November 17, 2025

Independent Regulatory Review Commission
Forum Place
555 Walnut Street, Suite 804
Harrisburg, PA 17101

Re: Proposed Regulation #14-557: Licensure of Crisis Intervention Services as developed by the Office of Mental Health & Substance Abuse Services (OMHSAS)

Dear Commission,

With more than 400 members, the majority of who serve over one million Pennsylvanians annually, Rehabilitation and Community Providers Association (RCPA) is among the largest and most diverse state health and human services trade associations in the nation. RCPA provider members offer mental health, substance use disorder, intellectual and developmental disabilities, children and youth, criminal and juvenile justice, brain injury, medical and pediatric rehabilitation, and physical disabilities and aging services, across all settings and levels of care.

On behalf of RCPA and our members, please accept these comments and recommendations on the Proposed Regulation #14-557 Licensure of Crisis Intervention Services Chapter § 5250.

RCPA commends OMHSAS and their efforts to ensure that any individual suffering a mental health crisis is able to access timely and impactful treatment by proposing updated regulations for Pennsylvania's Crisis system. OMHSAS' use of the SAMHSA Best Practices for Implementing the Continuum of Crisis Services Under Medicaid and CHIP as a strategic blueprint for the proposed regulations sets a strong foundation of standards that we hope we can collectively build on as the promulgation process proceeds.

The proposed regulations have been reviewed by members of RCPA's 988/Crisis Work Group, who are some of the most experienced and knowledgeable leaders in the State's Crisis system. The following comments highlight strengths and potential challenges that the proposed regulations could bring, with recommendations to mitigate any unintended negative consequences.

By far, the largest concerns in the proposed regulations are in regard to the staffing requirements. The nation is facing a workforce crisis in the health and human services field, and Pennsylvania is no exception. There are not enough licensed clinicians in the State, and even fewer are interested in the demanding work of the Crisis system. The proposed regulations require all five crisis services to operate 24 hours a day, 7 days a week, 365 days a year, and finding the staff to operate such requirements may present challenges, especially in rural areas.

The proposed regulation requiring these services being delivered in the community around the clock in two person teams, while well intended, would call for additional professionally credentialed staff that the current Crisis system could never meet. While these minimum staffing qualifications would support a more robust crisis delivery system and enhance guaranteeing of quality care, we must not do so at the expense of current crisis staff who have the knowledge, skills, and experience; many who have dedicated their careers to the system but do not meet new requirements.

The unfortunate reality is that the Medicaid mental health workforce is at critical mass, as professionals flee this arena for private pay systems that offer zero regulatory inertia, less administrative burden, and

minimal payor documentation. All of these existing factors in our Medicaid system are driving our professionals away. Smart regulations and singular payor processes that reflect the work landscape and capacities could stem the exodus from the Commonwealth's largest behavioral health delivery system. We all believe that OMHSAS can lead that effort.

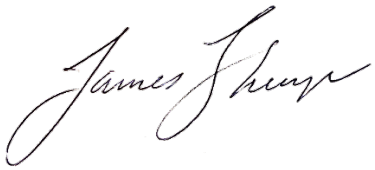
The fiscal impacts as outlined in the proposed regulations are not, from our perspective, built on a realistic platform. The true costs of implementing the regulations are speculative and may not be reflective of the true cost of staffing and implementing the services. We would be deeply interested in the fiscal analysis of the Behavioral HealthChoices Primary Contractors and Behavioral Health Managed Care Organizations on the cost to implement these regulations from the proposed cuts to Medicaid and the State. We also suggest that a provider cost analysis based upon these standards would provide a more accurate picture and reflection of true costs to government and legislative decision makers. Lastly, the reported necessary funding levels for the County crisis operation of $35M is not based on any historic funding realities going back decades. As an example, the Shapiro Administration's $20M a year investment over the last three years to County-Based Mental Health represents the only funding increase in more than 15 years. The notion of the legislature approving a one-time $35M allocation, let alone an annual one of this amount to fund the county crisis compliance with the proposed regulations, while optimistic, is unrealistic.

The creation of multiple levels of crisis services in a codified fashion represents OMHSAS' commitment to their strategic plan of expanding and rebuilding crisis services in Pennsylvania. As we reviewed the walk-in crisis centers, we wanted to make sure the proposed standards would not exclude or eliminate the community outpatient clinics that have these walk-in crisis services embedded in their programs. While not connected to larger hospital systems, these programs represent a critical part of the delivery system, and we seek greater clarity on their ongoing place in the continuum.

We ask, as the promulgation unfolds, that OMHSAS reconvene those originally involved in the development of these proposed regulations, including providers, payors, County entities, and the community stakeholders all critical to the crisis system. The last time this group fully met was during the public health emergency, and since then, many of the functioning systems these regulations depend on have changed significantly; workforce, funding, lab testing, and pending Medicaid drift/shift, among others. OMHSAS did this for the Psychiatric Residential Treatment Facilities (PRTF) regulations process and it yielded great insights and benefits to all stakeholders.

I commend OMHSAS in their recent efforts to engage stakeholders in deeper partnerships and transparency in developing regulatory standards. The past several regulations packages, including Psychiatric Rehabilitation and the aforementioned PRTF, have greatly benefited from this collaboration under Deputy Secretary Jen Smith.

Respectfully Submitted,



Jim Sharp
COO and Mental Health Services Director
RCPA

November 17, 2025

RCPA Crisis Regulation Comments

Subchapter B. General Requirements

§ 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.

- **Question**: What is the Department's time frame for responding to waiver requests?

§ 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.

- **Comment**: How will this plan intersect with or impact existing plans and data collection requirements regarding the following:
  - County services and 988 and 911 call centers and administration;
  - BH-MCOs and payors; and
  - Existing quality management plans within organizations.
- **Question**: Is there a specific template for this plan? Will there be technical assistance efforts by the Department for implementation?

Subchapter D. Staffing

§ 5250.31. Minimum staffing credentials.

(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.

- **Comment**: OMHSAS must consider the ability of providers to hire and retain professional staff to work in these positions, and must be based on realistic access to staff. Previous attempts to build regulatory staffing compliance have yielded ongoing vacancies and subsequent lack of access to the regulated service.

§ 5250.31. Minimum staffing credentials.

(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.

- **Question**: Will any consideration be given to those individuals currently working in the crisis system that do not meet the proposed standard? Is there a possibility to grandfather current staff to ensure staffing compliance can be met?
- **Recommendation**: Specificity is needed in regard to the supervision requirements for a streamlined auditing and licensure process. We recommend monthly individual clinical supervision as well as monthly staff meetings to provide support and oversight to the staff. There will need to be flexibilities for virtual supervision, as coordinating in-person supervision with a 24/7/365 staff may not be feasible.

§ 5250.31. Minimum staffing credentials.
(f) A volunteer shall meet one of the staff qualifications under subsection (a), (b), (c), or (d).

- **Comment**: A requirement of a high school degree as well as the other education requirements may eliminate capable and current crisis system volunteers. As the workforce infrastructure continues to collapse in behavioral health services, it is crucial to avoid excluding those willing to work as volunteers at minimal or no cost under the supervision of qualified professionals.

§ 5250.31. Minimum staffing credentials.
(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.

- **Question**: Will interns have the capacity to bill Medicaid for services if they are in compliance with this section?

§ 5250.33. Emergency first aid training.
(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.

- **Question**: Will Naloxone administration be part of the State's free training curriculum?

Subchapter E. Physical Site

§ 5250.42. Smoking.
(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.

- **Comment**: Please clarify what this constitutes or the validation of this type of furniture, and if it is consistent with other DHS regulations.

§ 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).

- **Question**: Is the reception/intake area appropriate for posting these notifications? Is it recommended or required to have postings in individual exam rooms?

§ 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).

AND

§ 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.

- **Comment:** Please define the plan elements as they related to the audit tool that will be used to measure compliance with emergency preparedness and fire safety plans.
- **Question**: What is the applicability or guidance for non-hospital settings? Please clarify.

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.

- **Comment**: Please clarify required reports from these entities.
- **Question**: Do these include the newly required Quality Management Plans?

§ 5250.51. Responsibilities of providers.

(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.

- **Comment**: Specifically in regard to (b)(6), while interpretive services including sign language would be preferred, this service may not always be available 24/7/365 and could be cost prohibitive. This is especially true in rural areas.
- **Question**: What alternative solution could be considered to meet the need (e.g., tele-audio interpretive services)?

§ 5250.51. Responsibilities of providers.

(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.

- **Comment**: In very rural communities, we cannot afford to have a psychiatrist available 24/7/365 for consult. Due to the volume in a small community, we could potentially pay thousands of dollars for the psychiatrist not to be utilized, but still have to pay for their time. Additionally, many psychiatrists would not feel comfortable providing consults, especially in regard to medications, to a patient that they have not formally seen and evaluated, and would likely refer them to an emergency room to be seen in person.

Subchapter G. Crisis Call Centers

§ 5250.61. Requirements for crisis call center services.

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

- **Comment**: There are not enough licensed staff in many counties who are interested in working 24/7/365 hours in Crisis to accommodate for this requirement. Due to the lack of licensed staff willing to work in the Crisis system, the burden of this role will fall upon a small number of staff, thereby resulting in burnout and potential high turnover, which would lead to a loss of expertise in the field and higher costs for hiring. Vicarious trauma and compassion fatigue also pose as additional risks.

  Staffing one licensed behavioral health professional per shift could be especially challenging in rural areas, who already suffer professional shortages. The following chart demonstrates the severe lack of professional staff in some of Pennsylvania's rural counties. Out of the 297 licensed

individuals that would qualify as behavioral health professionals, only 2.5 (including part-time employees) currently work in the crisis system.

These standards continue to support staffing viability concerns across the regulations and the workforce. The current workforce infrastructure has been deeply impacted; first, by the exodus of professional staff during and after the Public Health Emergency and second, the pace of these professionals leaving the Medicaid services due to poor rates, noncompetitive salaries, as well as the administrative burden by regulating standards and Medicaid documentation and paperwork requirements.

	County			
Position	Tioga	Bradford	Sullivan	Fayette
BSW	0	0	0	4
LSW	18	35	0	50
LCSW	23	16	2	50
LMFT	1	0	0	2
LPC	12	22	1	50
LaPC	1	1	0	8
LaMFT	1	0	0	0

- **Question**: Will full funding be provided that would incentivize these clinicians to work in Crisis? Also, if the director and supervisor are not on shift, would they be able to act as the CIS LBHP?
- **Recommendation**: Supervisor and/or director could be considered to meet this need, even if they are not technically on a shift. Additionally, adequate funding could be provided to support the recruitment and retention of licensed staff in Crisis programs.

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

(a) A crisis call center service providers shall maintain a written plan, developed in collaboration with the mental health county administrator and 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.

- **Comment:** Agencies have developed partnerships to ensure that all calls are answered by a person and not a device, as it can be impossible to staff for an unlimited amount of simultaneous Crisis service needs. Crisis staff are limited, and staff are not able to disconnect from one call or leave a mobile or walk-in service in order to answer an additional call that may come in at the time.
- **Question**: Are the existing partnerships void if those agencies are not licensed as an OMHSAS Crisis provider?

- **Recommendation**: The Department could facilitate the arrangement that surrounding counties are required to support each other for backup call coverage, and assist in the development of a call center to support providers with backup call coverage. There is also the opportunity for 988 call centers to provide backup call coverage. Providers could also be permitted to retain their current partnerships with agencies who are not licensed by OMHSAS as a Crisis provider to support this coverage.

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

(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.

- **Comment:** It is already a challenge to staff Crisis programs, let alone staff for both team services as well as for all 302s.
- **Recommendation**: Providers could be permitted to partner with another agency who is not an OMHSAS licensed Crisis provider to perform a team response, as long as those individuals meet the criteria. Adequate funding could also be provided to double or triple the number of Crisis staff that providers would have on hand to meet both the team requirement as well as the requirement to present for the delivery of all 302s.

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.

- **Comment**: There are typically few to no mobile requests between midnight and 8:00 am. Rural counties have determined that it is not cost effective to pay for this service during these times of low volume. Experience of providers indicates the emergency services meet any needs during this time and that most mobile needs occur during business hours. Staffing in the Crisis field is already a challenge, and staffing for 24 hours a day, 7 days a week, 365 days a year would be a far more significant challenge. This requirement is also inconsistent with other crisis response programs such as ACT, FBMH, and CSBBH, which are not required to staff a 24/7/365 team.

- **Recommendation**: This requirement could be individualized by counties or regions dependent upon assessed needs of the population.

§ 5250.71. Requirements for mobile crisis team services.
(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.

- **Comment**: This requirement will actually limit the availability of mobile crisis response as there are no permissible alternatives. Providers will not always have two staff within a one-hour radius for every mobile response; for instance, staff may have another role they are performing at the time, one staff may live close and the other farther away from the mobile need, or there may be times of staffing shortages, PTO, or unexpected sickness or leave of absence.
- **Question**: If two staff are not available due to staffing shortages, are there options for response such as a single responder, or with a person who does not meet the qualifications? Considering a lack of staffing resources in rural counties, will there be allowable exceptions for items such as call offs, vacancies, conflict of interest, holidays, medical leave, etc.? Or will the mobile unit simply not be able to be billed since it is individually delivered?
- **Recommendation**: Acceptable alternatives could be built into the regulations to ensure the mobile need can be met, even if not with two people.

§ 5250.71. Requirements for mobile crisis team services.
(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.

- **Comment**: The requirement of the person present on scene to remain engaged may create conflict with the individual requesting mobile services, as well as what is the clear defined role of this person. For example, a school-delivered mobile service in which a member or parent are in disagreement with school personnel involvement, which may not be known until after dispatch and arrival. Additionally, individuals currently present with the person in crisis (e.g. school staff, therapists, police) have already exhausted their skills and ability, which is the reason a mobile crisis team is sought out. It is also possible that the person already on the scene may not have the time, desire, or ability to stay for the duration of the mobile crisis contact.
- **Recommendation**: Another professional, such as an EMS trained in Crisis, who is present for the duration of the service, could be considered to meet the team requirement. A clinical determination could also be made by the Crisis provider as to whether the mobile service requires a team or individual response.

§ 5250.71. Requirements for mobile crisis team services.
(e) Mobile crisis team services shall be deployed in real-time through 988 or county lines.

- **Comment**: This requires significant integration with 988, and because 988 continues to be staffed by volunteers, there is a lack of knowledge of local resources with no guarantee the call answered by 988 is local to the caller. Currently, there is minimal interface between 988 and Crisis providers, and there is little ability to collaborate as a team on a case, unless the Crisis provider is also the 988 call center.
- **Question**: How will the department ensure seamless integration with 988 and address high risk concerns with 988 transfers to local crisis response? Will 988 be held to expectations as well as providers regarding answering one hundred percent of calls, staff qualifications, etc.?
- **Recommendation**: Additional clarification is needed on the process and roles with regard to the interface between 988 and the Crisis provider.

§ 5250.71. Requirements for mobile crisis team services.
(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.

- **Comment**: Motivational Interviewing could include a cost to providers.
- **Question**: Is the development of a service plan intended to be a safety plan, and what are the requirements for such a document? Also, will the state offer Motivational Interviewing training free of charge to providers?
- **Recommendation**: A definition regarding Motivational Interviewing is needed on whether this would be a one-time training or an ongoing process.

§ 5250.71. Requirements for mobile crisis team services.
(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.

- **Comment**: Resource availability and timeliness of the initiation of those resources is a concern for rural providers. This could present as a barrier to the effectiveness of the Crisis intervention.
- **Recommendation**: Consideration could be made to allow for providers to individualize their support based on the need, such as ongoing support stabilization, case management, and resource linkage following the resolution of the crisis to ensure the individual's needs are met, rather than the regulation restricting the ability of the Crisis team to help divert from a higher level of care.

§ 5250.71. Requirements for mobile crisis team services.
(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.

- **Comment**: Provider success will be dependent upon the first responders' willingness to develop an agreement. Police departments consider their staffing, funding, and training requirements, and for some departments this excludes a collaboration with Crisis providers.
- **Question**: What is the county's responsibility to help educate and train their first responders and uphold this expectation? How does each county coordinate Crisis, delegates, and police based on their resources? What is the viewpoint on dual roles, such as crisis and delegates being the same person, adding flexibility to meet the need?
- **Recommendation**: Consideration could be made that this is a process that may take several years to fully implement due to ongoing training and engagement with first responders.

§ 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.

- **Question**: Would the State consider providing technical assistance to providers at no cost for consultation and program development?

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

- **Comment**: The provider requirements increase cost for staffing, recruitment, and retention. There are current barriers across all providers for CPS that include available potential hires, training, certification, recruitment, and retention. Supervision for CPS is different from the supervision for mobile crisis team services. For example, the approach must be tailored for CPS or there will be high turnover considering the job expectations and performance of crisis intervention. There must be a significant increase in self-care, wellness, and overall debriefing to retain CPS and

incorporate their role in Crisis response. Concerns exist with the overall cost of crisis intervention services in rural areas and how to comply with a mobile team that utilizes CPS.

- **Question**: Will the State address the significant lack of training for CPS, as well as the cost to the provider to send an individual to CPS training?
- **Recommendation**: Clarification in the regulation regarding whether CPS in Crisis are required or optional is needed.

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

(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.

- **Comment**: Availability of licensed behavioral health professionals 24/7/365 is not realistic given the workforce challenges. There are not enough licensed clinicians, and especially not enough licensed clinicians interested in working in Crisis to accommodate for this requirement. Many agencies have licensed supervisors and directors who would be available to help oversee this, but will not always be available 24/7/365 in the moment of mobile dispatch. Additionally, the fact that an individual has a license does not necessarily equate to that person having the experience, desire, or knowledge to be competent to dispatch and oversee mobile crisis.
- **Question**: What will be acceptable in terms of delayed signoff or some other waiver to meet this requirement? For example, Wisconsin has a waiver for delayed signoff on dispatch.
- **Recommendation**: The licensed staff requirement could be shared in coordination between the 988-call center and the mobile crisis provider. A credentialing process could also be used to ensure competency to authorize crisis MHPs with experience, which could be built to develop an equivalent to a license, and would expand all providers' ability to meet the intent of the regulation and still maintain the valuable expertise and staff in the field. There is precedence for this type of credentialing with the FBMH process for graduates of the Training Center to be considered the equivalent to an MHP.

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).

- **Comment**: There are typically few to no mobile requests between midnight and 8:00 am. Rural counties have determined that it is not cost effective to pay for this service during these times of low volume. Experience of providers indicates that emergency services meets any needs that arise during these times and that most mobile needs occur during business hours. Staffing in Crisis is already a challenge, and staffing for 24 hours a day, 7 days a week, 365 days a year would prove a far more significant challenge for medical mobile crisis team services. Also, this requirement is inconsistent with other Crisis response programs such as FBMH, ACT, and CSBBH, which do not require a 24/7/365 team.
- **Recommendation**: This requirement could be individualized by counties or regions dependent upon assessed needs of the population.

§ 5250.81. Requirements for medical 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.

- **Comment**: This requirement will actually limit the availability of medical mobile crisis response as there are no permissible alternatives. Providers will not always have two staff within a one-hour radius for every mobile response. For instance, staff may have another role they are performing at the time, one staff may live close and the other farther away from the mobile need, or there may be times of short staffing, PTO, or other unexpected sickness or leave of absence.
- **Question**: Can telehealth service delivery be defined or clarified? While the use of telehealth for crisis service delivery is not ideal, some current crisis providers are using this method of delivery and details need to be clarified.
- **Recommendation**: Acceptable alternatives could be built into the regulations to ensure the mobile need can be met, even if not with two people.

§ 5250.81. Requirements for medical mobile crisis team services.
(c) The medical mobile crisis team service may be utilized in situations where medication is known or anticipated to be required.

- **Comment**: There is a differentiation the regulations say "may be utilized." Explanation is as follows: 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. Clarification is needed.

§ 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.

- **Question**: Would the State consider providing technical assistance to providers at no cost for consultation and program development?

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

- **Comment**: The provider requirements increase cost for staffing, recruitment, and retention. There are barriers across all providers hiring CPS that include available potential hires, training, certification, and retention. Supervision requirements for CPS are different from supervision for mobile services, as the approach must be tailored to the CPS. Without an individualized approach there will be higher turnover considering the job expectations and performance of crisis intervention. There needs to be a significant increase in self-care, wellness, and overall debriefing to retain a CPS and incorporate them into Crisis services. Concerns exist with the overall cost of crisis intervention services in rural areas and how to comply with a mobile medical team that utilizes CPS.
- **Question**: Will the State address the significant lack of training for CPS, as well as the significant cost to the provider to send an individual to CPS training?
- **Recommendation**: Clarification is needed in the regulation regarding whether CPS in Crisis are required or optional.

§ 5250.82. Provider's responsibilities for 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.

- **Comment**: Availability of licensed staff, including qualified medical staff and BH professionals, is limited. 24 hours a day, 7 days a week, 365 days per year requirements are not realistic given to workforce challenges. There are not enough licensed clinicians in Pennsylvania, and even fewer are interested in working Crisis services, especially in rural counties. Many agencies have licensed supervisors and directors who would be available to help oversee this requirement, but will not always be available 24/7/365 in the moment of mobile dispatch. Additionally, the fact that an individual has a license does not necessarily equate to them having the experience, desire, or knowledge to be competent to dispatch and oversee mobile medical crisis services.
- **Recommendation**: The licensed staff requirement could be shared in coordination between the 988 call center and the mobile medical crisis provider. Also, a credentialing process to authorize crisis mental health professionals could be built to develop an equivalent to a license, which would expand all providers' ability to meet the intent of this regulation, while also retaining valuable expertise and staff who are willing to work in the Crisis field. There is precedence for this type of credentialing with the FBMH process for graduates of the Training Center to be considered equivalent to an MHP.

Subchapter J. Emergency Behavioral Health Crisis Walk-In Center Services

Program Overview Comments:
The regulatory parameters of these proposed walk in centers seemingly refer to hospital-like settings. There are numerous community-based outpatient clinics that currently have these walk-in center services embedded in their operating programs. Is it the expectation that these clinics would be required to be in compliance with these hospital-like program settings under a 24/7/365 platform? For these clinics to retrofit and redesign their staffing, operations, and physical premise would be not be fiscally viable. If this is the case and these models can only be licensed as the proposed regulations intend, what happens to these programs? Without them we would be losing access to critical crisis services across the Commonwealth. The elimination of these existing clinic based walk-in centers would conceivably remove a major piece to the crisis continuum.

§ 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.

- **Comment**: Please clarify the requirement for medical assessment and what type of assessment is required (pregnancy, flu, COVID, etc.).

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

- **Comment**: Concerns over access to advanced practitioners, especially in rural communities, and current reimbursement rates are prohibitive for hiring and retention.
- **Question**: In the event that providers are unable to fill these positions as required, will the Department consider waivers?
- **Recommendation**: Staffing considerations for using mental health clinicians, RNs, and peer support staff. Also, consideration for mental health clinicians not to be licensed due to lack of access to these positions.

§ 5250.91. Requirements for emergency behavioral health crisis walk-in center services.
(c) An emergency behavioral health crisis walk-in center shall accept all walk-ins.

- **Comment**: The requirement to accept all walk-ins may facilitate the need for the 24/7/365 walk-in centers to have security. What is the Department's position on this matter and how would these costs be reimbursed?
- **Question**: What stipulations will be required to serving individuals who are actively aggressive, possess weapons, or have medical issues that the facility cannot serve?

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

- **Comment**: The workforce requirements as currently operationalized could not meet this standard. While providers fully support the use of peers in mental health services delivery, there are not enough certified peer staff to fulfill current requirements in other licensed programs.
- **Recommendation:** Peers as optional staff.

§ 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.

- **Comment**: Please clarify the intent of the regulation, as currently positioned; each county has a different way of interacting with provider organizations to provide crisis services. Will there be a universal organizational plan for all county crisis services? Can existing plans be utilized?

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

(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.

- **Question**: Will the new regulations require revision for current organizational policies? Additionally, will there be specific requirements for screening, including standardized assessments and time frames?

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

(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.

- **Comment**: Please clarify the utilization of peer support with adults but not children, as clinics conceivably will offer services to both populations.
- **Comment**: Please clarify (1).
- **Comment**: A no-rejection policy will require providers to assume other costs associated with ensuring safety, including the use of security staff. How will these costs be integrated into the cost of care and rate?
- **Comment**: Does the no-rejection requirement go beyond the assessment process? Would a provider be required to accept an individual who they may not be able to service?

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

(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.

- **Question**: Are there specific time frames for responses? Additionally, what is the OMHSAS requirement for having an individual reviewed on the phone with an on-call provider versus being seen in-person?

§ 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.

AND

§ 5250.93. Premises requirements.

(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.

- **Comment**: This is another example of where an "in-between" level of care may be needed for those who have walk-in crisis services within a licensed outpatient facility.
- **Question**: How will physical plant modifications be factored in to the cost of implementation and physical site compliance?

§ 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.

- **Comment**: Please specify the exact location for the AED and first aid kit, especially for facilities with multiple programs in operation.

§ 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.

- **Question**: In what areas must the video monitoring notification be posted? Can the sign be posted in the reception/intake area?

§ 5250.95. Cameras.

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

- **Comment**: Clarification is needed on the timeframe for how long video must be saved prior to destruction. Current system varies in length of memory.
- **Question:** How would this apply to programs that utilize video cameras that are tied into local police departments?

§ 5250.97. Medication administration.

(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.

- **Question**: Does this section only pertain to those facilities that have automated medication dispense systems?
- **Comments:** To address potential waiver scenarios and shortage of nurses, will OMHSAS consider the utilization of other staff permissions and/or training in alternative medication administration curriculums (e.g., ODP Med Admin Guidelines and or self-administration practices)?

§ 5250.99. Medication records.
(b) The information in paragraphs (a)(12) and (13) shall be recorded at the time a medication is administered.

- **Question**: Will the Department outline those individuals who are qualified to administer medication?

§ 5250.99. Medication records.
(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.

- **Question**: Does this include all prescription medications? Or only those prescribed at the walk-in clinic?

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

- **Question**: Will OMHSAS provide technical assistance for the requirements under 42 CFR § 493.1101?

§ 5250.100. Requirements for stock medications and 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 window from intake.

- **Comment**: Many rural communities do not have labs that can meet this requirement, thus eliminating the choice to provide in-house or outside services.

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

- **Comment**: Without a clear understanding of the costs associated with either in-house or outside lab services, it would be difficult to determine operationalization of this service into the walk-in

centers. We feel it would be beneficial, during this pre-promulgation period, for OMHSAS to convene a stakeholder group to better gauge the implementation factors and costs.

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

(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.

- **Comment**: Please provide guidance clarifying regarding CLIA waived testing utilization.

Subchapter K. Crisis Stabilization Unit Services

§ 5250.101. Requirements for crisis stabilization unit services.

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

- **Comment**: Availability of licensed behavioral health professionals 24 hours a day, 7 days a week, 365 days a year is not realistic given the workforce challenges.

§ 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.

- **Comment**: The language implies integration of mental health and substance use disorders. The Single County Authority should be at the table to assist with operations, P&P, and budget development.
- **Question**: If a provider does not currently provide services for children what are the licensing parameters?

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

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

- **Question**: Will the State develop a system to maintain advance directives?

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

(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

- **Comment**: Since stabilization is a "no wrong door," including treatment of individuals dropped off by police, individuals with intellectual/developmental disabilities, substance use disorders, or aggressive behaviors, training will be needed to assist providers on regulations for hands-on intervention, de-escalation, etc.
- **Question:** With the proposed no-rejection standards, there will be a need for onsite security; how will this cost be realized in the rate methodology?
- **Question:** What will be the protocol for individuals with high end behaviors?

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

(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 50 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.

- **Comment**: There should be an accompanying cost analysis by providers based upon these proposed regulations so that the State has a valid assumption on the cost of implementation.
- **Question:** How is the room and board cost included in rate?

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

(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.

- **Comment**: The length of stay is longer than the average length of stay for inpatient psychiatric treatment. Current authorization process from the BH-MCO does not currently follow this protocol.

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

(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.

- **Comment**: There are concerns regarding the cost of licensed medical professionals under the Medicaid spend for behavioral health. Crisis stabilization with be competing with inpatient psychiatric services, hospitals, outpatient mental health services, outpatient substance use disorder treatment, emergency departments, urgent care, etc. This is moving Crisis to a medical model with a significant increase in the cost of operations.
- **Question**: Does the State have any plans or strategies to attract more licensed medical professionals, fund medical school, increase salaries, and enhance the supply of medical professionals across Pennsylvania? Is the State's plan to bill physical health for Crisis Stabilization or commercial insurance?
- **Question:** As referenced in (4), is this referring to a medical assessment or medical clearance as these are seen as different processes.

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

(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.

- **Comment**: Availability of licensed staff, including qualified medical staff and BH professionals, is limited. 24 hours a day, 7 days a week, 365 days per year requirements are not realistic given to workforce challenges. There are not enough licensed clinicians in Pennsylvania, and even fewer are interested in working Crisis services, especially in rural counties. Many agencies have licensed supervisors and directors who would be available to help oversee this requirement, but will not always be available 24/7/365 in the moment of mobile dispatch. Additionally, the fact that an individual has a license does not necessarily equate to them having the experience, desire, or knowledge to be competent to dispatch and oversee mobile medical crisis services.
- **Recommendation**: The licensed staff requirement could be shared in coordination between the 988 call center and the mobile medical crisis provider. Also, a credentialing process to authorize crisis mental health professionals could be built to develop an equivalent to a license, which would expand all providers' ability to meet the intent of this regulation, while also retaining valuable expertise and staff who are willing to work in the Crisis field. There is precedence for this type of credentialing with the FBMH process for graduates of the Training Center to be considered equivalent to an MHP.

§ 5250.103. Peer-run crisis stabilization unit services.
(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.

- **Comment**: Please define "access." There is a lack of specificity on whether this is on call, telehealth, in person, or a combination.

§ 5250.103. Peer-run crisis stabilization unit services.
(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.

- **Comment**: There are concerns pertaining to the recruitment and retention of CPS, as well as the cost of certification to the provider and lack of training opportunities which greatly impact the availability of staff.
- **Question**: Will the State address the concerns of the CPS workforce and training?

§ 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.

- **Question**: The incorporation of these models requiring 24/7/365 coverage will result in potential unaccounted for overtime staffing costs. What is the State formulary for accounting of this in the rates?

§ 5250.108. Premises requirements.
(c) Units and programs for individuals under the age of 18 shall be age-appropriate and may include distinct units for children and youth.

AND

§ 5250.109. Bedrooms.
(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.

AND

§ 5250.109. Bedrooms.
(g) Each bedroom shall have a window with a source of natural light.

AND

§ 5250.109. Bedrooms.
(m) Each bedroom shall be ventilated by operable windows or mechanical ventilation.

AND

§ 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.

AND

§ 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.

- **Comment**: How will the requirement for physical plant compliance cost be attributed into the rate or costs. Will there be grant of alternative funding available specific to these costs?

§ 5250.122. Emergency preparedness.
(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.

- **Comment:** Please define the plan elements as they related to the audit tool that will be used to measure compliance with emergency preparedness and fire safety plans**.**
- **Question**: What is the applicability or guidance for non-hospital settings? Please clarify.

§ 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.

- **Comment**: Medical-based facilities will require recruitment and retention of dietary staff, kitchen staff, nutritionists, etc. to address special diets and restrictions; all of which fall in alignment with diagnosis and prescribing medications. Physical facilities will need to take into consideration the cost of a commercial kitchen, food prep, food management, and food storage.
- **Question:** Does this nutrition requirement apply to all levels of crisis stabilization?
- **Question:** How will these costs be attributed to the rate?

§ 5250.125. Individual service plans.

(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.

- **Comment**: This is similar to inpatient mental health, inpatient substance use disorder, and residential level treatment.
- **Question:** This is current practice; correct?

§ 5250.126. Medication administration.

(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.

- **Comment:** To address potential waiver scenarios and shortage of nurses, will OMHSAS consider the utilization of other staff permissions and/or training in alternative medication administration curriculums (e.g., ODP Med Admin Guidelines and or self-administration practices).
- **Question**: Does this section only pertain to those facilities that have automated medication dispense systems?