14-521-20

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November 19, 2010

Noraliz Campanella
OMHSAS
P.O. Box 2675, DGS Complex
Harrisburg, PA 17105-2675

Re: Regulation # 14-521; IRRC #2879

Dear Ms. Campanella:

I am writing on behalf of NHS Human Services to provide comment on the proposed Psychiatric Rehabilitation Regulations, 55 PA. CODE Ch. 5230. While having been afforded the opportunity to participate on the OMHSAS workgroup and engage in the development of the proposed regulations, there remain a number of areas requiring additional consideration and/or clarification.

The attached document outlines the identified issues as well as our recommendations for ensuring both the successful implementation and ongoing sustainability of this much needed recovery oriented service in Pennsylvania.

The opportunity to participate in the development of the proposed regulations and provide comment is greatly appreciated. Should you have additional questions, please contact me at cmurphy@nhsonline.org.

Sincerely,

Cathy Murphy

Cathy Murphy
Vice President for Adult Behavioral Services

Cc: Betty Simmonds, PCPA

14-521-20

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OMHSAS Draft PRS Regulations Feedback
November 2010

1. **Organizational Structure (5230.10.a.) "A PRS facility shall develop a PRS advisory board that includes participation by individuals and families who utilize mental health services."**

   Question: Can the advisory board be combined with other advisory boards (i.e. ACT)?

2. **Physical Site Requirements (5230.13.b.) "Space for the PRS distinct from other services offered simultaneously."**

   Issue: Both Psych Rehab and Soc Rehab have been running in one space. The ability to continue this model has been found to be successful. The building does contain separate group rooms/individual meeting rooms /separate files, for the PRS programming within the same building. This allows for separate programming on a daily basis. In addition this model allows individuals to interact and discuss PRS on a peer level following PRS activities. The program has found this to be a positive aspect by increasing awareness of the benefits of PRS to individuals attending the Soc Rehab programming at STAR (Steps toward Advocacy and Recovery). Due to the rural nature of the area served and the issues of transportation involved, separation of PRS from the building would lessen individual's access to the service, and impact the #'s of individuals presently receiving PRS. In addition, the County will still want to pursue a waiver on this standard.

   Transformed, recovery focused day programs in Philadelphia County operate as blended Outpatient and PRS services. This approach was taken to ensure that treatment and rehabilitation services were merged to most effectively address participants' needs and promote their recovery. These blended service components comprise a single program that necessarily occupies the same facility space. Consequently, it is recommended that physical site allowances be made to accommodate service configurations such as those implemented in Philadelphia.

3. **Record Security, Retention, and Disposal (5230.21.c.) "Entries shall be signed and dated by the responsible licensed provider."**

   Questions: Since staff are certified or non-certified, but not licensed themselves, who is the licensed provider? Does this statement mean to say that a staff member of the PSR program is supposed to sign and date any documentation entries? If so, it should be more clearly stated.

NHS
HUMAN SERVICES

4. **Admission Requirements (5230.30.a.) "The allowance for diagnostic eligibility exceptions has been eliminated."**

   Issue: Current PRS Standards allow for diagnostic exceptions. Specifically, they state that, "Any other mental health diagnosis* must be reviewed and approved by the BHMCO on an exception basis. Such requests must include appropriate documentation of factors such as the scope of the treatment history and severity of the illness." This provision allows much needed local flexibility to respond to individualized need and, as such, it should be reinstated.

   * Allowable diagnoses include schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder or borderline personality disorder.

   The proposed regulations differ from the existing standards as they exclude all other diagnoses outside of schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder or borderline personality disorder. The previous standards allowed for review of the diagnoses, treatment history and severity of the illness by the BHMCO to determine if an exception would be made. Individuals who are diagnosed with a mental illness other than those listed above can experience severe functional impairments. The interventions associated with psychiatric rehabilitation can result in individuals achieving goals, better managing psychiatric symptoms and feeling an increased satisfaction with the quality of their lives.

5. **Staffing Qualifications (5230.50.a.1 & 2) "A PRS Director shall have a bachelor's degree and CPRP certification, or a bachelor's degree and at least 3 years work experience in mental health direct service, 2 years of which must be work experience in PRS."**

   Issue: Required qualifications may result in recruiting issues.

   Staffing Qualifications (5230.50.b.2) "A psychiatric rehabilitation specialist shall have CPRP certification."

   Question: For current individuals who are working as psychiatric rehabilitation specialists who are not CPRP certified, must they attain CPRP certification within 2 years from their date of hire, two years from the publication of the final regs., or are they grandfathered with their current credentials?

6. **General Staffing Patterns (5230.51.d.) and Staff Qualifications (5230.50). "When a service is delivered, a PRS facility shall schedule a Specialist or Worker to be present."**

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HUMAN SERVICES

Issue: Clarity is requested regarding this requirement related to the fact that many Certified Peer Specialists (CPSs) will not qualify as Workers until they have gained a full year of experience working in a PRS program ("1 year of mental health direct service"). This is problematic because program participants frequently feel more comfortable relating directly to Peer Specialists on a 1:1 basis, than to other staff. A strict interpretation of the aforementioned regulation could be understood to prohibit this 1:1 service provision until CPSs have gained sufficient experience to achieve "Worker" status. This requirement would also seem to prevent many CPSs from providing services in community settings for up to a year after their hire date, unless another staff person is present (Worker or Specialist). To avoid these impediments, it is recommended that certification as a Peer Specialist be considered sufficient to qualify these personnel as "Workers."

7. **General Staffing Pattern (5230.51.c.) "When a service is delivered in a facility, a PRS facility shall have an overall complement of one FTE staff for every ten individuals (1:10), based upon average daily attendance."**

   Issue: Staffing based on average daily attendance is preferable to ratios based upon licensed capacity. However, it would be better to allow staffing ratios to correspond to average, "shift-based" attendance rather than average daily attendance. Philadelphia County has been granted this exception with regard to the current PRS Standards and it has proven especially beneficial for programs with extended hours of operation that include evenings and weekends. I.e., agencies do not have to have a full compliment of personnel on duty, based on daily attendance, whenever the program is operational. Rather, staff can be deployed efficiently in complements sufficient to serve the average number of people who attend during particular periods. E.g., morning, afternoon, evening, or weekend hours.

8. **Group Services (5230.53.a.2.) "One staff may serve a group of two to five (2:5) ratio individuals (ratio of 1:2-5)."**

   Recommendation: Might be more clearly stated as follows: "one staff may serve a group of two to five individuals (ratio of 1:2-5).

9. **Staff Training Requirements (5230.55) "A PRS facility shall implement a staff training plan that ensures initial and ongoing training in PRS practices."**

   Issue: Because training for Psych Rehab is very difficult to get, and not scheduled frequently, only 25% of staff are certified.

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Staff Training Requirements (5230.55.a) "Staff that provides services in a PRS shall complete a 12-hour psychiatric rehabilitation orientation course approved by the Department no later than 1 year after hire."

Question: Is there an approved training that is currently conducted, and where can this training be located?

Staff Training Requirements (5230.55.c.2) "A PRS facility shall assure competency of new staff by providing an additional PRS service specific orientation that includes six hours of face-to-face mentoring of service deliver by a supervisor for new staff before services are delivered independently."

Question: Do supervisors have to be certified to conduct mentoring?

10. **Assessment (5230.60) "The Assessment must be updated annually and when the individual completes a goal or objective."**

    Issue: The statement below (5230.61.c.2) that details why revising a plan after the completion of each objective (i.e. sequential step) is not feasible, applies to this mandate as well.

11. **Individual Rehabilitation Plan (5230.61.c.2) "A PRS facility and an individual shall review and revise the IRP no less than every 90 days and when an objective is completed"**

    Issue: The IRP is a comprehensive and often times sequential document, listing multiple steps in meeting a component of the Overall Rehabilitation Goal (ORG). Therefore when the objective is achieved, there are several more objectives listed for the PRS staff and individual to address collaboratively. Can you clarify if this requirement can be met by inserting a notation on the plan when the objective is completed rather than assuming that an entirely new document must be re-written, reviewed and signed off on?

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