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PAPRS
PENNSYLVANIA ASSOCIATION FOR PSYCHIATRIC REHABILITATION SERVICES
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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
Commonwealth Towers, 11th Floor
303 Walnut Street, Harrisburg, PA 17105
RA-PWPsychRehab@pa.gov

August 8, 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 as Regulation #14-548 in the *Pennsylvania Bulletin* on July 9, 2022, under 52 Pa.B 3828.

On behalf of the Pennsylvania Association of Psychiatric Rehabilitation Services (PAPRS), we are submitting the following comments regarding the Department's "as proposed" amendments to 55 Pa. Code Chapter 5230 - Psychiatric Rehabilitation Services. We are a 501(c) (3) organization representing the providers and recipients of PRS in the state. We represent 35 individual members and 61 organizational members who employ 915 Psychiatric Rehabilitation staff. We are the largest State Chapter of the Psychiatric Rehabilitation Association (PRA), a national organization whose focus is to grow and train the recovery workforce. We are actively involved in advocating for Psychiatric Rehabilitation Services throughout the state of Pennsylvania and providing training, education, and consultation to our members on the delivery of effective psychiatric rehabilitation services.

We appreciate having been part of the workgroup and the opportunity to provide input in the development of this amendment. The following is our response to the request for comment on the proposed amendment.

Preamble

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

We would like to point out that psychiatric rehabilitation services are recovery-oriented services, not medical, clinical, or therapeutic services. PRS is an evidenced-based approach utilizing strength-based interventions that focus on functioning in life roles and environments using skill building and support development. PRS does not focus on the medical diagnosis or the impairment, the focus is on strengths and skills already in place as well as those that need to be developed to improve functioning.

We support the broadening of the list of diagnoses eligible for PRS. This will assist in opening access to PRS and help to eliminate the need for as many exceptions.

We support the elimination of the individual's signature for each daily entry. This will reduce the obstacle that providers experience during telehealth services and reduce the paperwork requirements.

We support the addition of LCSW, LPC, and LMFT as Licensed Practitioners of the Healing Arts (LPHA). This will improve an individual's access to PRS and will reduce an obstacle for the individual to obtain the required recommendation.

We appreciate that the Preamble identifies telehealth for psychiatric rehabilitation services and supports its use in PRS. We are concerned that telehealth or the revised guidelines for the delivery of telehealth services under bulletin OMHSAS-22-02 are not referenced in the Annex and we will include specific comments in the Annex section. Our intent is to reduce the confusion for PRS providers and members.

We will address specific areas of both approval and concern under Annex A.

Annex A

§5230. 3 Definitions

We suggest adding a definition for the term "Telehealth."

We suggest including a reference to services including the use of the telephone, at least in a limited way. We support the use of audio only services as allowed in the Peer Support Services Bulletin, which limits telephone-only services to 25% of all services provided per calendar year. Many individuals do not have access to technologies needed to support telehealth as defined.

We support the addition of the fifth domain; however, the wording of the definition of the Wellness domain is vague and does not clearly define what is intended. In our profession, wellness encompasses eight different dimensions: physical, intellectual, emotional social, spiritual, vocational, financial, and environmental. Wellness is a holistic integration of activities and lifestyle intended to enhance all the life domains listed in the regulation. If the intent is to create a new domain with a focus on health – either physical or mental health – that assures focused psychiatric rehabilitation goals, then a different domain name is needed. Under the existing Chapter 5230, these goals were included in the Living domain. We are not opposed to a separate domain but suggest the domain name be changed to Health Self-Maintenance and defined as 'A life domain that is focused on attaining and sustaining optimal physical, behavioral and mental health'.

§5230. 4 PRS processes and practices

(a) The term 'wellness' being used is not clear. We suggest rewording consistent with the name and definition changes suggested above in §5230.3.

(f) The addition of the phrase "or in the individual's home" in the Preamble and in this section seems to be intended to remove an obstacle to telehealth. However, the home has always been an acceptable community location for PRS, as opposed to PRS offered in the facility. Some PRS programs provide only facility-based services, some provide only community-based services, and some provide both, consistent with an approved service description. The physical license is coded accordingly. We are concerned that this new distinction will create a paperwork burden to revise service descriptions, re-code license documents, and revise billing practices with the Managed Care Organization. The distinction may also create confusion for billing when the service starts in the home, and then moves to a community location. We suggest that the section be re-worded as follows: "A PRS agency may offer PRS at a PRS facility or in the community, which may include the individual's home, or both."

§5230. 31 Admission Requirements

(a)(4) We oppose the deletion of the requirement for an individual to choose to receive PRS. We note that this requirement was not deleted in the Continued Stay section. Individual consent is fundamental to PRS principles.

(b) and (d) We oppose the requirement under (d) for the PRS to conduct a functional impairment screening upon admission because screening is different from an assessment. An assessment is more thorough and lists the skills and resources needed for the individual to achieve a goal. The assessment is currently required under 5230.61 prior to developing the Individual Rehabilitation Plan (IRP) and does not need to be done twice. This assessment is based upon functioning and goals, not upon the medical diagnosis. PRS focuses on functional and resource assessments of skills and supports needed for success in a goal environment of choice. It is completed by the PRS provider staff and the individual collaboratively at the start of services. An assessment of functioning is critical to delivering appropriate and effective services. Eliminating the term assessment and replacing it with screening could circumvent the purpose of the assessment, eliminate the accuracy of the form, and negatively affect the voluntary collaborative nature of PRS participation. OMHSAS has published a sample Functional Assessment Tool at https://www.dhs.pa.gov/Services/Mental-Health-in-PA/Pages/CDP-Provider-Information.aspx , and the tool is widely used by many PRS provider agencies. A change could also create an unnecessary paperwork burden.

(c) (3) The LPHA must now detail the expected benefit of PRS, and this adds burden onto PRS providers through recreating forms and overseeing proper completion by LPHA. The documentation that must be included on the LPHA is unclear. Often the LPHA is aware of broad need areas but is not aware of the individual's specific goals and objectives because those are developed and chosen by the individual in a collaborative process with PRS staff, and therefore cannot accurately propose an expected benefit of PRS participation. We suggest that this new requirement be deleted from the final form of the Chapter.

§5230. 32 Continued stay requirements

(b)(2)(i) We oppose the negative language in (b)(2)(i), and suggest this sub-section be re-worded to focus on strengths-based approaches, as follows: "As a result of a serious mental illness or serious emotional disturbance, there are domains of functioning that continue to be addressed in the IRP."

§5230. 51 Staff qualifications

We recommend clarification under this section. PRS workers and PRS assistants are eligible to work in agencies that serve youth and must have the same credentials as PRS workers and assistants who work only with adults.

Also, PRS specialists that work in an agency that serves both youth and adults would have to meet the higher standard required to work in the program serving youth and young adults.

§5230. 53 Individual Services

Please see the comments related to the delivery of telehealth services (§5230.3) and the addition of the phrase "in the home" (§5230.4). We recommend that this section include language that allows individual services to be delivered by telehealth.

§5230. 54 Group Services

Please see the comments related to the delivery of telehealth services (§5230.3) and the addition of the phrase "in the home" (§5230.4). We recommend that this section include language that allows individual services to be delivered by telehealth.

§5230. 56 Staff training requirements

(2) We support the addition of resiliency training; however, this section is unclear. Will the six hours of training that is focused on youth services count toward the requirement for 12 hours of recovery and/or resiliency training? Is the intent that 6 out of the 12 recovery or resiliency focused training hours are further focused on youth, or is the requirements for 6 hours in addition to the 12 recovery or resiliency focused hours? Or does this section mean 6 out of the 18 training hours required annually? Does OMHSAS intend to revise the content of the required 12-hour Orientation to PRS course to include topics in youth services?

(3)(ii) In this section the word "mentoring" is being used. This needs a clear definition. How is this different from or similar to training, supervision, or on the job support?

§5230.61 Assessment

(b)(3) We propose keeping the term "health care facilities" due to the importance that health care facilities have on an individual's physical wellness. We suggest re-writing this subsection as follows: "Identify existing and needed natural and formal supports, including other health care facilities and human service programs."

(b)(6) We suggest that keeping the requirement that the individual sign the assessment (or document verbal consent to sign the assessment) and delete the phrase that documentation of the assessment was

reviewed with the individual and the date of the review. Retaining the signature (including documenting verbal agreement to sign) confirms the collaborative standard between staff and the individual. We recommend that the language include a provision to document verbal confirmation of intent to sign the assessment, as may be needed in a telehealth situation. We recommend the following language which is more consistent with that of the requirements of the IRP: "Dated signatures of the individual, the staff working with the individual, or documentation of consent to the assessment by the individual, the date consent was provided and the dated signature of the staff working with the individual."

(b)(7)(i1) The requirement to update the assessment upon a change in diagnosis is unclear. PRS is focused on functioning in environments of choice, not on the medical diagnosis. The change in diagnosis may not have a direct impact on the functioning of the individual. We recommend removal of the word "diagnosis" from this section. We suggest the following: "The individual's identified needs change."

§5230. 62 Individual Rehabilitation Plan

(a)(7)) We suggest keeping the requirement that the individual sign the IRP or document that verbal consent to sign the IRP was obtained to confirm the collaborative standard between staff and the individual. We recommend that the language include a provision to document verbal confirmation of the intent to sign the IRP, as may be needed in a telehealth situation.

(d)(5) and (d)(6) We support the proposed changes in these subsections.

§5230. 63 Daily Entry

(4) We agree and support eliminating the need for the individual's signature on the daily entry.

PAPRS appreciates having been included in the original workgroup. We support adoption of the proposed amendment with the changes recommended above. Thank you for the opportunity to provide public comment.

Respectfully submitted,

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President of the Board of Directors
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