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Department of Human Services
Office of Mental Health and Substance Abuse Services
Attention: Laurie Madera, Bureau of Policy, Planning and Program Development
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July 15, 2022

Dear Ms. Madera:

This letter is offered as public comment on the Department's "as proposed" amendment to 55 Pa.Code Chapter 5230 – Psychiatric Rehabilitation Services, published in the *Pennsylvania Bulletin* on July 9, 2022, under 52 Pa.B 3828.

I believe the following credentials and experience establish my qualifications to enter comments. I am certified as a CPRP and a CFRP. Prior to my retirement, I was both a Human Services Program Representative 1 and 2 at OMHSAS operations. As a Rep 1, I was the OMHSAS-Harrisburg Field Office lead worker for Psychiatric Rehabilitation Services (PRS), and one of two OMHSAS employees who remained continuously involved in the original drafting of Chapter 5230 from the start of the workgroup in 2009 through the IRRC hearing and codification of the chapter in 2013. I participated in writing the Frequently Asked Questions document available at: https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/CDP/Psychiatric%20Rehabilitation%20FAQ.pdf. I was part of the OMHSAS team that developed and delivered training on Chapter 5230 at the PAPRS conference and the PA Clubhouse Coalition conference on several occasions between 2009 and 2014. As a Rep.2, I was involved in the early drafting of this proposed amendment, and I supervised OMHSAS licensing staff who inspected facilities licensed under Chapter 5230. I am currently employed as the Operations Manager for the Pennsylvania Association of Psychiatric Rehabilitation Serves, where I frequently assist members with questions related to PRS licensing. Please note that this comment is my own personal comment and is offered on behalf of myself only.

Preamble Comments

I applaud the Department for the considerable effort to produce this publication.

I support the expansion of eligibility for PRS to include youth between ages 14-17. This change will eliminate current regulatory waivers needed to serve the youth population, greatly reducing paperwork, and will increase the possibility that more PRS providers will reach this underserved population.

I support the broadening of the list of diagnoses eligible for PRS. This change will increase access to PRS and eliminate the need for many exceptions.

I support requiring CFRP certification for PRS staff who serve youth. This addition will assure a competent and well-trained workforce.

I support the elimination of a requirement for the individual's signature on each daily entry. This change will eliminate an obstacle to telehealth and reduce paperwork requirements for providers.

I support allowing remote supervision by telephone or video connection. This change will improve accessibility of supervision and will potentially improve service quality.

I support including LCSW, LPC and LMFT as Licensed Practitioners of the Healing Arts (LPHA). This change is consistent with state law and will improve an individual's access to PRS without making other more costly mental health services necessary for an individual to obtain the required recommendation.

I support the increased focus on involvement of natural supports/family in the PRS process, although involvement of natural supports, especially the individual's family of choice, has always been central to PRS.

In the Background section of the Preamble, PRS is described as an "integrated therapeutic approach". PRS does not provide therapy. PRS is a recovery and resiliency approach, as defined by the Boston University Center for Psychiatric Rehabilitation in its "Choose, Get, Keep" approach to service delivery. I suggest editing this wording accordingly.

The Preamble contains a reference to telehealth that is not included in the Annex. I support the inclusion of telehealth as an appropriate method of service delivery, and recommend it be specifically mentioned in the Annex. I also suggest specific wording to allow the use of services delivered by telephone, at least in a limited way, similar to what is currently allowed in Peer Support Services. It is noted that previous Medicaid obstacles to delivering services by telephone were largely eliminated by the changes to Federal regulation promulgated as a final rule by the Centers for Medicare and Medicaid Services (CMS) in November 2021. To read more about these changes, go to: https://www.cms.gov/newsroom/press-releases/cms-physician-payment-rule-promotes-greater-access-telehealth-services-diabetes-prevention-programs

Under §5230.62 – Individual rehabilitation plan, the Preamble states: "This proposed rulemaking allows individuals the option of verbally consenting to their individual rehabilitation plan and any updates to the plan." Unfortunately, the word verbal was not included in the respective section of the Annex, as it should have been.

Under §5230.63 Daily entry, the Preamble suggests that the change to eliminate a requirement for an individual to sign the daily entry eliminates a burden on the individual. This is a licensing regulation, and its scope is "PRS agencies as defined in the chapter" (55. Pa.Code 5230. Scope). Currently, the burden is on the provider to obtain the signature. This change is supported because it improves access to services for individuals by eliminating an obstacle to services delivered via telehealth, and it reduces the burden on the provider. See §5230.23 in the Annex section of this

comment for suggestion on wording that preserves the opportunity for the individual to comment and sign the daily entry.

Finally, the Preamble should also note that the proposed amendment will also benefit both providers and the Department, who are currently using a lengthy waiver process to approve services for youth. Elimination of the need for the regulatory waiver will decrease paperwork significantly. More importantly, it will increase access to PRS for the currently underserved youth population.

Any other comments on the Preamble are covered in the comments to specific sections of the Annex, below, and are not duplicated here.

Annex Comments

There are several places within the proposed Annex where the row of ****, intended to indicate section(s) not subject to editing, were missed. Hopefully, this will not confuse those unfamiliar with the Department's style guide.

§ 5230.3. Definitions.

I suggest adding a definition for telehealth. I suggest including a reference to services delivered by telephone, even if there is a limitation on the amount of telephone services to be allowed.

I support the addition of a fifth domain; however, I object to the wording of the definition of the Wellness domain. A domain does not help the individual do anything. It is a classification of a life area. I suggest renaming the domain and revising the definition, as follows. "Staying Healthy: A domain that focuses on the maintenance and improvement of both physical and mental health." It is noted that the other four domains (living, learning, working, socializing) are not defined within the chapter because their definition is obvious. Really, work to increase skills and supports in all PRS domains is geared toward overall wellness.

§5230.4 PRS processes and practices

Not all PRS providers offer community-based (mobile) services, and not all offer facility-based services. For this reason, the physical license document is coded to reflect approval to provide services in the facility/clubhouse or in the community, or both. There is no current coding for the home, which was previously considered a community location (as opposed to a facility location). Will this addition mean that the licensing coding must be amended? My concern is that if the license does not say the agency is approved to provide PRS in the home, licensing representatives might issue citations unfairly when services are provided in the home. Additionally, although it is important to note that this is a licensing regulation, it will have impact on billing. Most managed care organizations (MCO) require PRS to bill by location, so this change would make a new location code necessary for billing under HealthChoices supplemental, which could vary by MCO. The addition of a new service location would make an unwarranted paperwork burden for PRS providers, especially when the service begins in the home and moves to a different community location, or when the PRS is contracted to more than one MCO Perhaps this section should be re-worded to say "...in a PRS facility, or in the

community, which may include the individual's home, or both." This would provide clarity, eliminate the extra work of changing coding and re-training licensing staff, and still provide the identification of the home, especially as this location relates to telehealth services. It may be useful to define services delivered in the community under §5230.3 as services delivered anywhere other than the licensed facility, including services delivered in the home either in-person or by telehealth. See also §5230.53 and §5230.54 for the same issue.

Also, to be consistent with the Preamble, I suggest adding to §5230.4 a new section: (g) A PRS agency may offer PRS through telehealth, consistent with an approved agency service description.

§5230.13 Agency Records

(11) Suggest adding: "and as required under 5230.57". Note: this section seems duplicative of (6)(ii).

§5230.15 Agency service description

(a)(6) See above comment regarding the coding of the license document. Suggest rewording: "...in a PRS facility or in the community, which may include the individual's home, or both".

(a)(9-12) Note that services to youth should not conflict with school hours. PRS is not to be confused with IBHS. This does not appear anywhere in this chapter--perhaps it should.

§5230.31 Admission requirements

(a) I agree that this section needs to be re-worded. Chapter 5230 is a licensing regulation, and the scope of the regulation is PRS providers, as identified in the chapter. It is noted that the term individual is already defined under §5230.3 as a person who is age 14 or older, so it is not necessary to repeat the age requirement in this section. I suggest the following substitution (indented), which will add clarity and minimize the need to renumber the section:

> **5230.31 Admission requirements**
> (a) **[***General rule.***]** To **[be eligible for PRS, an individual shall meet the following:]** **admit an individual** for PRS, **the PRS facility shall include in the individual record the following:**
> (1) **[Have a]A** written recommendation for PRS by an LPHA acting within the scope of professional practice **that documents the presence or history of a serious mental illness, or serious emotional disorder.**
>
> (2) [**Have the presence or history of a serious mental illness, based upon medical records, which includes]Documentation of** one of the following diagnoses **[by an LPHA]listed in the current DSM or ICD.**

(a)(2)(i-ix) I support the inclusion of additional diagnoses, consistent with the current version of the Diagnostic and Statistical Manual (DSM-5) to reduce the use of exceptions for adults, and to prevent unnecessary use of exceptions for youth. However, the section alternates between

allowing entire diagnostic groups vs. allowing only certain specified diagnoses within a group. Use of the DSM-V grouping "Depressive Disorders" would eliminate need for additional exceptions. In the current DSM-V, post-traumatic stress disorder (PTSD) is part of a grouping of disorders labeled “Trauma and Stressor-Related Disorders”. Also included in this group are reactive attachment disorder, disinhibited social engagement disorder, acute stress disorder, adjustment disorders (various), other specified trauma, and unspecified trauma. I recommend broadening this category by replacing "PTSD" with the more general "Trauma and Stressor Related Disorders" to reduce the number of exceptions needed for youth who often have a diagnosis within this grouping. Note that attention deficit hyperactivity disorder (ADHD) is included in the DSM-5 grouping of neurodevelopmental disorders and might be the one disorder where it is more appropriate to list the specific diagnosis, rather than the broader grouping, since other diagnoses in the neurodevelopmental group are not disorders for which PRS can have an impact. There are other personality disorders that are amenable to PRS interventions (see Cluster C in the DSM-V). I suggest including the group "Personality Disorders" rather than being specific to only Borderline Personality Disorder.

(a)(4) This re-arrangement lessens clarity and omits the requriement under (4) that the individual chooses to participate in PRS, which should be maintained.

(b) and (d) I favor re-ordering this section to delete the requirement under (b) and move it to a separate sub-section (d), to separate the functional assessment from the requirements on the recommendation by the LPHA, However, I oppose the change of the term to the word “screening”. A screening is not the same as an assessment. A screening searches for existence of impairment when there are no clear symptoms. An assessment is much more thorough and lists all skills and resources needed to meet a goal and reduce functional impairment, as well as to differentiate between skills and resources in place and those that need to be developed. In this way PRS is a strength-based service. The functional assessment is currently completed by the PRS provider staff in collaboration with the individual (and where appropriate, the family or natural supports) at the start of services. The functional assessment is critical to delivering appropriate and effective services. OMHSAS has provided a sample Functional Assessment Tool for this purpose that has been in use since 2013. A change would create a paperwork burden with no significant positive effect. The Functional Assessment sample form is available at: https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/CDP-Provider-Information.aspx

§5230.32 Continued stay requirements

(b)(2)(i) I oppose removal of the term "skill deficit". Recovery has many phases and individuals define recovery differently and have different goals from one another. For Example: An individual is living in a supervised placement where his functioning is fine. He would not qualify for continued stay. However, his goal is to live independently, but he lacks skills to advance to that level of recovery where he can live independently-- i.e.: he has a skills deficit and is eligible for continued stay.

§5230.51 Staff qualifications

(d) Please clarify whether this requirement applies to both adult and youth programs, as it should.

(g) This is a licensing regulation, and this section is vague. Who is responsible to produce this documentation of accreditation? Is this something that must be part of the PRS agency records? Please clarify.

§5230.52 General staffing requirements

(a)(2) Earlier suggestions about telehealth seem to apply here, as well. Remember that a psychiatric rehabilitation assistant cannot work alone per the rule under §5230.52 (d). Suggest rewording this sub-section as follows: "Deployment of staff for PRS delivered in person in either the facility or the community, including the home, or by telehealth."

§5230.53 Individual services

See the comment for §5230.4, above. Suggest rewording this section: "...in a facility or in the community, which may include the individual's home…". The home has always been considered a community location as opposed to a facility location.

§5230.54 Group services

(a) See the comment for §5230.4, above Suggest rewording: "...in a facility or in the community, which may include the individual's home…". The home has always been considered a community location as opposed to a facility location.

(a)(3) This sub-section seems vague. If the intent is that group services in the home can be delivered by telehealth only, as stated in the preamble, I suggest re-wording the sub-section , as follows: (3)...group services in a home, the services shall be delivered by telehealth."

(f.1) Group services should be attended only by people who receive PRS from the PRS agency, regardless of location (this applies to telehealth, in-home service, community-based services, or facility-based services). I suggest the term "delivered in the community" be stricken and replaced with "at any service delivery location and when delivered by telehealth"

§5230.55 Supervision

(c) I support elimination of the term “face to face” so that supervision can be done by telephone or video link. This should increase opportunities for supervision, adding quality to the overall service.

§5230.56 Staff training requirements

(2)(ii) This section is unclear. Is the intent that 6 of the 12 recovery or resiliency focused training hours are further focused on youth, or is the requriement for 6 hours in addition to the 12 recovery or resiliency focused hours? Or does it mean 6 of the total 18 hours of training required annually? Within the 18 hours there must be space for training topics such as confidentiality, workplace safety, etc., none of which are recovery or resiliency oriented.

(2.1) This newly added sub-section appears to be mis-numbered; it should be numbered (iii). The content of this section is unclear. Is this requirement in addition to the 18 hours per year

required above, or is the intent to count it toward the 18 hours of annual training required of all PRS staff?

§5230.57 Criminal history checks and child abuse certification

This section heading contains a formatting error related to absence of bold typeface.

This section is problematic. Some facilities, especially in rural locations, will serve both age groups, and §5230.15 (3)(ii) seems to allow this flexibility in the service description. The point of the addition of youth services is to smooth transition to adult services. §5230.57 (b) and (c) seem to suggest that a facility serving youth must serve only youth. Suggest insertion of a new sub-section "(d) a facility that serves both age groups must meet the higher standard for youth and young adults under §5230.57 (c) and (d)" and reordering this sub-section to move the current proposed content under (d) to (e).

§5230.61 Assessment

(a)(7)(i.1) I am opposed to this unnecessary change. The LPHA treating the individual may change the diagnosis but not report it to the PRS. This could potentially result in an unfair citation at inspection time, if the PRS facility did not confirm the diagnosis. All of this is adequately covered if the individual requests a change (for any reason), or at the annual update. The diagnosis is not the main force in development of an Individual Rehabilitation Plan. The focus is on the individual's functioning and preferred goals for recovery.

(b)(3) I am opposed to this change. There is a need to keep the reference to health care facilities to ensure that PRS efforts to support staying healthy include physical health, not just mental and behavioral health. Otherwise, the true spirit of the "Wellness" domain is not going to be met. Suggest rewording as follows: "...other health care facilities and human services programs or facilities."

§5230.62 Individual rehabilitation plan

(a)(7) This sub-section is poorly worded with respect to consent. Was it the intent to require "documentation of <u>verbal</u> consent", as stated in the preamble? I suggest adding the word "verbal" to the preceding sentence. This sub-section is poorly worded with respect to signatures. I suggest rewording to include the underlined phrase, as follows: " ….staff working with the individual <u>and the dated signature of</u> the PRS director".

(d)(5) Was the intent to allow for documentation of "verbal" consent as stated in the preamble? I suggest addition of the word verbal.

(d)(6) I support the deletion of this sub-section, which is no longer needed if there is no signature requirement for the individual.

§5230.63 Daily entry

(4) It is understood that, especially with telehealth, this requirement was difficult to meet. However, it is important to still allow the individual the opportunity to review, comment and sign the record when it is written if possible, or at a later day or time. I suggest rewording this

sub-section as follows: "(4) Documents that the individual was offered the opportunity to review, comment and sign and date the entry on request." One of the most important facets of PRS is the partnership and collaboration between the individual and the service provider. This must not be weakened just so that the provider has an easier time achieving compliance.

Thank you for the opportunity to review and comment on this proposed amendment to Chapter 5230. I support adoption of the proposed amendment, with the recommended changes listed above. Please feel free to contact me for additional information as needed.

Respectfully submitted,

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