PCCYFS
PA COUNCIL OF CHILDREN YOUTH & FAMILY SERVICES
A UNITED VOICE FOR PROVIDERS

November 25, 2024

Pennsylvania Department of Human Services (DHS)
Office of Mental Health and Substance Abuse Services (OMHSAS)
Bureau of Children's Behavioral Health Services
Attention: Mr. Donald Hindmarsh
Commonwealth Tower
303 Walnut Street, 11th Floor
Harrisburg, Pennsylvania 17105

RE: Pennsylvania Council of Children, Youth, & Family Services Comments for IRRC #3417 - Regulation #14-555: Psychiatric Residential Treatment Facilities

Dear Mr. Hindmarsh,

The Pennsylvania Council of Children, Youth & Family Services (PCCYFS) is the collective voice for private agencies that serve Pennsylvania's most vulnerable children and families. PCCYFS represents nearly 100 private agencies employing more than 12,000 professionals statewide. These services include foster/kinship care, adoption, residential treatment, counseling, education, behavioral health services, independent/transitional living services and others.

PCCYFS would like to thank you in advance for reviewing and taking these comments, questions and concerns into consideration. Rewriting these proposed regulations is no easy feat and we recognize the level of commitment that went into drafting these guidelines so that Pennsylvania's children and youth receive high-quality care within our Psychiatric Residential Treatment Facilities (PRTF). PCCYFS values safe and therapeutic PRTF environments and as an association of providers that include a PRTF level of care, we share in your commitment and appreciate the opportunity to offer feedback. We want to specifically recognize the value that establishing these regulations will bring to the system, notably:

- PRTF is an important inpatient level of service for young people with particularly challenging care needs. OMHSAS' establishment of these regulatory guidelines exhibits a distinct recognition of the clinical nature of the work that exists within PRTFs.
- Providers will no longer be licensed by the Office of Children, Youth, and Families (OCYF) and then inspected and certified by OMHSAS. Establishing regulatory level guidelines will give OMHSAS the ability to license PRTF providers directly and this new structure offers a more streamlined option for PRTF providers.

In addition to our regulatory feedback, we share these initial themes and thoughts regarding this regulatory process and the needs of providers in relation to these changes generally:

- **Federal Standards**: PCCYFS encourages Pennsylvania to align the PRTF regulations with federal standards whenever possible to minimize confusion and duplication.
- **Workforce Needs**: These proposed regulations come at a time when providers are particularly challenged to recruit and retain high-quality workers due in large part to the nature of the work and insufficient funding to offer competitive wages. The workforce shortage in the behavioral health field is at a critical level and the ability for providers to be able to recruit and retain staff (mental health workers, professionals, psychiatrists, RNs, LPNs) is extremely difficult, although they are continuously working on ways to attract professionals to this field.
- **Provider Liability**: Children's services providers are struggling to manage skyrocketing rates for professional liability insurance, if they are even able to access liability insurance. Many aspects of these proposed regulations result in increased risks to providers, which will further limit their ability to access quality, affordable insurance options.
- **Interagency Coordination**: Additionally, given the overlap of PRTFs with OCYF, PCCYFS was dismayed to hear that there was not as much discussion between the two offices when formulating these regulations, especially as the PRTF regulations were transitioned from 55 Pa. Code Chapter 3800 regulations, which still fall under the purview of OCYF.
- **Transparency**: Overall, providers were generally disappointed in the minimal engagement throughout the PRTF regulatory process. Other than a few meetings held in 2020, the opportunities to offer thoughts and share feedback on concrete proposals and considerations prior to the release of the proposed regulations were minimal.
- **Individual Youth Needs**: PCCYFS feels strongly that OMHSAS should reconsider some of the blanket therapy requirements outlined below. Given OMHSAS' goal of establishing a PRTF network of services that are strongly grounded in clinical practice, there should be ample flexibility within these regulations for each youth's specific needs. A youth's therapeutic needs should be based on where the youth is in treatment, the trauma they have experienced, and other individual considerations.
- **Financial Impact**: The increased expenses related to implementing these new heightened standards come at a time when agencies are already struggling with rates that fail to adequately reimburse the expenses they incur. OMHSAS must provide PRTFs with ample opportunity to communicate the costs of the changes proposed in these regulations prior to their final promulgation and with Behavioral Health Managed Care Organizations (BHMCOs). Some BHMCOs are not paying current costs and some are already refusing to increase rates in 2025. In the worst-case scenario, some PRTF providers may find themselves unable to manage these requirements, especially without a significantly higher rate increase. Conducting a fiscal impact analysis after the

final regulations have been approved and implemented could shrink or deplete capacity levels significantly at a time when they are already decreased. PCCYFS encourages OMHSAS to bring together providers, and BHMCOs, to discuss cost implications and the process for addressing these increased rates.

The themes identified above are the most prominent concerns regarding this regulatory shift; it is against this backdrop that PCCYFS members share our regulatory recommendations:

Rights §§ 5330.31 — 5330.34
While § 5330.31(b)(5) elevates the client's right to appropriate clothing, §1330.38(a)(9)(xviii) lists clothing as a nonallowable cost. This discrepancy essentially forces a PRTF to regularly purchase and provide clothing in instances in which a parent cannot or will not supply clothing.

Recommendation: Reconcile this discrepancy so that PRTFs are not unfunded in their responsibility to support youth with appropriate clothing if a guardian is unwilling or unable.

General Payment §1330.31
Offering providers with a 12-month timeline to come into full compliance once the final regulations have been released is not sufficient time, especially when considering providers size, funds, and other factors. Much of providers' ability to comply with these new regulations will hinge on adequate rates from Behavioral Health Managed Care Organizations. This transition must understand the practical need for PRTFs to receive additional and adequate funding, and how those resources will impact aspects of this transition, especially hiring. If these changes go into effect in January 2026, providers will need to start filling positions no later than Q4 2025, despite uncertainties around licensing, waivers, funding, and other impactful areas. Further, providers should not be expected to operate at reimbursement levels that do not match the costs of providing services. If a provider accepted a low per diem, it would result in reduced staffing, followed immediately by reduced census, and eventually the closure of the program or organization.

Recommendation: Offer a longer time frame to come into compliance as budgets will need to be adjusted considerably, staffing changes will need to occur, and other aspects of PRTF programming may take more than 12 months to complete.

Annual Cost Reporting and Independent Audit §1330.39
While §1330.39 requires an initial cost report 3 months after the final regulations are published, this timeline will be too late, especially since PRTFs must come into compliance within 12 months of the final rule. PRTFs must have an opportunity to communicate the costs of the changes proposed in these regulations prior to their final promulgation and BHMCOs must be required to align their rates with these increases. Increased requirements around staffing, therapy, training – including the Adult Protective Services training requirements added in §5330.13, notice, medication, first aid equipment, increased contacts, and other changes will

all contribute to additional costs. At the worst-case scenario, some PRTF providers may find themselves unable to manage these requirements, especially without a significantly higher rate increase.

One of our largest providers, for example, who has already implemented many of the practices outlined within these proposed regulations, conducted a fiscal analysis of the impact of these proposed regulations. Their review determined that the changes proposed in these regulations would require an additional $6.6 million per year and 104.5 additional full-time equivalent direct care positions. They further estimate that had they not implemented some of these changes already, the impact would likely be double. Conducting a fiscal impact analysis after the final regulations have been approved could result in underfunding these changes, which will eliminate a large number of PRTF providers. Until providers are able to receive adequate reimbursement for the services stipulated within this chapter, this transformation of the PRTF system in Pennsylvania will not be achievable.

Similarly, since negotiations for cost are managed between providers and BHMCOs, OMHSAS must require BHMCOs to work with providers to meet costs associated with these new regulations, especially given the wide payment variation from one BHMCO to the other. While some BHMCOs only allow providers to receive an increase at certain increments, others operate with virtually no increases available. Rates will need to increase significantly to meet all of the changes outlined in the new regulations and sustain a viable network of PRTFs.

Recommendation: Given the enormous cost implications of these changes, realistic potential costs must be known to providers and OMHSAS prior to finalization. While we understand that OMHSAS' ability to discuss these regulations is limited, we would encourage OMHSAS to open communication with BHMCOs and providers regarding a real and calculated fiscal impact analysis to understand what the cost of these changes will be to the system and to providers generally. This fiscal analysis is a decisive and vital component of considering what changes will be implemented and which cannot; this consideration should be made before any regulations are finalized.

Reportable Incidents §5330.14

5330.14 specifically notes a "State Designated Protection and Advocacy System" and providers are unclear as to whether this is different from the Home and Community Services Information System (HCSIS), where these reports are traditionally made.

Recommendation: Minimize duplications in information systems and specify that HCSIS will be the only system for making these reports.

Reportable Incidents §5330.14 and Recordable Incidents §5330.15

These sections require a PRTF to call the Department and complete an incident report through the Department's information management system within 12 hours after the following

reportable incidents are known to the PRTF. Given the number of contacts that a provider must make for some reportable incidents, a 12-hour timeline will be challenging to meet. It is unclear as to how the current 24-hour standard was operating inefficiently and/or was detrimental to client care or safety, which would justify shortening this timeline. Instead, the requirement only increases the administrative burden with no documented client benefit.

Recommendation: Maintain the "24-hour/end of business day, whichever comes first" standard that presently exists.

Visits §5330.20

§5330.20(g) requires a provider to contact a parent once every 24 hours in certain circumstances, which can infringe on family privacy. PRTFs always make their contact information available to guardians but parents may not want their visit time interrupted by phone calls from PRTFs on a daily basis. The standard is also unclear as to who must make the call, does a PRTF have to ensure a phone conversation takes place which will result in frequent phone calls, how will holidays be handled, etc. Many PRTFs have standardized practices where therapists may check-in as needed.

Additionally, with an ongoing workforce shortage, PRTFs may resort to unqualified and unknowledgeable people or different people making calls out of necessity, which has the potential to worsen care or increase confusion. Such a requirement establishes benchmarks and expectations that may not fit a youth therapeutically.

Recommendation: Revise this requirement so that parents have contact information for the PRTF to use as necessary as opposed to requiring the PRTF to make an intrusive phone call every 24 hours.

Searches §5330.34

PRTFs have found that, on limited occasions, an unclothed body search of a child, youth or young adult has been a necessary option for the safety of the child and other youth in care.

Recommendation: Define "an unclothed body search of a child, youth, or young adult" as a search of a child that takes place when a child is entirely nude. However, permit searches in which youth may be asked to remove certain articles of clothing for safety-related searches.

Staffing §5330.41

§5330.41(a)(1): In a survey of PCCYFS PRTF members, very few if any reported that the medical director would naturally provide supervision to an RN. Supervision models vary from one organization to another but generally medical directors monitor medications, they are not expected to monitor RNs and give supervision.

Recommendation: The medical director should only be responsible for monitoring medication for youth as well as leading the treatment team, assisting with medical issues as needed and making recommendations for therapeutic/medical interventions, but not supervising the RN as this would then add to time and cost for the PRTF.

§5330.41(a)(3): Residential directors should supervise residential supervisors, and clinical directors should support clinical needs. While there is often discussion and guidance from clinical directors to residential supervisors, direct supervision is unnecessary.

Recommendation: The residential director should supervise residential staff and clinical director should supervise clinical mental health professionals.

§5330.41(a)(4): The rationale for an increase in supervision requirements to 2 hours a month is unclear. Most providers offer 1 hour a month, and a 2-hour minimum requirement will be especially challenging for part-time and substitute mental health workers.

Recommendation: Establish the supervision requirement to be a *minimum* of 1 hour/month or outline that the 2-hour requirement applies only to specific full-time workers.

Staff Requirements §5330.42

The language in §5330.42(c)(3) requiring a mental health professional to be on-ground for awake hours would be an extremely challenging one for providers to meet. Agencies have struggled tremendously to find employees and expecting mental health professionals to work weekends and holidays would make recruitment and retention of these positions virtually impossible, especially when telehealth and other options have been embraced everywhere else. Additionally, mental health professionals deserve better quality work-life balance and the ability to prioritize self-care to sustain the challenging work they do.

Recommendations: Mental health professionals should be permitted to be on-call, as in the past.

Clinical Director §5330.45

The strict licensure requirements in §5330.45(c) will eliminate professionals with a master's and high-quality experience who chose not to obtain licensure for a number of reasons.

Recommendations: The requirements should list a certain number of years' experience in lieu of license.

Registered Nurse §5330.47 and Additional Staff Positions §5330.50

Having an RN or an LPN for a third shift is increasingly challenging. While some providers don't have a nurse on site for certain hours, they have ensured that an RN is always on-call. This requirement is another example in which the regulations exceed the federal standard.

Recommendations: List requirement as RN to be on call for any OMHSAS licensed PRTF building on the campus, not for each licensed program, during times when they are not available to be on grounds.

Mental Health Professional §5330.48
PRTFs require some flexibility, especially temporarily, to allow a mental health professional to handle a temporary caseload that may exceed 8 children. For example, while the PRTF may be in the process of hiring an additional mental health professional or when a person is temporarily out of the office.

Recommendation: The mental health professional's assigned caseload may not permanently exceed eight children, youth or young adults. Exceptions may be made for short-term, temporary circumstances.

PRTFs often hire individuals who are applying immediately upon graduation. The additional year of experience and nine credits in clinical practice will be a challenging standard to meet.

Recommendation: Revise §5330.48 to state: *Have at least 1 year of experience in providing mental health direct services to children, youth or young adults **OR** a graduate degree with at least nine credits specific to clinical practice in psychology, sociology, social work or counseling from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education.*

Mental Health Worker §5330.49
The requirement for a mental health worker to have one-year experience is a change that is concerning as many do not have this experience. Inability to hire mental health workers will lead to reducing bed capacity.

Recommendation: Offer alternatives to the one-year experience like allowing the one-year experience to include internship experiences or offer on-the-job mentorships to offer support to a new graduate while allowing PRTFs to continue hiring new graduates.

Additional Staff Positions §5330.50
PCCYFS and its members appreciate the increased flexibility in qualifications for a mental health supervisor position, which allows providers to substitute education for work experience.

Initial Staff Training §5330.51
This section should be better tailored to identify which PRTF staff need training; as of now the section requires trainings of "PRTF staff" generally without accounting for human resources, staff who do not interact with children, finance, contracted clinicians, etc. Additionally, any

training requirements should be tailored for each discipline as 30 hours is significant, especially when the training topic may not relate to a professional's responsibilities at the PRTF.

Recommendation: The language should be revised to identify which PRTF staff will need to complete this training and the training for these staff should be tailored to their positions.

First Aid Supplies §5330.77
Requiring first aid kits to contain opioid reversal medication and be located on every floor of a PRTF is excessive. This will create more undue cost to a provider and more monitoring.

Recommendation: Revise the language to require that first aid kits must be available to staff in central locations which may not necessarily be located on every floor.

Initial Medical Assessment §5330.112
§5330.112(e) requires that a physician signs the assessment within 3 days. Realistically, a physician will not be able to review these assessments on a daily basis, rather, the assessment will be reviewed at least within 7 days.

Recommendation: Revise the language in §5330.112(e) to state: *If a physician did not complete the initial medical assessment, a physician shall review and sign the initial medical assessment within 7 days from the date the initial medical assessment was completed.*

Use of Drugs, Alcohol, E-cigarettes §5330.118
Recommendation: §5330.118 should specify illegal drugs as opposed to just "drugs." Many staff and youth at PRTF will need to have some access to drugs, generally but the prohibition should be based on *non-prescribed*, *illegal* drugs.

Staff Assessment §5330.121
Requiring a physical every two years is a challenge for providers to continuously remind staff and, especially given delays in medical appointments, staff struggle to complete this requirement in a timely manner.

Recommendation: Revise the requirement so that staff can present with a physical upon hire and unless they have a change in their medical status, another should not be required.

Maintenance of Treatment Plan §5330.143
Revising a treatment plan every thirty days may not be realistic or appropriate, depending on the goals being set for the youth and the extent of their needs. PRTFs may, however, revisit or review a treatment plan every thirty days, to determine whether a revision is necessary.

Recommendation: §5330.143(a) should state that the treatment plan is to be reviewed every 30 days and revisions to be made as necessary (not every 30 days if not needed).

Treatment Services §5330.145

While §5330.145(a) and (b) outline that a PRTF must offer services in accordance with all youths' unique needs, the remaining sections outline a seemingly contradictory series of requirements. PCCYFS is concerned that the language in §5330.145(c)-(g) will essentially result in the amount and type of therapeutic support and intervention is being driven by regulatory guidelines instead of a young person's needs.

- An hour with a psychiatrist is not appropriate for everyone and will result in significantly increased costs.
- Three hours of therapy per week is significant, especially for some children for whom therapy is not beneficial. Some youth may not find it engaging, others may not be able to sit for the time required, and some may need to work up to an hour based on their trauma. Therapeutic supports should be based on quality and need rather than standardized quantities and there is no research to show that three hours of clinical work is vest practice. Rather, there is sufficient research regarding oversaturation of clinical work and how counterproductive it can be.
    - This requirement would also require PRTFs to increase hours for positions that are scarce to find.
- While youth at a PRTF require support, they also need some semblance of normalcy and downtime. There should be overall balance between school, activities, and therapy.
- Families may not be willing to engage in therapy or, while well-intentioned, may have to manage significant travel needs in order to participate. Families cannot and should not be forced to engage if unwilling.

Recommendation: While the services outlined in §5330.145 may be options that a PRTF can have available to any youth, the PRTF treatment team is best positioned to determine what the youth needs and should, therefore, identify therapeutic service needs and document those in a treatment plan.

Discharge §5330.147

The requirements outlined in §5330.147 do not account for Against Medical Advice (AMA) discharges or instances that agencies don't have control over.

Recommendation: Include stipulation regarding Against Medical Advice (AMA) discharges and note that notification will be provided to parties as soon as possible.

Transportation §5330.151

Providers have serious concerns about requiring a minimum of two staff during transportation if a driver is not counted in a ratio. This requirement may impact a youth's ability to be transported for therapeutic leave, medical appointments, lab work, or even engaging in extracurricular activities as outlined in §5330.146(d). This requirement will have a significant financial impact and does not support workforce challenges that providers presently face.

Recommendation: Allow the driver to count towards a staff ratio when 2 or fewer youth are being transported or eliminate §5330.151(b).

§5330.151(e) requires some additional clarification. There are times when restraints must be initiated in a vehicle if a youth is a safety threat or trying to harm themselves or others. Additionally, youth need to be manually restrained when off-campus or in the community to maintain safety.

Recommendation: Clarify the circumstances in which a manual restraint cannot be performed (while in vehicle, while vehicle is moving, while off campus, etc.) as opposed to restricting the use of a manual restraint while off-campus with youth entirely.

Medication §5330.161
The administration of medication can sometimes be time-consuming and exceed an hour, depending on the circumstances. Generally, a treatment team is updated daily on any medication refusals.

Recommendation: Revise §5330.161(c) to state: *A PRTF shall inform the child's, youth's or young adult's treatment team leader of the refusal to take prescription medication as soon as possible, but no later than 4 hours after the refusal.*

Restrictive Procedures §5330.181
A general survey of PRTF members found that many of their policies limit the use of restrictive procedures to a maximum of an hour, while federal requirements allow them for up to four hours. Additionally, releasing and re-restraining a youth could create greater risk of injury if the youth is not stable.

Recommendation: Revise language to allow for a manual restraint for up to sixty minutes.

Application of a Manual Restraint § 5330.185
As outlined in §5330.185(a), having 2 PRTF staff members present during a manual restraint is ideal but not always realistic, especially when considering the safety of other youth in the PRTF and general staff complements.

Recommendation: Revise language in 5330.185(a) to state: *A PRTF shall have at least two PRTF staff persons present during the application of a manual restraint whenever possible.*

§5330.185(i) now requires a face-to-face assessment within 30 minutes while federal regulations allow for it to occur within an hour. The reduction to a half hour will be especially challenging when LPNs or RNs must be on-call, as it limits the radius that individuals have to arrive at the PRTF. This requirement is especially troubling for PRTFs in rural areas.

Recommendation: Revise §5330.185(i) to state: *Within 60 minutes of initiation of a manual restraint or immediately after a manual restraint is removed, a treatment team leader, physician, APP or RN, who is certified in the use of manual restraints, shall conduct a face-to-face assessment of the following…*

5330.185(k) dictates that a guardian must be notified of a restraint within one hour, while the federal standard requires 24 hours or the next business day. Pennsylvania's brief time limit is challenging and impractical for PRTF staff to meet, especially given all of the responsibilities that must now occur.

Recommendation: Revise the language to mirror the federal standard of 24 hours or next business day.

Documentation §5330.187

§5330.187(b)(10) requires written statements from all who were involved in the restraint, which again, exceeds the federal standard. Presently, the general practice is for a single statement that is supported and signed by all parties who witnessed the restraint.

Recommendation: Revise §5330.187(b)(10) to specify that a single written statement supported by all witnesses would be sufficient to meet this requirement.

Debriefing §5330.188

While the proposed regulation requires representatives from the treatment team to join for the staff debrief, those staff may be different than the PRTF staff that were part of the restraint, and some don't work evenings or weekends, which will make it difficult to complete within 24 hours. Also requiring a child's guardian to be involved within 24 hours does not take into consideration the parents' needs or preferences.

Recommendation: Revise this standard so that staff debriefing with the treatment team can be performed by the next business day.

PCCYFS has also submitted two questions to OMHSAS for clarification and still await response:

- **Waivers**: Providers are unclear on the status of their waivers as OMHSAS develops these regulations under an entirely new regulatory chapter. Waivers under 55 Pa. Code Chapter 3800 regulations should be grandfathered in rather than requiring providers to resubmit for new waivers under this chapter.
- **Billing:** Providers are unclear regarding the license to be billed under and whether the current payment structure will continue until the current license expires or after 12 months.

Again, thank you for the opportunity to share our thoughts, questions, comments, and concerns. If you have any questions, please do not hesitate to reach out to us.

Regards,

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