The Ohio Council
Of Behavioral Health & Family Services Providers

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OhioMHAS MRSS Rule Comments

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Thank you for the opportunity to provide comments and feedback on the OAC 5122-29-14 to support the statewide expansion of Mobile Response and Stabilization Services in Ohio. We appreciate the collaborative efforts to build this important, intensive service needed by a youth with urgent behavioral health needs and challenges.

Below are our specific comments on O.A.C. 5122-29-14.

1. The definition of crisis in paragraph (A)(2) differs from the definition of services defined in (B). The definition in (B) identifies that a crisis situation is a young person experiencing emotional symptoms, behaviors, or traumatic circumstances that have compromised or impact the young person's ability to function, although the definition in (A)(2) identifies that the situation is identified by the young person and family and is not limited to symptoms, behaviors or circumstances that are limiting functioning abilities across settings.
    a. Recommendations: Using consistent language from (A)(2) in (B) will not limit mobile responses to symptoms, behaviors, or circumstances, but whatever the family has defined as the crisis they need support with. Limiting the mobile responses to supporting the young person and family with symptoms, behaviors and circumstances may impact how the service is accessed and delivered.

2. (H)(1)(b)(i) and (H)(1)(b)(ii) use the definition for young person (individual under age 21) referenced in (A) but does not use the term young person.
    a. Recommendation: Using the term young person defined in (A) should be used instead of the definition being repeated several times in the rule.

3. (H)(1)(b)(i) as stated in the proposed rule does not include the lived experience of parents/caregivers and families of youth with mental health disorders and substance use disorders as a scope of practice. Identifying this scope of practice is important because certified family peer supporters work closely with parents and other family members to the young person utilizing MRSS services.
    a. Recommendations: Include language identifying parents/caregivers and family members lived experience to the scope of practice of certified peer supporters in addition to individuals with mental health disorders and substance use disorders.

4. The last paragraph under (D)(3) states that MRSS is to be delivered using a telehealth modality when there has been a mobile response, but a clinician is not available. The language "when there has been a mobile response" indicates that the initial response has already taken place. Further, this paragraph may imply that telehealth service may only be provided by a clinician or is complicated by the additional requirement that a clinician must be available by telehealth in these circumstances. The is confusing and needs clarified as we believe the intent is that a clinician is

accessible even when MRSS is provided by telehealth. Finally, the placement of the language under (D)(3) implies telehealth only impacts circumstance of inclement weather.

   a. Recommendations: Replace the language "when there has been a mobile response" with "when a mobile response *has been requested*". In addition, language is not related to just inclement weather and should move to (D) as it applies to all uses of telehealth modality for MRSS, not just inclement weather. Finally, clarify the that when a clinician must be accessible when MRSS services are delivered by telehealth.

5. (H)(1)(a) states that a clinician defined in 5122-29-30 of the Ohio Administrative Code holds a valid and unrestricted certification or license issued by an Ohio professional board that includes a scope of practice for behavioral health conditions. 5122-29-30 not only doesn't define the term clinician, but it does also not reference the term clinician in the rule. There is a inconsistent use of the terms young person and person under 21 years of age which should be combined with the use of young person.
   a. Recommendations: Use language that is consistent with 5122-29-30 (add language from paragraph A) instead of the term "clinician".
   b. (H)(1)(a) uses the definition of young person versus the term that was defined earlier in the rule; to be consistent, the term should be used in this paragraph with reference to (A) regarding the definition.

6. (H)(1)(b)(ii) outlines that QBHS and certified peer supports will demonstrate competency in the care and provision of services which will require regularly scheduled training opportunities. QBHS and certified peer supporters participation in regular training may impact the availability and provision of MRSS on an ongoing basis if adequate training is not offered. The extension of this paragraph also uses the term clinician in reference to 5122-29-30, where the term clinician is not used or defined. Please see feedback in #5.
   a. Recommendations: Trainings to be scheduled at a frequency to assist with the timeline of the statewide expansion of services, trainings are currently offered twice a month which does not meet the needs for service provision statewide. Currently, it appears there are only 2 MRSS Core Model Trainings offered each month. To ensure there are sufficient offerings for all staff and to support the expansion statewide, additional training options should be considered otherwise providers may be at risk of non-compliance due to circumstances beyond their control.

7. (I) uses the term MRSS Provider which lacks clarity in that it may mean both an individual provider (practitioner) or the provider organization Clarification this is indented to mean a provider organization is important.
   a. Recommendations: Clarification of the term provider regarding the individual provider or organizational provider.

      NOTE: Given the proposed regional MRSS provider (RMP) model, if subcontracts are established between the RMPs and OhioMHAS certified providers to serve a given region, additional clarification is needed as to whether both the RMP and subcontracting organizations be required to undergo fidelity reviews and maintain individual OhioMHAS certification for MRSS. It would be useful to address this issue.

8. Similarly, (J) uses the term MRSS provider regarding the requirement to provide required data to OhioMHAS. The assumption is that this would apply to the regional MRSS provider submitting data for all MRSS providers in the region, but clarification would eliminate any confusion.

   a. Recommendation: Clarify language related to the MRSS provider and if this is intended to represent a requirement of the regional provider.

9. (L)(2) states that MRSS Providers are to provide MRSS services twenty-four hours, seven days a week, including holidays within 3 years. Many MRSS programs throughout the state have been unable to secure staffing for the 8pm-8am range despite significant recruitment efforts like sign-on bonuses and work from home options. Data obtained through established MRSS programs demonstrate that the need for responses after 8pm is significantly low in communities across the state. Unless there is a significantly demonstrated need for MRSS services after 8pm, requiring the services to be available 24/7 will be a significant burden to behavioral health businesses and will impact their ability to recruit and retain employees. Ongoing workforce shortages in behavioral health and substance use disorder services require preservation and retention of existing workforce to address identified needs. Holiday, evening (after 8pm), and weekend coverage also pose barriers to staff recruitment and impacts work-life balance often leading to burnout and turnover. Further, three years is too short a time period to assume significant reductions in the behavioral health workforce shortages, particularly with existing licensure and training requirements for licensed providers.
   a. Recommendations: A review of MRSS data across the state regarding utilization of services outside of 8am-8pm hours in the first two years of operation of MRSS under this rule to consider the most effective use of staffing under a firehouse funding model prior to requirement of 24/7 operations.

10. (M)(1)(c) states that once the family is stabilized, the family is re-connected with an existing service. The word stabilized is not defined and is not an adequate description to understand when to re-connect with the existing services. For example, a young person engaged in an intensive home-based service may utilize MRSS and following the initial response may not be considered stabilized but would be considered de-escalated. Intensive home-based providers may be working with families to stabilize specific behaviors and symptoms and connecting the family with the intensive home-based service provider once de-escalated may be appropriate, although the client may not be considered stabilized. Furthermore, Rule 5122-29-28 (A)(3) defines crisis response for IHBT services and (C)(6) identifies that IHBT teams provide immediate crisis response as a component of IHBT which should be considered
   a. Recommendations: Clarification of terms de-escalated and stabilized in the context of re-connecting a young person with established intensive home-based services. For example, the language could be changed to “once the crisis that necessitated the MRSS call is de-escalated….”.
   b. Consideration of how language in Rule 5122-29-28 may impact interpretation of paragraph.

11. As drafted, (N) is inconsistent ORC 5122.04, which states that in order for a minor to consent to treatment without a guardian’s consent, the minor must be 14 or older. This statute does not offer authority for a minor to be treated under 14 years old without parental or guardian consent. Further, if a minor age 14 or older demonstrates concerns rising to substantial probability of harm to self or others, parents may be notified and the youth informed of notification. A crisis is broadly defined in this proposed MRSS rule as a situation defined by the young person, the young person's family, or those responsible for the welfare of the youth that is causing stress or discordance to the person, their family, or the community. Crisis responses are not limited to youth over age 14 and we are unaware of regulations that would allow a minor under age 14 to be treated unless there is clear substantial risk of harm to self or others as defined in ORC 5122.01 (B) that would allow for treatment without valid informed consent from at least one of the young person’s Further,

practitioners licensed by the CSWMFT board have a clear obligation to obtain "informed consent". Areas of required "informed consent" include people being aware of their "limits, rights, opportunities, and obligations which might affect decisions to enter into or continue the relationship". CSWMFT Board rules: 4757-5-02 (B) (2)(3) further elaborate on a licensed practitioner's responsibilities to obtain informed consent.

a. Recommendations: Expectations for obtaining consent for MRSS services should be aligned and consistent with limits defined in ORC 5122.01(B) and 5122.04.

Thank you for the opportunity to share these comments. We share the goal of successful implementation of statewide, regional Mobile Response and Stabilization Services within the continuum of care for children and youth. We appreciate the collaborative effort on these rules. These services are imperative for youth with significant behavioral health challenges to stabilize in their least restrictive environments. We look forward to continuing our collaboration to create a regulatory environment that will support statewide expansion of MRSS in Ohio. If you would like to discuss our comments further, please do not hesitate to contact me at thrasher@theohiocouncil.org or tlampl@theohiocouncil.org.