



14-548-19

Received 8/5/2022



Department of Human Services
Office of Mental Health and Substance Abuse Services
Attention: Laurie Madera, Bureau of Policy, Planning and Program Development
Commonwealth Towers, 11th Floor
303 Walnut Street, Harrisburg, PA 17105
RA-PWPsychRehab@pa.gov

August 8, 2022

Dear Ms. Madera:

Thank you for the opportunity to respond to the proposed rulemaking amendment to PA Code Chapter 5320 - Psychiatric Rehabilitation Services, published as Regulation #14-548 in the Pennsylvania Bulletin on July 9, 2022 under 52 PA.B 3828

My name is Jennifer McLaughlin and I am a Director of Mental Health Services for Community Services Group (CSG). I oversee all of the organization's Site-based and Mobile Psychiatric Rehabilitation Programs. I have worked in Psychiatric Rehabilitation Services (PRS) for more than 27 years. I had the pleasure of serving on the state workgroup that drafted the original regulations as well as the workgroup in 2014 that developed the expansion of Psychiatric Rehabilitation Services to include youth from 14 to 18 years of age.

CSG opened its first PRS in Northumberland County in 1994 under the then Draft Standards. Since that time CSG opened and is operating 5 licenced Clubhouses and 6 licenced Site-based/Mobile Psychiatric Rehabilitation Programs throughout central Pennsylvania. We employ 56 staff members in Psychiatric Rehabilitation Services and serve 533 Pennsylvania citizens.

The following is our response to the request for comment on the proposed regulation.

Preamble

We support the expansion of eligibility for PRS to include youth between the ages of 14 - 17. We believe this will allow for many opportunities for this underserved population.

We support the expansion of the diagnostic criteria for an individual to be eligible for PRS. The addition of these diagnoses will allow for more individuals to access this needed service and also reduce the burden of the exception process for providers.



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We support the elimination of member signatures for each daily entry. This will reduce an unnecessary burden on staff and individuals.

We support the inclusion of LCSW, LPC, and LMFT as Licensed Practitioners of the Healing Arts. This will improve individual's access to PRS and will reduce the burden from individuals and referral sources of obtaining the more restrictive required recommendations.

We support the idea of utilizing Telehealth in PRS. COVID has taught us that Telehealth can effectively be utilized in PRS. However nowhere in the preamble or proposed regulation is telehealth well defined. We have learned through COVID that many of the individuals that we serve do not have access to the equipment needed to participate in a telehealth (video and audio) appointment, although most do have access to telephone (audio only) usage. Additionally through COVID, our experience has been that individuals often prefer and benefit from face to face interaction; however, there are times that is not possible. During those times individuals call us for support and intervention. Case Management and Peer Support Services have learned the value of and are sanctioned to provide telephone service with individuals to ensure safety, provide intervention and support, and provide outreach to name a few; we are asking that PRS be provided that same consideration.

The expansion of location of services is unnecessary and potentially burdensome for OMHSAS and providers. Currently services are able to be provided at the facility or in the community depending upon the program's service description and licensure. To add home as a location, we believe is redundant and will be problematic for the state's oversight agency, providers, and payers. Working with an individual in their home (community) has always been considered part of the community. As long as the provider's licensure and service description identified the community as of service location area, PRS could be provided in the home/community. Adding home will require providers to resubmit their service descriptions to the Department for approval and updated licenses would need to be issued. Additionally this could negatively impact billing as only one location code can be utilized. So for example if an individual is receiving mobile service and the service begins in the individual's home then during the same appointment skills are also worked on in the community how would that be billed? Would 2 bills, thus 2 notes have to be generated? This would not be effective or efficient for the individual receiving service, the provider or the payer.



Annex

5230.3 Definitions

We recommend adding Telehealth and its definition.

5230.4 Psychiatric Rehabilitation Processes and Practices

(b) We recommend not changing the locations as this will require updated licensure, updated service descriptions and OMHSAS approval. It will negatively impact service delivery when the service is in both the community and the person's home; this would require 2 daily entries as billing can only list one location code at a time. We agree that clarification would be beneficial. We recommend the following alternative: *A PRS agency may offer PRS in a PRS facility or in the community which includes the individual's home and is consistent with an approved agency service description.*

5230.15 Agency Service Description

(2.1) Strategies for outreach to and engagement of individuals referred for PRS - This is unclear. When an individual is referred to PRS, staff does outreach to explain the benefits of the service and set up a visit/intake. Typically in PRS "outreach" describes the process that the service completed when an individual already enrolled is not attending the service regularly.

(6) We recommend that the service location be stated as: *The location of service, whether in a PRS facility or in the community, which includes the individual's home or a combination of both.*

5230.31 Admission Requirements

(c) 3. This is redundant. In (c) 2 it describes what the LPHA must include in a referral in the exception process "Documentation that includes a description of a moderate to severe functional impairment in at least one of the following domains...." To ask in (c) 3 for an LPHA to then restate how PRS will benefit the individual is redundant as the goal of PRS is to improve levels of functioning in domains where the person is experiencing moderate to severe impairment. This will put additional burden on providers to ensure that LPHA's are including this. It will be a burden on individual's seeking service and will delay the start of the service as they wait for the LPHA to update the referral.



(d) We recommend that wording should be consistent. Using the word screening is confusing and in our opinion is not as accurate as assessment. . A screening is not the same as an assessment. An assessment is more thorough and lists the skills and resources needed in order for the individual to meet a goal and reduce the functional impairment. The functional assessment is currently completed by the PRS provider staff and the individual at the start of services. The functional assessment is critical to delivering appropriate and effective services.

Eliminating this and replacing it with a screening could eliminate the accuracy of the form as well as the voluntary nature of PRS participation.

5230.32 Continued Stay Requirement

(2) i We recommend that the term skill deficit remain. Keeping both functional assessment and skill deficit better describes the need for an individual's continued stay.

5230.52 General Staffing Requirements

(e) 2 We recommend removing the word *home* as the community covers the individual's home as it is in their community.

5230.53 Individual Services

We recommend removing the work *home* as the community covers the individual's home as it is in their community.

5230.55 Supervision

We support removing the words *face to face* as we have learned through COVID that supervision can be competently completed without being face to face. We do recommend that there be an addition in the regulation that allows seasoned staff (those that have maintained successful employment with the PRS program for more than 1 year) be allowed to have individual supervision a minimum of one time a month.

5230.61 Assessment

(7) i.1 We recommend that this line be eliminated. Psychiatric Rehabilitation is a recovery/resiliency program that is strength based. We focus not on diagnosis but instead on



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functionality and skill acquisition. Because PRS is not a clinical service we do not diagnose individuals and do not have access to changes in diagnosis unless the individual in service chooses to share that information with us, beyond the initial referral diagnosis.

5230.62 Individual Rehabilitation Plan

(7) We support the review and signature of the PRS Director. We request clarification on the timing of the dated signature of the PRS Director. There is confusion regarding when an individual rehabilitation plan becomes effective. Is it "live" when the individual and staff person develop and complete the plan? Then the PRS Director reviews and signs the plan. Or does the plan become "live" after all three signatures are obtained? We recommend that the plan becomes "live" upon the signature of the staff and member. It would be a burden to the program and the individual if the PRS Director signature is required to make the plan "live". As per regulation the PRS Director is required to be on site an average of 7.5 hours per week in a calendar month. We recommend the following wording change:

(7) Dated signatures of the individual and the staff working with the individual or documentation of consent to the IRP by the individual and the date consent was provided and the dated signature of the staff working with the individual.

(8) Dated signature of the PRS Director indicating review and approval of plan.

5230.63 Daily Entry

(4) We support the removal of the requirement of obtaining individual signatures on the daily note.

5230.81 Quality Improvement Requirements

(1) (iv) and (iv.1) These added requirements of tracking the number of individuals and their average length of stay will provide an additional burden to providers. This information would be more easily tracked by payers of the service.



Again, we thank you for the opportunity to comment on the proposed proposed rulemaking amendment to PA Code Chapter 5320 - Psychiatric Rehabilitation Services, published as Regulation #14-548 in the Pennsylvania Bulletin on July 9, 2022 under 52 PA.B 3828.

Sincerely,

Jennifer McLaughlin
Director of MH Services
Community Services Group