3176 14-538-01

Champa, Heidi

From:	Ralph May <rmay@thecgc.com>
Sent:	Tuesday, August 15, 2017 3:34 PM
To:	PW, OPCRegs
Cc:	Ann Williams
Subject:	Proposed Rulemaking for 55 Pa Code CHS 1153 and 5200

RECEIVED
IRRC
2017 AUG 17 P 2:08

As the Chief Clinical Officer of the Community Guidance Center, one of the 279 clinics in PA, I appreciate the opportunity to provide feedback to DHS, on behalf of my agency, regarding this long overdue update to the Outpatient Regulations in PA. CGC serves Indiana, Clearfield and Jefferson Counties at present with our OP Services, and contract with several MCOs and County authorities. As such, the vast majority of our consumers are rural, and lack access to reliable transportation or MATP. The distances in our counties is great between communities, and the challenges associated with travel to meet consumers in our other Mobile programs (e.g. BCM, Mobile Psychiatric Rehabilitation), are well known to us. Outpatient MH services remain the most cost effective and evidenced based means of address mental health disorders, and to help individuals and families struggling with MH and Dual recovery to remain in their homes and communities is the key to meaningful outcomes.

In this regard, there are several comments:

1) Mobile MH Treatment will remain elusive as a solution in rural counties, as the costs associated with travel and maintaining qualified staff to provide the services will not be addressed effectively. Routine appointments will be difficult to sustain, and severe weather will impede care. We are having increasing difficulties recruiting and retaining qualified office based staff, let alone clinicians who will travel for hours a day to see consumers. The labor supply in all MH areas is decreasing, and rural areas are differentially punished by the dearth of staff and limited ability to retain them.
2) The expansion of the 30 day window to complete the Treatment Plan is welcome, and reflects the reality of time needed to formulate meaningful goals and review them with the consumer and psychiatrist.
3) Likewise, both the increase in group size to 12 members and the allowance for Treatment plan updates at 180 days, with psychiatric review at one year on established consumers accurately reflects the ongoing nature of outpatient care for our population, and the team approach that reduces unnecessary burden of redundant documentation that interferes with, rather than supports consumer involvement in goals and objectives.
4) While the expansion of the use of CRNPs and PA-Cs is applauded, the proposal does not go far enough. These extenders are quite able, with consultation and/or supervision, to fully conduct evaluations and use telemedicine platforms. The 50% on site requirement for having a psychiatrist will not be able to be met in many clinics, as the shortage of psychiatrists is critical and going to worsen over the next decade, at least. In national meetings, a model that been developed uses the psychiatrist as a consultant to the on site prescribers, and allowing that time to counted toward licensure and oversight would go a long way to sustainability. While not specifically addressed here, the use of CRNPS and PA-Cs in Partial Hospitalization programs will also be essential to safe, accessible and quality care in this intensive treatment service.
5) While certain MCOs will allow licensed psychologists to provide teletherapy, this area is not even considered in the revision. Frankly, in a review of our 2,500 consumers, most have internet access and at least a smart phone. They may not have any type of reliable or consistent transportation. Medicare supports teletherapy as well. Rather than MMHT, the expansion of teletherapy would be the most costs effective, reliable and effective means of providing OP services to consumers in their homes. Electronic medical records, effective tracking of utilization, billing and compliance is no longer an issue using even the current technology. Medicine is well ahead of the state in this regard, with available consultation and intervention using mobile technology. Mental health is even better suited than physical health in this area. I would advise a thorough review of teletherapy as an innovative and cost effective, consumer friendly means of providing quality care. Data from our outcome studies clearly demonstrates that telepsychiatry and teletherapy are equally effective when compared with on site services. If we hope to meet the clear needs in our rural areas, this will become essential.