE

§ 5250.41. Individual safety.

(a) A crisis intervention service provider shall develop a policy and procedure that addresses all of the following:

(1) Use of locks.

(2) Use of security personnel.

(3) Use of external law enforcement.

(4) Key access control.

(b) Stairways, hallways, doorways, passageways, and egress routes from rooms and from the building shall be unobstructed and lighted to ensure that staff and individuals can safely move through the premises and quickly evacuate.

(c) Interior and exterior stairways shall have securely fastened handrails and non-skid surfaces or non-skid devices. If present, stair coverings shall be securely fastened.

(d) When there is an elevator, the crisis intervention service provider shall obtain a certificate of operation for the elevator from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

§ 5250.42. Smoking.

(a) Smoking is not permitted indoors.

(b) A crisis intervention service provider shall comply with the Clean Indoor Air Act (35 P.S. §§ 637.1 – 637.11), including signage prominently posted and properly maintained at every entrance to the premises.

(c) A facility that permits smoking outdoors shall limit smoking to designated smoking areas.

(d) A facility that permits smoking outdoors shall develop and implement written fire safety policies and procedures that include proper safeguards to prevent fire hazards involved in smoking, including the following:

(1) Fireproof receptacles and ashtrays.

(2) Fire-resistant furniture.

(3) Fire extinguishers in the smoking areas.

(4) Fire extinguishing procedures.

(e) A crisis intervention service provider shall have policies that incorporate tobacco-free recovery principles into overall service objectives and provide individuals with access to resources that support tobacco-free recovery.

§ 5250.43. Building exterior and grounds.

A crisis intervention service provider shall meet all of the following:

(a) Maintain structures, fences, and equipment on the grounds of the premises that are

free from any danger to health and safety.

(b) Keep the grounds of the premises clean, safe, sanitary, and in good repair at all times for the safety and well-being of individuals, staff, and visitors.

(c) Keep the exterior of the building and the building grounds or yard free of hazards.

(d) Keep exterior exits, stairs, and walkways designated for emergency exit routes lighted at night.

(e) Store all trash in noncombustible, covered containers that prevent the penetration of insects and rodents.

§ 5250.44. Exit signs.

The following requirements apply to crisis intervention service providers:

(a) Signs bearing the word ‘‘EXIT’’ in plain legible letters shall be placed at all exits.

(b) If the exit or way to reach the exit is not immediately visible, access to exits shall be marked with readily visible signs indicating the direction to travel.

(c) Exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

(d) Any doors, passageways, or stairways that are not exits must be marked as “NOT AN EXIT.”

§ 5250.45. Postings.

A crisis service provider shall maintain all required postings. Required postings include all of the following:

(a) Telephone numbers for the nearest hospital, police department, fire department, ambulance, and poison control center on or by each telephone with an outside line.

(b) A copy of the Patient Bill of Rights under § 5100.53 (relating to bill of rights for patients).

(c) A list of local and state advocacy organizations and contact information.

(d) Information about the local county MH/IDD program, Single County Authority and relevant contact information.

(e) All licenses issued to the crisis intervention service provider.

(f) Certificate of occupancy issued to the crisis intervention service provider, as required under § 5250.11 (relating to fire safety approval).

§ 5250.46. Emergency preparedness.

(a) A crisis intervention unit operated by a general hospital that has been inspected by the Department of Health, holds a current license issued under the authority of the Health Care Facilities Act (35 P.S. §§ 448.101 - 448.904b), and is in compliance with the requirements 28 Pa. Code Chapter 151 (relating to fire, safety and disaster services) is deemed to be in compliance with subsections (b) and (c).

(b) Emergency plan.

(1) The crisis intervention service provider shall develop an emergency plan that includes a documented premises-based and community-based risk assessment, utilizing an all-hazards approach.

(2) The plan must include strategies to address emergency events identified in the risk assessment, including the following:

(i) Evacuation plan.

(ii) Shelter in place plan.

(iii) Needs of individuals served.

(iv) Staffing in the event of an emergency.

(v) Needs of staff including continuity of operation needs, delegation of authority, and succession plans.

(vi) A process for collaboration with emergency management agencies during an emergency and during the planning and testing phase of preparation.

(c) Policy and procedures.

(1) The crisis intervention service provider shall develop written policies and procedures for the implementation of the disaster plan.

(2) The crisis intervention service provider shall review annually, and update policies and procedures as needed.

(d) Communication plan.

(1) The crisis intervention service provider shall develop and maintain an emergency preparedness communication plan that follows Federal, State and local laws, and is reviewed annually, and updated as needed.

(2) The communication plan shall include names and contact information for the following:

(i) State and local emergency preparedness agencies.

(ii) Emergency service providers such as police, fire, ambulance, and utility shut-off organizations.

(iii) Local physicians and community service providers.

(iv) Crisis intervention service staff who will be contacted in the event of an emergency, including their names, addresses, and telephone numbers.

(v) Other crisis intervention service facilities in the area.

(vi) The communication plan shall include a primary and alternate method of communication with staff and with State and local emergency response officials.

(e) A crisis intervention service provider that is part of a health care system shall demonstrate the capability to implement the emergency plan adopted by the health care system.

§ 5250.47. Fire safety.

(a) A crisis intervention service provider operated by a general hospital that has been inspected by the Department of Health and holds a current license issued under the authority of the Health Care Facilities Act (35 P.S. §§ 448.101 - 448.904b) and is in compliance with the requirements under 28 Pa. Code § 151 (relating to fire, safety and disaster services) is deemed to be in compliance with this section.

(b) Fire safety systems shall be inspected and approved annually by a certified fire safety inspector.

(c) The crisis intervention service provider shall post either exit diagrams or lighted signs, or both, throughout the premises to designate escape routes.

(d) The crisis intervention service provider shall make manual fire alarm systems and portable fire extinguishers immediately accessible to all staff on duty.

§ 5250.48. Fire drills.

(a) For all modalities of crisis intervention services, the following shall apply:

(1) An unannounced fire drill shall be held at least once every 2 months.

(2) Alternate exit routes shall be used during fire drills.

(3) Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when individual attendance is low.

(4) Individuals shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

(5) A fire alarm or smoke detector shall be set off during each fire drill.

(6) Elevators may not be used during a fire drill or a fire.

(b) For crisis stabilization units, a fire drill shall be held during sleeping hours once every 6 months.

(c) A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of individuals in the facility at the time of the drill, the number of individuals evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Subchapter F. RESPONSIBILITIES

§ 5250.51. Responsibilities of providers.

(a) A crisis intervention service provider shall:

(1) Comply with this chapter.

(2) Submit reports as required by the Department and the county administrator.

(b) A crisis intervention service provider shall establish a written protocol for each crisis intervention service. The protocol shall state the policy and guidelines for responding to a specific situation. The protocol shall meet all of the following:

(1) Address services to children, youth, special populations, and family members.

(2) Address substance use, misuse, and overdose, including the use of Naloxone or other appropriate medications used to reverse a substance overdose.

(3) Address notification to family members of children, youth, and adults in accordance with state and federal privacy laws.

(4) Address procedures that will provide continuity of care for individuals and monitor outcomes.

(5) Be approved and reviewed annually by a team of individuals that represents multi-disciplinary team membership and provider quality.

(6) Ensure interpretive services including sign language interpretation are available, and language services are offered to individuals with limited English proficiency as required by Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d – 2000d-7) and applicable Federal guidance.

(7) Address threats of harm to self or others and other common or anticipated crisis situations.

(c) A crisis intervention service provider who administers medication shall maintain a written protocol for the storage and administration of medication which has been approved by a physician and reviewed annually.

(d) A crisis intervention service provider shall respond to, stabilize, and seek to facilitate the resolution of a crisis situation. The provision of services shall take precedence over intake and other administrative processes.

(e) A crisis intervention service provider shall have a signed agreement on file which assures that psychiatric or other physician consult is available when needed by telephone, in-person or other audio-video communication device.

(f) A crisis intervention service provider shall maintain and make available a current list of community resource providers for individuals and family members in crisis.

(g) A crisis intervention service provider shall establish and maintain relationships with community resource providers to ensure accessibility for substance use, misuse, and substance use disorder services.

(h) A crisis intervention service provider shall establish letters of agreement for substance use, misuse, and substance use disorder services.

(i) A crisis intervention service provider shall make available to each individual or caregiver or legal guardian, a listing of behavioral health treatment, rehabilitation, and support services available within a reasonable proximity to the individual's home where needed services could be obtained. Crisis intervention services staff shall assist the individual in accessing those services, if requested by the individual, or the individual's caregiver or legal guardian.

(j) When a crisis intervention service provider also provides other behavioral health services, the crisis intervention service provider shall:

(1) Allow the freedom of choice of an individual, or the caregiver or legal guardian, when nonemergency referrals are made, or other services are solicited in a non-emergency situation.

(2) Fully disclose that other services that the crisis intervention provider performs could be obtained from another provider if the individual so desires.

§ 5250.52. Recordkeeping.

(a) Crisis intervention service provider records shall, at a minimum, contain the following:

(1) Copies of required licensing inspection summaries, certifications, and licenses by Federal, State, and local agencies.

(2) Documents that verify employee work schedules, such as payroll records and employee time sheets.

(3) A job description for each employee.

(4) A schedule of fees or charges.

(5) Documents that verify intern, volunteer, and employee qualifications and training as described in this chapter.

(6) A record of supervision and training for each employee.

(7) Letters of agreement with frequently used referral sources, such as other crisis intervention service providers and community-based support services providers, hospitals, and police departments.

(8) On-call schedule of medical and psychiatric care coverage.

(9) Emergency plans.

(10) Copies of complaints, investigations, resolution, and related documentation.

(b) Crisis intervention service provider records shall be maintained as follows:

(1) Be permanent, legible, dated, and signed by the staff person providing the service.

(2) Indicate the type of service being provided, show the dates of service, and show the beginning and end time of each service.

(3) Be organized and maintained according to a uniform format so that information is readily located.

(4) Be reviewed annually for quality by a crisis intervention service licensed medical professional, crisis intervention service licensed behavioral health professional, or crisis intervention service behavioral health professional.

§ 5250.53. Case records.

(a) Records for a crisis intervention service shall be specifically identified and may be integrated with the individual's other service records which are maintained by the provider.

(b) The individual case record shall contain, at a minimum, the following information, as applicable:

(1) Identifying information on the individual served.

(2) A description of the contact detailing the reason for the contact, staff involved, services provided, crisis resolution referrals and outcomes.

(3) Individual service plans and updates.

(4) Documentation of the crisis intervention service licensed medical professional or crisis intervention service licensed behavioral health professional recommendation.

(c) Entries in an individual's case record must meet all of the following:

(1) Be permanent, legible, dated, and signed by the staff person providing the service.

(2) Show the dates of service and the time of the beginning and end of each service.

(3) Be organized and maintained according to a uniform format so that information is readily located.

(4) Be reviewed annually for quality by a crisis intervention service licensed medical professional or crisis intervention service licensed behavioral health professional in accordance with § 5250.14(b) (relating to quality management).

§ 5250.54. Record retention and disposal.

(a) Unless another law requires a longer retention period, crisis intervention service providers shall maintain records for a minimum of 4 years following discharge or until any audit or litigation is resolved.

(b) Records shall be retained and disposed of in a manner consistent with applicable law.

Subchapter G. CRISIS CALL CENTERS

§ 5250.61. Requirements for crisis call center services.

(a) A crisis call center shall provide confidential support services to individuals in suicidal crisis or emotional distress requiring emergency behavioral health intervention.

(b) A crisis call center shall operate 24 hours a day, 7 days a week, 365 days a year.

(c) A crisis call center shall deliver telephonic, text, or chat crisis intervention services. The center shall triage the interaction to assess an individual's behavioral health needs and, based on the assessment results and the individual's preferences, coordinate connections to support.

(d) A crisis call center shall provide the following for an individual who exhibits substance use disorder, disturbed thought, behavior, mood, or problems with social relationships:

(1) Behavioral health counseling.

(2) Consultation.

(3) Information and referral services.

(e) A crisis call center shall provide services to callers who seek assistance on behalf of another individual (third-party callers).

(f) A crisis call center shall employ a minimum of one crisis intervention service licensed behavioral health professional per shift.

§ 5250.62. Provider's responsibilities for crisis call center services.

(a) A crisis call center service provider shall maintain a written plan, developed in collaboration with the mental health county administrator and the Single County Authority, and shall contain all of the following:

(1) The provision of services. Telephone calls shall be answered by a member of the crisis staff. Calls may not be answered by a recording or other mechanical device.

(2) How collaboration involves communication with county agencies serving the following populations, including, but not limited to:

(i) Aging and older adults.

(ii) Children and youth.

(iii) Individuals with intellectual and developmental disabilities.

(iv) Individuals with substance use, misuse, and substance use disorder.

(3) An organizational chart, showing the organizational structure of the program.

(b) A crisis call center service provider shall have written policies regarding all of the following:

(1) Active engagement with callers and establishing rapport to promote the caller's collaboration in securing an individual's safety.

(2) Real-time deployment of mobile crisis teams when an in-person crisis response is determined necessary, including all cases when an involuntary emergency intervention may be necessary.

(3) Dispatch of life-saving services for emergencies in progress, which do not require the individual's consent to initiate medically necessary rescue services.

(4) Dispatch of emergency rescue to secure the immediate safety of the individual if the caller remains unwilling or unable, or both, to take action to prevent an emergency or life-threatening incident when the individual remains at imminent risk.

(5) Active engagement with third-party callers towards determining the least restrictive, most collaborative actions to best ensure the safety of the individual.

(6) Supervision of staff during hours of operations to ensure timely consultation with individuals and third-party callers to determine the most appropriate intervention for an individual who may be at imminent risk of an emergency or life-threatening incident.

(7) The process for acquiring and documenting informed consent. Documentation shall be maintained.

(c) A crisis call center service provider shall ensure the telephone crisis service meets the following, except when circumstances dictate diversion to other services or providers:

(1) Operates 24 hours a day, 7 days a week, 365 days a year.

(2) Be staffed with crisis intervention service behavioral health professionals overseeing responses to crisis events.

(3) Answers every call or coordinates overflow coverage with a resource that meets the minimum crisis call center requirements established under this chapter.

(4) Assesses the risk of suicide.

(5) Coordinates connections to mobile crisis services.

(6) Refers an individual to follow-up services with permission by the individual, to support connection to ongoing care following a crisis event.

(7) Connects an individual to facility-based care with providers and coordinates transportation as needed.

(d) A crisis intervention service behavioral health professional shall supervise the crisis call center, as well as individual supervision.

(e) Crisis call center services shall be provided by crisis intervention service behavioral health professionals and crisis intervention service crisis workers qualified under § 5250.31 (relating to minimum staffing credentials).

Subchapter H. MOBILE CRISIS TEAM SERVICES

§ 5250.71. Requirements for mobile crisis team services.

(a) Mobile crisis team services shall provide community-based emergency behavioral health intervention to an individual in suicidal crisis or emotional distress 24 hours a day, 7 days a week, 365 days a year.

(b) Mobile crisis team services shall provide community-based emergency behavioral health intervention to an individual in suicidal crisis or emotional distress at any location the individual is experiencing a behavioral health crisis, including place of residence, work, or in the community.

(c) Except as provided under subsection (d), when responding to home and community settings, mobile crisis team services shall be delivered by two-person teams staffed by any combination of crisis intervention service licensed behavioral health professionals, crisis intervention service behavioral health professionals, and crisis intervention service crisis workers.

(d) A single mobile crisis responder is permitted to respond when responding to a setting where a person who meets one of the following is already present at the location and will remain engaged in the crisis situation until it is resolved:

(1) Is a crisis intervention service licensed behavioral health professional.

(2) Is a crisis intervention service behavioral health professional.

(3) Is a crisis intervention service crisis worker.

(4) Is a crisis intervention service licensed medical professional.

(e) Mobile crisis team services shall be deployed in real-time through 988 or county lines.

(f) Mobile crisis team services include the following:

(1) De-escalation.

(2) Suicide risk assessment.

(3) Service needs assessment.

(4) Motivational interviewing.

(5) Supportive engagement.

(6) Development of a service plan.

(7) Ensuring the crisis is resolved or an individual is connected to the next level of service.

(8) Referral and follow-up, including referrals for assessment and treatment for substance use disorder.

(g) Mobile crisis team services shall provide linkages with other services and referrals and serve as a mechanism for diversion from emergency department services and the criminal justice system.

(h) Mobile crisis team services shall be familiar with local crisis resources and the required intake process for emergency behavioral health walk-in centers and crisis stabilization programs.

(i) Mobile crisis team services shall develop agreements to guide the interaction between first responders and mobile crisis providers in responding to behavioral health crisis calls.

§ 5250.72. Provider's responsibilities for mobile crisis team services.

(a) A mobile crisis team service provider shall maintain a written plan, developed in collaboration with the mental health county administrator and the Single County Authority, and shall contain the following:

(1) A description of service availability.

(2) How collaboration involves communication with county agencies who serve the following populations, including, but not limited to:

(i) Aging and older adults.

(ii) Children and youth.

(iii) Individuals with intellectual and developmental disabilities.

(iv) Individuals with substance use, misuse, and substance use disorder.

(3) An organizational chart, showing the organizational structure of the program.

(b) A mobile crisis team service provider shall maintain written policies regarding all of the following:

(1) How the mobile crisis team service provider operates 24 hours a day, 7 days a week, 365 days a year.

(2) How certified peer professionals are incorporated within the mobile crisis team service.

(3) How the mobile crisis team service provider responds without law enforcement or emergency medical services accompaniment unless special circumstances warrant inclusion.

(4) How the mobile crisis team service provider refers outpatient follow-up appointments, as authorized by the individual.

(5) The availability of a crisis intervention service licensed medical professional or a crisis intervention service licensed behavioral health professional for consultation, as needed.

(6) The supervision of staff during all hours of operations for consultation in determining the most appropriate intervention for individuals who may be at imminent risk of an emergency or life-threatening incident.

(c) A crisis intervention service licensed behavioral health professional, as defined under § 5250.31 (relating to minimum staffing credentials), shall direct the provision of mobile crisis team services.

Subchapter I. MEDICAL MOBILE CRISIS TEAM SERVICES

§ 5250.81. Requirements for medical mobile crisis team services.

(a) A medical mobile crisis team shall meet the requirements of Subchapter H (relating to mobile crisis team services), with the exception of § 5250.72(b)(5) (relating to provider's responsibilities for mobile crisis team services).

(b) A medical mobile crisis team service shall be provided in the community directly to an individual experiencing a behavioral health crisis.

(c) The medical mobile crisis team service may be utilized in situations where medication is known or anticipated to be required.

(d) A medical mobile crisis team service shall be accessed through a crisis intervention service licensed behavioral health professional.

§ 5250.82. Provider's responsibilities for medical mobile crisis team services.

(a) A medical mobile crisis team service provider shall maintain a written plan, developed in collaboration with the mental health county administrator and the Single County Authority, and shall contain the following:

(1) A description of service availability.

(2) How collaboration involves communication with county agencies serving the following populations, including, but not limited to:

(i) Aging and older adults.

(ii) Children and youth.

(iii) Individuals with intellectual and developmental disabilities.

(iv) Individuals with substance use, misuse, and substance use disorder.

(3) An organizational chart, showing the organizational structure of the program.

(b) A medical mobile crisis team service provider shall have policies regarding all of the following:

(1) How the medical mobile crisis team service provider operates 24 hours a day, 7 days a week, 365 days a year.

(2) Responding without law enforcement or emergency medical services accompaniment unless circumstances warrant inclusion in accordance with the operating procedures of a locality.

(3) Referring outpatient follow-up appointments, as authorized by the individual.

(4) Availability of a crisis intervention service licensed medical professional, as defined by § 5250.31 (relating to minimum staffing credentials), 24 hours a day, 7 days a week, 365 days a year.

(5) Supervision of staff during all hours of operations for consultation in determining the most appropriate intervention for individuals who may be at imminent risk of an emergency or life-threatening incident.

(6) How the medical mobile crisis team service provider uses, administers, and stores medications.

(c) A crisis intervention service licensed medical professional or crisis intervention service licensed behavioral health professional, as defined by § 5250.31 (relating to minimum staffing credentials), shall supervise the medical mobile crisis team services.

(d) A medical mobile crisis team service shall be provided in teams by at least one crisis intervention service licensed medical professional who can administer medications, and any one of the following qualified under § 5250.31:

(1) A crisis intervention service licensed behavioral health professional.

(2) A crisis intervention service behavioral health professional.

(3) A crisis intervention service crisis worker.

Subchapter J. EMERGENCY BEHAVIORAL HEALTH CRISIS WALK-IN CENTER SERVICES

§ 5250.91. Requirements for emergency behavioral health crisis walk-in center services.

(a) An emergency behavioral health crisis walk-in center shall provide short-term crisis medical assessment and stabilization services to an individual in a safe, recovery-oriented environment for emergency behavioral health care.

(b) An emergency behavioral health crisis walk-in center shall have continuous access, at the center or via tele-behavioral health, to a physician for the purpose of completing the required process outlined in Section 302 of the Mental Health Procedures Act (50 P.S. § 7302). If a physician conducts the emergency examination via tele-behavioral health, an advanced practice professional as defined in § 5200.3 (relating to definitions) shall be present at the facility and engaged in the assessment process.

(c) An emergency behavioral health crisis walk-in center shall accept all walk-ins.

(d) An emergency behavioral health crisis walk-in center shall provide all of the following services:

(1) Medical and behavioral health assessments.

(2) Medication, when deemed medically necessary.

(3) Stabilization within 23 hours and referral to appropriate level of care.

(4) Peer support services.

(5) Evaluation and follow-up, including referrals for assessment and treatment for substance use disorder, as appropriate.

§ 5250.92. Provider's responsibilities for emergency behavioral health crisis walk-in center services.

(a) An emergency behavioral health crisis walk-in center service provider shall maintain a written plan, developed in collaboration with the mental health county administrator and the Single County Authority, and shall contain the following:

(1) How services are provided.

(2) How collaboration involves communication with county agencies serving the following populations, including, but not limited to:

(i) Aging and older adults.

(ii) Children and youth.

(iii) Individuals with intellectual and developmental disabilities.

(iv) Individuals with substance use, misuse, and substance use disorder.

(3) An organizational chart, showing the organizational structure of the program.

(b) An emergency behavioral health crisis walk-in center service provider shall have written policies regarding all of the following:

(1) How the emergency behavioral health crisis walk-in center service provider operates 24 hours a day, 7 days a week, 365 days a year.

(2) Intervening in a behavioral health crisis event.

(3) Screening and referrals for community resources, including emergency services, short-term crisis stabilization service needs, or psychiatric inpatient services.

(4) Intake, assessment, evaluation, documentation, and follow-up care.

(5) Screening for suicide risk and completing comprehensive suicide risk assessments and planning, if applicable.

(6) Screening for violence risk and completing comprehensive violence risk assessments and planning, if applicable.

(7) How the emergency behavioral health crisis walk-in center service provider ensures safety of all individuals within the emergency behavioral health walk-in center which may include security staff or comprehensive staff training to manage anticipated situations that elevate risk of harm to individuals or others.

(8) Ensuring the security of the premises, including written protocols for security emergencies.

(c) An emergency behavioral health crisis walk-in center service provider shall meet the following, except when treatment of a physical health emergency is needed:

(1) Allow intake without requiring medical clearance.

(2) Incorporate certified peer professionals where available, within the emergency behavioral health crisis walk-in center services.

(3) Provide capacity to accept all referrals and maintain a no-rejection policy for individuals.

(d) A crisis intervention service licensed medical professional shall direct the emergency behavioral health crisis walk-in center services.

(e) An emergency behavioral health crisis walk-in center service shall be provided by crisis intervention service licensed medical professionals, crisis intervention service licensed behavioral health professionals, crisis intervention service behavioral health professionals, and crisis intervention service crisis workers qualified under § 5250.31 (relating to minimum staffing credentials).

(f) An emergency behavioral health crisis walk-in center provider shall have available for response at all times a person whose scope of practice permits diagnosing, prescribing and administering medication.

§ 5250.93. Premises requirements.

(a) An emergency behavioral health crisis walk-in center service facility shall provide anti-ligature devices to eliminate points where a cord, rope or other items that can be looped or tied to a fixture to create a point of ligature.

(b) Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, water heaters, and radiators exceeding 120°F that are accessible to the individual must be equipped with protective guards or insulation to prevent the individual from coming in contact with the heat source.

§ 5250.94. First aid.

(a) An emergency behavioral health crisis walk-in center service provider shall have a first aid kit that includes, at a minimum, the following:

(1) Nonporous disposable gloves.

(2) Antiseptic.

(3) Adhesive bandages.

(4) Gauze pads.

(5) Thermometer.

(6) Adhesive tape.

(7) Scissors.

(8) Breathing shield.

(9) Eye coverings.

(10) Tweezers.

(11) Naloxone or other appropriate medications used to reverse a substance overdose.

(12) Automated external defibrillator.

(b) The first aid kit shall be stored in a location that is easily accessible to staff.

(c) An emergency behavioral health crisis walk-in center service provider shall establish a policy that ensures the contents of the first aid kit have not expired and are in good working order.

§ 5250.95. Cameras.

(a) Notification of video monitoring and recording equipment. The following applies:

(1) An emergency behavioral health crisis walk-in center service provider shall notify individuals in their preferred language, including American Sign Language, at the time of admission, if the provider uses video monitoring and recording equipment.

(2) An emergency behavioral health crisis walk-in center service provider shall post written notice of the use of video monitoring and recording equipment in a conspicuous and public place within the premises.

(b) An emergency behavioral health crisis walk-in center service provider shall develop a written policy and procedure for the security and retention of recorded and transmitted recorded camera images.

(c) An emergency behavioral health crisis walk-in center service provider shall destroy recorded material in a manner that protects confidentiality.

(d) The angle of video monitoring and recording equipment may not be placed to record areas designated as bedrooms, bathrooms, exam rooms, or any area where treatment or services requiring privacy are provided.

(e) Audio monitoring is prohibited.

§ 5250.96. Restraint and seclusion.

An emergency behavioral health crisis walk-in center service provider shall meet the restraint and seclusion requirements under 42 CFR 483.358 (relating to orders for the use of restraint or seclusion) regardless of the age of the individual being served.

§ 5250.97. Medication administration.

(a) For medication that is prescribed and dispensed by the facility, all requirements of applicable Federal and State medication statutes and regulations shall be met.

(b) Prescription medication that is not self-administered by an individual shall be administered in accordance with the practitioner's scope of practice.

(c) Prescription medication may be administered through an automated medication system if the following are met:

(1) The automated medication system electronically records the activity of each authorized personnel with the time, date and initials or other identifier so that a clear, readily retrievable audit trail is established.

(2) Policies and procedures exist for system operation, safety, security, accuracy, access, and confidentiality.

(3) Medications in the automated medication system are inspected, at least monthly, for expiration date, misbranding, and physical integrity, and the automated medication system is inspected, at least monthly, for security and accountability.

(4) The automated medication system is stocked accurately, and an accountability record is maintained in accordance with the written policies and procedures of operation.

(5) The automated medication system and its use comply with the applicable provisions of State and Federal law.

(d) An emergency behavioral health walk-in center that uses an automated medication system to fill prescriptions or medication orders shall create and operate according to a written program for quality assurance of the automated medication system that:

(1) Requires monitoring of the automated medication system.

(2) Establishes mechanisms and procedures to test the accuracy of the automated medication system at least every 6 months and whenever any upgrade or change is made to the system.

§ 5250.98. Storage and disposal of medications and medical supplies.

(a) Prescription medications, over-the-counter medications, and syringes shall be kept in an area or container that is locked.

(b) Prescription medications, over-the-counter medications, and syringes stored in a refrigerator shall be kept in an area or container that is locked.

(c) Prescription medications and over-the-counter medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light and in accordance with the manufacturer's instructions.

(d) Prescription medications and over-the-counter medications that are discontinued, expired, or for individuals who are no longer receiving crisis services in the facility shall be destroyed in

a safe manner according to the Department of Environmental Protection and Federal and State regulations.

§ 5250.99. Medication records.

(a) A medication record shall be kept and include the following for each individual for whom medications are administered:

(1) Individual's name.

(2) Drug allergies, if applicable.

(3) Name of medication.

(4) Strength.

(5) Dosage form.

(6) Dose.

(7) Route of administration

(8) Frequency of administration.

(9) Administration times.

(10) Special precautions, if applicable.

(11) Diagnosis or purpose for the medication, including pro re nata (PRN).

(12) Date and time of medication administration.

(13) Name and initials of the staff person administering the medication.

(b) The information in paragraphs (a)(12) and (13) shall be recorded at the time a medication is administered.

(c) If an individual refuses to take a prescribed medication, the refusal shall be documented in the individual's record and on the medication record.

§ 5250.100. Requirements for stock medications and blood or urine lab testing.

(a) An emergency behavioral health crisis walk-in center shall have a current license from the Department of Health's Board of Examiners or the Department of State's State Board of Pharmacy and a Drug Enforcement Agency (DEA) registration and shall prescribe and dispense stock medication as needed.

(b) An emergency behavioral health crisis walk-in center shall meet the requirements under 42 CFR § 493.1101 (relating to standard: facilities) for blood or urine lab testing.

(c) An emergency behavioral health crisis walk-in center shall secure blood or urine lab results to diagnose and prescribe behavioral health medications within a 12-hour from intake.

(d) An emergency behavioral health crisis walk-in center may perform blood or urine lab testing onsite if appropriately certified and licensed or may contract with an outside agency that is appropriately certified and licensed.

(e) An emergency behavioral health crisis walk-in center may contract with an outside agency to perform blood or urine lab testing if:

(1) The outside agency is appropriately certified and licensed to perform such testing;

(2) The emergency behavioral health crisis walk-in center maintains:

(i) A copy of the outside agency's current CLIA certificate.

(ii) A list of diagnostic procedures that the outside agency's laboratory is CLIA-certified to perform with the corresponding Healthcare Common Procedure Coding System (HCPCS) codes.

Subchapter K. CRISIS STABILIZATION UNIT SERVICES

§ 5250.101. Requirements for crisis stabilization unit services.

(a) Crisis stabilization unit services shall be provided 24 hours a day, 7 days a week, 365 days a year.

(b) Crisis stabilization unit services shall be an intensive, crisis stabilization service for individuals experiencing a behavioral health emergency.

(c) Crisis stabilization unit services shall provide for continuous supervision for an individual.

(d) Crisis stabilization unit services shall offer a temporary place for an individual to stay for relief from a stressful environment, or for ongoing stabilization, or until other arrangements are made.

(e) Crisis stabilization unit services shall be accessed through a crisis intervention licensed behavioral health professional.

§ 5250.102. Provider's responsibilities for crisis stabilization unit services.

(a) A crisis stabilization unit service provider shall maintain a written plan, developed in collaboration with the mental health county administrator and the Single County Authority, and shall contain the following:

(1) How services are provided.

(2) How collaboration includes the following populations, but are not limited to:

(i) Aging and older adults.

(ii) Children and youth.

(iii) Individuals with intellectual and developmental disabilities.

(iv) Individuals with substance use, misuse, and substance use disorder.

(3) An organizational chart, showing the organizational structure of the program.

(b) A crisis stabilization unit service provider shall have on file a list of regional referral sources.

(c) A crisis stabilization unit service provider shall offer an individual the opportunity to create or revise a mental health advance directive.

(d) A crisis stabilization unit service provider shall have policies regarding all of the following:

(1) How the crisis stabilization unit service provider addresses security, including training and qualifications for security contractors or security staff, if applicable.

(2) How the crisis stabilization unit service provider will ensure the security of the premises, including written protocols for security emergencies.

(3) How the crisis stabilization unit service provider will screen for suicide risk and completion of comprehensive suicide risk assessments and planning, if applicable.

(4) How the crisis stabilization unit service provider will screen for violence risk and completion of comprehensive violence risk assessments and planning, if applicable.

(e) A crisis stabilization unit service shall include the following services:

(1) Intake.

(2) Examination and evaluation completed within 24 hours, including when a medical examination and diagnoses are completed for an individual who stays in the unit for more than 24 hours unless the individual was directly transferred from an emergency behavioral health walk-in center or hospital after a comprehensive

psychiatric assessment and has received medical clearance 24 hours prior to transfer with a completed examination and diagnoses provided.

(3) Room and board.

(4) Counseling, peer support, and other services intended to support stabilization.

(5) Recreational activities.

(6) Connection and referral through county mental health case management service providers.

(7) Administration of medication.

(f) The maximum stay in a crisis stabilization unit is 168 hours. An additional stay of up to 48 hours is authorized if recommended by a crisis intervention service licensed medical professional or crisis intervention service licensed behavioral health professional.

(g) The crisis stabilization unit shall operate as follows:

(1) A crisis intervention service licensed medical professional or a crisis intervention service behavioral health professional shall supervise the service and crisis intervention service staff.

(2) Non-supervisory staff may be crisis intervention service crisis workers.

(3) Staff persons shall qualify under § 5250.31 (relating to minimum staffing credentials).

(4) The crisis stabilization unit may not require medical clearance prior to intake.

(h) A minimum of two staff members shall be on duty at all times, one of whom shall be a crisis intervention service licensed behavioral health professional or crisis intervention service behavioral health professional.

(1) A person authorized under State law to diagnose shall be available for response at all times.

(2) A person authorized under State law to prescribe medication shall be available for response at all times.

(3) A person authorized under State law to administer medication shall be present on the premises at all times.

§ 5250.103. Peer-run crisis stabilization unit services.

(a) A peer-run crisis stabilization unit shall be exempt from the following regulations:

(1) Section 5250.52(a)(8) (relating to recordkeeping).

(2) Section 5250.102(e)(2), (3), (4), (7), and (g)(2), (3), (4) (relating to provider's responsibilities for crisis stabilization unit services).

(3) Section 5250.124(a), (b), (c), (d), and (e) (relating to nutrition).

(4) Section 5250.127(d), and (e) (relating to storage and disposal of medications and medical supplies).

(5) Section 5250.128 (relating to medication records).

(6) Section 5250.129(a)(11) (relating to records).

(b) A peer-run crisis stabilization unit shall provide peer support and crisis stabilization services.

(c) The maximum stay in a peer-run crisis stabilization unit is 168 hours. An additional stay up to 48 hours can be authorized if recommended by a crisis intervention service licensed medical professional or crisis intervention service licensed behavioral health professional.

(d) A peer-run crisis stabilization unit must have access to a crisis intervention service licensed medical professional or crisis intervention service licensed behavioral health professional at all times.

(e) A peer-run crisis stabilization unit shall provide room and may provide board.

(f) A peer-run crisis stabilization unit must have a minimum of two staff at all times, with one staff person to four individuals served ratio. The two minimum staff shall be certified peer professionals.

(g) A peer-run crisis stabilization unit shall have a full-time designated supervisor who meets one of the following:

(1) Be a MHP who has completed the Department-approved certified peer professional supervisory training within 6 months of hire.

(2) An individual who meets all of the following:

(i) Has a bachelor's degree in sociology, social work, psychology, gerontology, nursing, anthropology, political science, history, criminal justice, theology, counseling, education or a related field from a program that is accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation, or an equivalent degree from a foreign college or university approved by the United States Department of Education.

(ii) Two years of mental health direct service experience that may include peer support services.

(iii) Has completed the Department-approved CPS supervisory training within 6 months of hire.

(3) An individual who meets all the following:

(i) Has an associate's degree in sociology, social work, psychology, gerontology, nursing, anthropology, political science, history, criminal justice, theology, counseling, education or a related field from a program that is

accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation, or an equivalent degree from a foreign college or university approved by the United States Department of Education.

(ii) Three years of mental health direct service experience.

(iii) Has completed the Department-approved CPS supervisory training within 6 months of hire.

(4) An individual who meets all the following:

(i) Has a high school diploma or GED.

(ii) Four years of mental health direct service experience that may include, but not limited to PSS and crisis services.

(iii) Has completed the Department-approved CPS supervisory training curriculum within 6 months of hire.

§ 5250.104. Maximum capacity.

(a) The maximum capacity is the total number of individuals who are permitted to receive crisis intervention services on the premises at the same time. A crisis stabilization unit services provider shall submit requests to increase the capacity to the Department. The request must be approved prior to the admission of additional individuals. The maximum capacity is limited by physical plant space and other applicable laws and regulations.

(b) The maximum capacity specified on the license may not be exceeded without approval.

(c) Capacity is limited to 16 beds, or the capacity identified on the certificate of compliance, whichever is less.

§ 5250.105. Staffing policy.

The crisis stabilization unit service provider shall have policies approved by the Department to ensure staffing meets service volume needs of the program and shall have a minimum of two staff persons on duty at all times for every eight individuals served.

§ 5250.106. Staffing.

A staff person counted as specified in § 5250.105 (relating to staffing policy) shall be awake.at all times when individuals are present.

§ 5250.107. Additional staffing based on the needs of the individuals.

(a) A crisis stabilization unit service provider shall provide staffing to meet the needs of the individuals as specified in the individual's assessments and individual service plans.

(b) The Department may require additional staffing as necessary to protect the health and safety of the individuals. Requirements for additional staffing will be based on the individual's service plan, the design and construction of the facility, and the operation and management of the facility.

§ 5250.108. Premises requirements.

(a) The premises shall be appropriate for the purpose for which it is used.

(b) There must be separate units and programs for crisis intervention service providers who serve both adults and individuals under the age of 18.

(c) Units and programs for individuals under the age of 18 shall be age-appropriate and may include distinct units for children and youth.

(d) Crisis stabilization units shall provide anti-ligature devices to eliminate points where a cord, rope, or other items can be looped or tied to a fixture to create a point of ligature.

§ 5250.109. Bedrooms.

(a) Bedrooms shall be designed to hold one or two individuals.

(b) Exemptions. The following applies:

(1) A crisis stabilization unit service provider licensed to operate with more than two individuals per bedroom prior to the effective date of this chapter is exempt from limitations in subsection (a), except as provided under paragraph (2).

(2) A crisis stabilization unit service provider that undertakes new construction or reconfiguration of the physical layout of a bedroom on or after the effective date of this section shall meet the requirements under subsection (a).

(c) A crisis stabilization unit service provider shall provide an individual with a place to store clothing and personal items, separate from furnishings assigned to roommates, within the bedroom area.

(d) A crisis stabilization unit service provider shall provide an individual with a bed that is clean and in good repair, and has a solid foundation separate from furnishings assigned to roommates, within the bedroom area.

(e) Bunk beds and other raised beds that require individuals to climb steps or ladders to get into or out of bed are prohibited.

(f) Mattresses shall be fire retardant and shall have a moisture barrier that is permanent and can be easily cleaned. The use of removable moisture barriers or fire-retardant mattress covers is prohibited.

(g) Each bedroom shall have a window with a source of natural light.

(h) A bedroom window shall have window coverings such as drapes, shades, curtains, blinds, shutters, or other devices that:

(1) Are clean and in good repair.

(2) Provide privacy and cover the entire window when closed.

(3) Have anti-ligature qualities as specified in § 5250.108(d) (relating to premises requirements).

(i) A crisis stabilization unit service provider shall provide pillows, bed linens, and blankets for each bed that are clean and in good repair.

(j) Each bedroom shall have direct access to a corridor that leads to an external exit or an external exit.

(k) A bedroom may not be used as a means of egress from or access to shared common areas within the premises by individuals other than the bedroom's assigned occupants.

(l) Sole entrances to internal stairways or basements may not be located in an individual's bedroom.

(m) Each bedroom shall be ventilated by operable windows or mechanical ventilation.

§ 5250.110. Bathrooms.

(a) There shall be at least one functioning flush toilet for every six individuals.

(b) There shall be at least one sink and wall mirror for every six individuals.

(c) There shall be at least one bathtub or shower for every 10 individuals.

(d) Bathtubs and showers must have slip-resistant surfaces.

(e) Privacy shall be provided for toilets, showers, and bathtubs by a door in a bathroom designed for use by only one individual at a time.

(f) At least one option for privacy shall be provided for toilets, showers, and bathtubs by a partition or door in a bathroom designed for use by more than one individual at a time.

(g) Toilet paper shall be provided for every toilet at all times.

(h) A dispenser with soap and either individual paper towels or a mechanical dryer shall be provided in each bathroom.

(i) Bathrooms shall be ventilated by an exhaust fan or a window.

§ 5250.111. Dining area.

(a) A crisis stabilization unit service provider shall provide a separate dining room area. The separate dining room area shall be equipped with tables and chairs of the appropriate size for the population served and able to accommodate the maximum number of individuals scheduled for meals at any one time.

(b) Serving items such as plates, bowls, dishes, beverage containers, and utensils shall be provided for eating, drinking, preparing, and serving food. These items must be clean, and free of chips and cracks.

§ 5250.112. Lounge and visiting areas.

(a) A crisis stabilization unit service provider shall have at least one furnished lounge area for individuals. The lounge area shall contain tables, chairs, and lighting to accommodate the individuals.

(b) A crisis stabilization unit service provider shall provide visiting space for individuals and their guests.

§ 5250.113. Counseling rooms.

A crisis stabilization unit service provider shall:

(a) Maintain space for both individual and group counseling sessions.

(b) Have counseling room walls that extend from the floor to the ceiling to provide privacy for the individuals using the room.

§ 5250.114. First aid.

(a) A crisis stabilization unit service provider shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings, tweezers, Naloxone or other appropriate medications used to reverse a substance overdose, and an automated external defibrillator.

(b) The first aid kit shall be stored in a location that is easily accessible.

(c) Crisis stabilization unit service providers shall establish a policy that ensures the contents of the first aid kit have not expired and are in good working order.

§ 5250.115. Laundry and linens.

(a) A crisis stabilization unit service provider shall maintain access to an onsite laundry area or have an agreement with an external contracted provider for laundering linens.

(b) The supply of bed linens and towels shall be sufficient to ensure a complete change of bed linen and towels at least once per week.

(1) Bed linens and towels shall be changed at least once every week and more often as needed to maintain sanitary conditions.

(2) Clean linens, towels, and washcloths shall be stored in an area separate from soiled linen and clothing.

(c) A crisis stabilization unit service provider shall maintain laundry equipment and supplies onsite for the individuals to wash and dry personal clothing at no cost to the individual.

(d) A crisis stabilization unit service provider shall establish and implement procedures to ensure that individuals' clothing items are not lost or misplaced during laundering or cleaning.

(e) To reduce the risks of fire hazards, the crisis stabilization unit service provider shall:

(1) Remove lint from the lint trap and drum of clothes dryers after each use.

(2) Clean the clothes dryer vent duct and internal and external ductwork according to the manufacturer's instructions.

§ 5250.116. Housekeeping and maintenance.

(a) The crisis stabilization unit premises shall be free of hazards such as loose or broken window glass, loose or cracked floors and floor coverings, and loose or cracked plaster on walls or ceilings.

(b) When unexpected damage or wear creates a hazard, the crisis stabilization unit service provider shall implement safety precautions immediately, and within 24 hours shall document plans to correct the hazardous condition.

(c) A crisis stabilization unit service provider shall have a written policy in place for remediation and use appropriate vector control measures to keep the premises free of insects, bed bugs, rodents, and other pests.

(d) Cleaning equipment, chemicals, and supplies shall be stored in a locked location separate from food or other consumables.

§ 5250.117. Furnishings, equipment, and supplies.

(a) A crisis stabilization unit service provider shall maintain at least a 3-day supply of the following culturally appropriate personal care items for an individual's personal use:

(1) Hairbrush or comb.

(2) Toothbrush.

(3) Toothpaste.

(4) Shampoo.

(5) Soap.

(6) Deodorant.

(7) Shaving equipment.

(8) Sanitary supplies.

(b) A crisis stabilization unit service provider shall maintain a supply of informational brochures, books, or other materials that provide information on mental illness, recovery and treatment methods in either print or digital media for the use of individuals in treatment.

(c) The premises shall be equipped with furnishings that are clean and in good repair and appropriate for the needs of the population served.

§ 5250.118. Water.

(a) A crisis stabilization unit service provider shall provide hot and cold water under pressure in each bathroom and laundry area to accommodate the needs of the individuals.

(b) Hot water temperature in areas accessible to the individual may not exceed 120°F.

(c) A crisis stabilization unit service provider that is not connected to a public water system shall be in compliance with the Pennsylvania Safe Drinking Water Act (35 P.S. §§ 721.1 – 721.17) and shall obtain a permit in accordance with the act.

§ 5250.119. Sewage and sanitation.

(a) A crisis stabilization unit service provider that is not connected to a public sewer system shall have written sanitation approval for the sewage system by the sewage enforcement official of the municipality where the premises is located.

(b) A crisis stabilization unit service provider shall maintain sanitary conditions that include, at a minimum, the following:

(1) Adherence to universal precaution for prevention of infectious diseases.

(2) No evidence of infestation of insects or rodents within the premises.

(3) Trash removal from the premises at least once a week.

(4) The use of covered trash receptacles in the kitchen area that prevent the penetration of insects and rodents.

§ 5250.120. Temperature and heat sources.

(a) A crisis stabilization unit service provider shall maintain an indoor temperature of at least 70°F in the winter.

(b) A crisis stabilization unit service provider shall use mechanical ventilation such as fans or air conditioning when indoor temperatures exceed 80°F.

(c) Exterior doors and windows opened for ventilation shall be screened.

(d) Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, water heaters, and radiators exceeding 120°F that are accessible to the individual must be equipped with protective guards or insulation to prevent the individual from coming in contact with the heat source.

(e) Heaters that are not permanently mounted or installed are prohibited.

(f) A crisis stabilization unit service provider shall keep documentation of annual cleaning and inspection of the furnace or heat source by a professional heating, ventilation, and air conditioning (HVAC) company.

§ 5250.121. Cameras.

(a) Notification of video monitoring and recording equipment. The following applies:

(1) A crisis stabilization unit service provider shall notify individuals in their preferred language, including American Sign Language, at the time of admission, if the provider uses video monitoring and recording equipment.

(2) The crisis stabilization unit service provider shall post written notice of the use of video monitoring and recording equipment in a conspicuous and public place within the premises.

(b) A crisis stabilization unit service provider shall develop a written policy and procedure for the security of recorded and transmitted recorded camera images.

(c) A crisis stabilization unit service provider shall destroy recorded material in a manner that protects confidentiality.

(d) The angle of video monitoring and recording equipment may not be placed to record areas designated as bedrooms, bathrooms, exam rooms, or any area where treatment or services requiring privacy are provided.

(e) Audio monitoring is prohibited.

§ 5250.122. Emergency preparedness.

(a) In addition to the requirements in § 5250.46 (relating to emergency preparedness), the emergency plan must include strategies to address emergency events identified in the risk assessment, including the following:

(1) Availability of consumables such as non-perishable food, water, and medication sufficient to last a minimum of 3 days.

(2) Availability of staff to meet individuals' care needs for a minimum of 3 days.

(3) Availability of transportation for individuals and staff if evacuation and relocation is required.

(4) Availability of first aid supplies and personal protective equipment.

(b) In addition to the requirements at § 5250.46, the written policies and procedures shall address:

(1) A system to track the location of on-duty staff and sheltered individuals in the care of the crisis stabilization unit service provider during and after the emergency.

(2) If individuals are relocated during the emergency, a crisis stabilization unit service provider must document the specific name and location of the receiving provider or location.

(3) Safe evacuation which considers the treatment and safety needs of individuals, staff, and volunteers present at the time of the emergency.

(4) A means to safely shelter in place for individuals, staff, and volunteers who remain on the premises during the emergency.

(5) A system of medical documentation that preserves the individual's information, protects confidentiality, and secures and maintains the availability of records.

(6) The use of volunteers in an emergency, including the process for integration of local, State or Federally designated health care professionals to address needs during the emergency.

(7) The development of arrangements with other facilities to receive individuals and provide continuity of care in the event of limitation or cessation of operations on the premises affected by the emergency.

(8) The role of the crisis stabilization unit service provider in the provision of care to individuals at an alternate care site identified by emergency management officials.

§ 5250.123. Fire safety.

(a) In addition to the requirements at § 5250.47 (relating to fire safety), the crisis stabilization unit service provider shall conduct fire drills at least quarterly on every shift for staff, and under varied conditions.

(b) A crisis stabilization unit service provider shall maintain a written report of fire drills that includes the following:

(1) Date of the fire drill.

(2) Time of day of the fire drill.

(3) Length of time from start to completion of the fire drill.

(4) The exit route used.

(5) Number of participating staff.

(6) Number of participating individuals.

(7) Number of individuals who did not evacuate and the reason for non-participation in the drill.

(8) Problems encountered.

(9) Whether the smoke detector was operative.

§ 5250.124. Nutrition.

(a) Meals shall be offered that meet the recommended dietary allowances established by the United States Department of Agriculture.

(b) At least 3 nutritionally well-balanced meals shall be offered daily. Each meal shall include an alternative food and drink item from which the individual may choose.

(c) An individual's special dietary needs as prescribed by a physician, physician assistant, certified registered nurse practitioner, or dietitian shall be met. Documentation of the individual's special dietary needs shall be kept in the individual's record.

(d) Dietary alternatives shall be available for an individual who has special health needs or religious beliefs regarding dietary restrictions.

(e) There may not be more than 15 hours between the offered evening meal and the first meal of the next day. There may not be more than 6 hours between the offering of breakfast and lunch, and the offering of lunch and dinner. This requirement does not apply if an individual's crisis intervention service licensed medical professional has prescribed otherwise.

(f) Drinking water shall be available to individuals at all times.

§ 5250.125. Individual service plans.

(a) An individual service plan is required for each individual within 24 hours of initiation of crisis stabilization unit services.

(b) A crisis intervention service behavioral health professional or the crisis intervention service crisis worker under the supervision of the crisis intervention service behavioral health professional and the individual receiving crisis intervention services shall develop, sign, and date the individual service plan. In the event the individual does not sign the individual service plan and updates, the crisis intervention service behavioral health professional shall document the attempt to obtain a signature in the individual's record.

(c) An individual service plan shall be developed in collaboration with the individual, as appropriate.

(d) An individual service plan shall contain specific goals, objectives, and interventions to address the identified crisis intervention service needs with definable and measurable outcomes.

(e) An individual service plan shall be reviewed and updated as needed.

(f) An individual service plan update shall be based upon the assessment, diagnosis, and input from the crisis intervention service team and the individual receiving services.

(g) The individual service plan shall be kept in the individual's record.

(h) A crisis intervention service shall be provided in accordance with the identified goals in the individual service plan and updates.

§ 5250.126. Medication administration.

(a) If medication is prescribed or dispensed by the facility, the requirements of applicable Federal and State medication statutes and regulations shall be met.

(b) Prescription medication that is not self-administered by an individual shall be administered in accordance with the practitioner's scope of practice.

(c) Prescription medication may be administered through an automated medication system if the following are met:

(1) The automated medication system must electronically record the activity of each authorized personnel with the time, date, and initials or other identifier so that a clear, readily retrievable audit trail is established.

(2) There are policies and procedures for system operation, safety, security, accuracy, access, and confidentiality.

(3) Ensuring that medications in the automated medication system are inspected, at least monthly, for expiration date, misbranding, and physical integrity, and ensuring that the automated medication system is inspected, at least monthly, for security and accountability.

(4) Ensuring that the automated medication system is stocked accurately, and an accountability record is maintained in accordance with the written policies and procedures of operation.

(5) Ensuring compliance with the applicable provisions of State and Federal law.

(d) A crisis stabilization unit that uses an automated medication system to fill prescriptions or medication orders shall create and operate according to a written program for quality assurance of the automated medication system which:

(1) Requires monitoring of the automated medication system.

(2) Establishes mechanisms and procedures to test the accuracy of the automated medication system at least every 6 months and whenever any upgrade or change is made to the system.

§ 5250.127. Storage and disposal of medications and medical supplies.

(a) Prescription medications, over-the-counter medications, and syringes shall be kept in an area or container that is locked.

(b) Prescription medications, over-the-counter medications, and syringes stored in a refrigerator shall be kept in an area or container that is locked.

(c) Only current prescription, over-the-counter, and sample medications for individuals receiving crisis services in the facility may be kept in the facility.

(d) Prescription medications and over-the-counter medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light and in accordance with the manufacturer's instructions.

(e) Prescription medications and over-the-counter medications that are discontinued, expired, or for individuals who are no longer receiving crisis services in the facility shall be destroyed in

a safe manner according to the Department of Environmental Protection and Federal and State regulations.

§ 5250.128. Medication administration records.

(a) A medication record shall be kept and include the following for each individual for whom medications are administered:

(1) Individual's name.

(2) Drug allergies, if applicable.

(3) Name of medication.

(4) Strength.

(5) Dosage form.

(6) Dose.

(7) Route of administration

(8) Frequency of administration.

(9) Administration times.

(10) Special precautions, if applicable.

(11) Diagnosis or purpose for the medication, including pro re nata (PRN).

(12) Date and time of medication administration.

(13) Name and initials of the staff person administering the medication.

(b) The information in subsection (a)(12) and (13) shall be recorded at the time a medication is administered.

(c) If an individual refuses to take a prescribed medication, the refusal shall be documented in the individual's record and on the medication record. The refusal shall be reported to the

prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

§ 5250.129. Records.

(a) A crisis stabilization unit service provider shall include the following information in each individual's record:

(1) Name.

(2) Date of birth.

(3) Gender, gender identity or expression.

(4) Language or means of communication spoken or used by the individual.

(5) Social Security number.

(6) The individual's medical insurance information, if applicable.

(7) An inventory of the individual's personal property as voluntarily declared by the individual upon admission.

(8) Date of entry into the crisis intervention facility.

(9) Intake information.

(10) The individual service plan and individual service plan updates.

(11) Medication administration records.

(12) Progress notes and other documentation.

(13) Referral activity, correspondence, reports of emergencies, accidents, and illness.

(14) Written consent for treatment.

(15) Written consent for disclosure of information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104 - 191) and the applicable regulations.

(b) A crisis stabilization unit service provider shall include the following emergency and contact information in the individual's record:

(1) Name, address, telephone number, and contact person for the individual, if any.

(2) Name and telephone number of the person designated by the individual to be called in case of emergency.

(3) Name and telephone number of individual's primary care physician, if applicable.

(4) Mental health advance directives, if applicable.

(c) A crisis stabilization unit service provider shall include the following medical information in the individual's record:

(1) Dietary restrictions.

(2) Allergies.

(3) Medication regimen.

(4) Medical conditions.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

October 1, 2025

Mr. David Sumner, Executive Director
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, Pennsylvania 17101

Dear Executive Director Sumner

Enclosed is a proposed regulation that codifies the minimum standards for the issuance of licenses to provide behavioral health crisis intervention services in the Commonwealth. Crisis intervention services are immediate, crisis-oriented services designed to amend or resolve precipitating stress. The services are provided to individuals and their families who exhibit an acute problem of disturbed thought, behavior, mood, or social relationships. The services provide emergency response to crisis situations that threaten the well-being of the individual or others. Crisis intervention services include the intervention, assessment, counseling, screening, and disposition of services that are commonly considered appropriate to the provision of crisis intervention services.

The proposed regulation is needed to provide necessary oversight to protect the health and safety of individuals who access behavioral health services in a crisis situation. By setting minimum training standards and requiring staff training in trauma-informed care, de-escalation techniques, and suicide risk assessment procedures, the proposed rulemaking will ensure that staff are appropriately trained. The proposed rulemaking provides codified and consistent standards for licensure or approval of all modalities of crisis intervention services within the scope of this chapter.

This proposed regulation, which amends the ***Pennsylvania Code***, Title 55, by adding a new Chapter 5250 (relating to crisis intervention services), is submitted for review pursuant to the Regulatory Review Act.

The Department of Human Services will provide the Commission with any assistance required to facilitate a thorough review of this proposal.

Sincerely,

Valerie A. Arkoosh, MD, MPH
Secretary

Enclosure

From:	Burnett, David
To:	Curley, Maeve
Cc:	Stein, Marianne; Duckett, Danielle A.; Whare, Jennifer (GC); Dietrich, Dawn; Fischer, Kendrick; Madden, Victoria
Subject:	RE: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services
Date:	Wednesday, October 1, 2025 9:25:33 AM
Attachments:	image001.jpg

Good morning,

This email is to confirm receipt of the proposed rulemaking.

Regards,
-David

David Burnett
Counsel and Executive Director
Senate Health & Human Services Committee
Harrisburg, PA 17120

From: Curley, Maeve <macurley@pa.gov>
Sent: Wednesday, October 1, 2025 9:24 AM
To: Burnett, David <dburnett@pasen.gov>
Cc: Stein, Marianne <maristein@pa.gov>; Duckett, Danielle A. <dduckett@pa.gov>; Whare, Jennifer (GC) <jwhare@pa.gov>; Dietrich, Dawn <dadietrich@pa.gov>; Fischer, Kendrick <kendfische@pa.gov>; Madden, Victoria <vmadden@pa.gov>
Subject: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services
Importance: High

Good morning,

DHS is submitting Reg. No. 14-557, Licensure of Crisis Intervention Services (Proposed Rulemaking) to the Senate Health and Human Services Committee and the House Human Services Committee.

Please provide written (email) confirmation that this rulemaking was received by the Committee chair's office.

Best,
Maeve

Maeve Curley
Pronouns: She/Her
Regulatory Coordinator
PA Department of Human Services | Office of Policy Development
macurley@pa.gov
https://www.dhs.pa.gov

From:	Freeman, Clarissa
To:	Curley, Maeve
Cc:	Stein, Marianne; Duckett, Danielle A.; Whare, Jennifer (GC); Dietrich, Dawn; Fischer, Kendrick; Madden, Victoria
Subject:	RE: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services
Date:	Wednesday, October 1, 2025 9:36:52 AM
Attachments:	image001.jpg

Good morning,

Received.
Thank you,

Clarissa L. Freeman
Deputy Chief Counsel | Senate Democratic Caucus
Executive Director-Health and Human Services Committee
Office of the Democratic Leader
Room 535 MCB
Harrisburg, PA 17120-3043
717-783-1220

From: Curley, Maeve <macurley@pa.gov>
Sent: Wednesday, October 1, 2025 9:24 AM
To: Freeman, Clarissa <clarissa.freeman@pasenate.com>
Cc: Stein, Marianne <maristein@pa.gov>; Duckett, Danielle A. <dduckett@pa.gov>; Whare, Jennifer (GC) <jwhare@pa.gov>; Dietrich, Dawn <dadietrich@pa.gov>; Fischer, Kendrick <kendfische@pa.gov>; Madden, Victoria <vmadden@pa.gov>
Subject: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services
Importance: High

Good morning,

DHS is submitting Reg. No. 14-557, Licensure of Crisis Intervention Services (Proposed Rulemaking) to the Senate Health and Human Services Committee and the House Human Services Committee.

Please provide written (email) confirmation that this rulemaking was received by the Committee chair's office.

Best,
Maeve

Maeve Curley
Pronouns: She/Her
Regulatory Coordinator
PA Department of Human Services | Office of Policy Development
macurley@pa.gov

RECEIVED
Independent Regulatory Review Commission
October 1, 2025

From: Annmarie Robey
To: Curley, Maeve
Cc: Stein, Marianne; Duckett, Danielle A.; Whare, Jennifer (GC); Dietrich, Dawn; Fischer, Kendrick; Madden, Victoria
Subject: Re: [EXTERNAL]: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services
Date: Wednesday, October 1, 2025 9:53:00 AM
Attachments: image001.jpg

Good morning. The regulation has been received. Thank you. Annmarie Robey

Get Outlook for Android

From: Curley, Maeve <macurley@pa.gov>
Sent: Wednesday, October 1, 2025 9:24:07 AM
To: Annmarie Robey <Arobey@pahousegop.com>
Cc: Stein, Marianne <maristein@pa.gov>; Duckett, Danielle A. <dduckett@pa.gov>; Whare, Jennifer (GC) <jwhare@pa.gov>; Dietrich, Dawn <dadietrich@pa.gov>; Fischer, Kendrick <kendfische@pa.gov>; Madden, Victoria <vmadden@pa.gov>
Subject: [EXTERNAL]: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services

Good morning,

DHS is submitting Reg. No. 14-557, Licensure of Crisis Intervention Services (Proposed Rulemaking) to the Senate Health and Human Services Committee and the House Human Services Committee.

Please provide written (email) confirmation that this rulemaking was received by the Committee chair's office.

Best,
Maeve

Maeve Curley
Pronouns: She/Her
Regulatory Coordinator
PA Department of Human Services | Office of Policy Development
macurley@pa.gov
https://www.dhs.pa.gov

RECEIVED

Independent Regulatory
Review Commission

October 1, 2025

From: Bulletin
To: Curley, Maeve
Cc: Whare, Jennifer (GC); Duckett, Danielle A.; Stein, Marianne; Dietrich, Dawn; Serafin, Kenneth; Madden, Victoria
Subject: [External] Re: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services
Date: Wednesday, October 1, 2025 9:43:57 AM
Attachments: image001.jpg

Good morning Maeve!
Thank you for submitting this rulemaking. Someone from our office will be in touch regarding the publication date.
Have a great day!
Leah

From: Curley, Maeve <macurley@pa.gov>
Sent: Wednesday, October 1, 2025 9:28 AM
To: Bulletin <bulletin@palrb.us>
Cc: Whare, Jennifer (GC) <jwhare@pa.gov>; Duckett, Danielle A. <dduckett@pa.gov>; Stein, Marianne <maristein@pa.gov>; Dietrich, Dawn <dadietrich@pa.gov>; Serafin, Kenneth <kserafin@pa.gov>; Madden, Victoria <vmadden@pa.gov>
Subject: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services

Good morning,

DHS is submitting Reg. No. 14-557, Licensure of Crisis Intervention Services (Proposed Rulemaking) to the Senate Health and Human Services Committee, the House Human Services Committee, LRB, and IRRC.

Please provide written (email) confirmation that this rulemaking was received by LRB.

Best,
Maeve

Maeve Curley
Pronouns: She/Her
Regulatory Coordinator
PA Department of Human Services | Office of Policy Development
macurley@pa.gov
https://www.dhs.pa.gov

From:	Wright, Imogen L.
To:	Curley, Maeve
Cc:	Stein, Marianne; Duckett, Danielle A.; Whare, Jennifer (GC); Dietrich, Dawn; Fischer, Kendrick; Madden, Victoria
Subject:	RE: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services
Date:	Wednesday, October 1, 2025 9:36:39 AM
Attachments:	image001.jpg

Good morning Maeve,

I'm writing to confirm receipt of the proposed rulemaking.

Thank you,
Imogen

Imogen Wright | Executive Director
House Human Services Committee (D)
36 East Wing, Harrisburg PA
Office: (717) 705-1925 |Cell: (717) 317-2197
iwright@pahouse.net

From: Curley, Maeve <macurley@pa.gov>
Sent: Wednesday, October 1, 2025 9:24 AM
To: Wright, Imogen L. <IWright@pahouse.net>
Cc: Stein, Marianne <maristein@pa.gov>; Duckett, Danielle A. <dduckett@pa.gov>; Whare, Jennifer (GC) <jwhare@pa.gov>; Dietrich, Dawn <dadietrich@pa.gov>; Fischer, Kendrick <kendfische@pa.gov>; Madden, Victoria <vmadden@pa.gov>
Subject: DHS Proposed Regulation #14-557 Licensure of Crisis Intervention Services
Importance: High

Good morning,

DHS is submitting Reg. No. 14-557, Licensure of Crisis Intervention Services (Proposed Rulemaking) to the Senate Health and Human Services Committee and the House Human Services Committee.

Please provide written (email) confirmation that this rulemaking was received by the Committee chair's office.

Best,
Maeve

Maeve Curley
Pronouns: She/Her
Regulatory Coordinator
PA Department of Human Services | Office of Policy Development
macurley@pa.gov
https://www.dhs.pa.gov