Package #: 14-557
Date Received: 10/27/2025
Commentator #: 14-557-03

From: PW, CrisisServicesRegs
To: Kelly Goshen
Cc: PW, CrisisServicesRegs
Subject: RE: [External] Crisis Intervention regulation response
Date: Monday, October 27, 2025 3:06:48 PM
Attachments: 14-557-03.LETTER.20251027.pdf

Good afternoon,

Please find the attached response from OMHSAS.

Thank you,

OMHSAS Policy Team.

From: Kelly Goshen <kegoshen@keystonehealth.org>
Sent: Monday, October 27, 2025 9:00 AM
To: PW, CrisisServicesRegs <RA-PWCRISISSRVSREGS@pa.gov>
Subject: [External] Crisis Intervention regulation response

Thank you for the opportunity to comment on the Crisis regs. Please see comments attached.

Kelly

Kelly L. Goshen

Director of Behavioral Health

Keystone Health

100 Chambers Hill Drive

Chambersburg, PA 17201

Ph: 717-709-7930 ext. 3010

Fax 717-709-7931

kgoshen@keystonehealth.org

sensitive information, and are intended solely for the use of the individual or entity to whom they are addressed. If you have received this e-mail in error, please notify the sender by reply e-mail immediately and destroy all copies of the e-mail and any attachments.

Public comment in response to the proposed Crisis Intervention regulations.

I have worked in this system for 45 years in varying capacities, from direct care to County MH/IDD/EI and D&A Administrator to Director of Behavioral Health for a large FQHC. I totally understand the need for minimum program and operational standards for providers. I also believe that communities are not all the same, and what works in one area may not work in another.

My immediate concern is that the crisis service "someone to contact, someone to respond and a safe place for help," "no wrong door," no longer means that, in some communities, you can walk into your local crisis office to receive that help and support. Many have used traditional walk-in services in communities for years and now will be losing access to those locations. Clearly, there are not enough financial resources for every community to have an Emergency Behavioral Health Walk-in as defined in these regulations, except perhaps for local hospitals to provide it as part of their ER. Do we really want everyone to go to the ER? Or to a medical type of facility? Medical-type facilities have a place, but they are costly and unnecessary for most situations.

The offer to meet people has been made for many years through Mobile Crisis Services in our Franklin County community. In some communities, that is not what people want. Our community is made up of proud, hard-working, private people who are concerned about what others think of them and do not want someone in their home. They want to come to the crisis office wherever it is located. Our Crisis Call Center staff offer mobile services to see the individuals and their families but are consistently declined. Our transient population also has a better experience of coming to the crisis office than meeting in a McDonald's or somewhere where they are judged and not comfortable.

Some Crisis programs have been located in local hospitals for at least 40 years. Patients can walk in and either go to the Crisis Office to be seen or go to the ER. As previously mentioned, there does not seem to be a huge influx of funding coming along to build Emergency Behavioral Health Walk in Programs, it seems as though hospitals will need to carve some space out of their emergency rooms in order to manage this level of care. This seems to be the only option for someone who prefers to walk into a crisis program. The option is costly to the individual seeking help and often unnecessary unless the individual is seeking inpatient and/or needs inpatient treatment.

We currently have crisis staff co-located with outpatient providers as part of a walk in behavioral health service. The individual can see a crisis worker to determine their needs, resources and develop a safety plan or if needed a nurse practitioner for an evaluation or medication management. If either professional determines the need for inpatient services,

they can ensure that that takes place. There is a good chance that the individual can be treated in this environment and that inpatient hospitalization or what has been defined as Emergency Behavioral Health Services is not necessary.

In regard to Crisis Call Centers: There does not seem to be any mention of 988. My understanding is that 988 will come under telephone services but my suggestion would be to address this in the regulations in order to help solidify the need for funding for 988. Funding will definitely need to be addressed to fully staff call centers particularly those that are currently operating at a financial loss and with less staff than would be ideal.

Mobile Teams: 5250.71 In our area, Mobile services have been offered to the public for years and are typically declined. However, in order to change that culture funding will need to be available for marketing/advertising and fully staffing the teams as presented in the regulations. In order to fully staff with 2 person teams 24/7, our crisis program will need at least 8 additional staff and previously determined the additional cost to be around $255,788.

Staffing 5250.31-35 I understand that the requirement is in the Medical Assistance regulations, but we have not found a need to have this position in the past and will need some kind of flexibility and financial resources to make this happen. As an FQHC that also provides outpatient behavioral health services and has been recruiting licensed staff of the same qualifications for clinical therapist positions, I can confidently say that recruiting and paying for this level position for each shift is going to be an issue for all crisis providers.

The need for a certified peer specialist is also understandable; however, there also seems to be a shortage of Certified Peer Specialists in addition to the fact that the billing processes make it difficult to make this work financially. My understanding of the billing is that there is a team rate for Crisis Mobile in particular. Will the rate be high enough to cover the costs of both team members, mileage, phone, computer etc. Secondly, if the peer is contracted through a peer service it will be difficult to separate that rate to pay for the Peer. We have been fortunate to have staff that have lived experience, they often do not want to be identified as a Peer but there should be some way to take that into consideration.

I appreciate the need for training requirements; however, this is written for those that would be full-time employees. We need to be flexible in how long it takes employees to complete the training. We would not use that employee until they have completed the requirements however, in our experience, all of our part time staff, which is the majority of the staff, have other full time employment and getting them through the training in10 scheduled working days does not happen.

Regarding Emergency Behavioral Health walk-in services, many communities do not have the volume for a facility like that which is proposed, and patients will still be going to the ER, especially in light of not having their local crisis walk in available. As previously mentioned, there are many crisis situations that can be managed without a psychiatrist and with the use of crisis workers and advance practice professionals on a short-term basis with the need being resolved in 15 minutes to an hour. For example, we have a Crisis Intervention Specialist co located in our FQHC Behavioral Health Walk- In/Outpatient Program available to see and assess those that walk in off the street who need something. It makes no sense for us to send someone to that facility for a mobile visits when the Crisis worker is already located there. The patients can see the crisis worker and if need be an advance practice professional, such as a psychiatric nurse practitioner. This option is part of our no wrong door approach. These regulations do not seem to allow for any walk in options that are not an ER or Emergency Behavioral Health option. Patients can still be referred to or sent to the hospital if needed for inpatient services and medical clearance.

5350.31 3. A licensed certified registered nurse practitioner with two years of Behavioral Health experience. There should be another designation for those that are trained Psychiatric Mental Health Nurse Practitioners, the psych specialty should eliminate the need to be required to practice for 2 years.

Staffing and funding issues are truly a concern for us every day. We often operate our program in the red and without the truly dedicated staff that we have, we would not have been able to provide this service to the community. We need the resources to recruit, retain and train staff appropriately and to meet these new requirements.

Thank you for the opportunity to comment.

Kelly L. Goshen