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Independent Regulatory Review Commission

SALISBURY BEHAVIORAL HEALTH, LLC
A DIVISION OF RHA HEALTH SERVICES

PAHrtners DEAF SERVICES
A DIVISION OF RHA HEALTH SERVICES

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 5, 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 Salisbury Behavioral Health, LLC and PAHrtners Health Services, both Divisions of RHA Health Services, we are submitting the following comments regarding the Department's "as proposed" amendments to 55 Pa. Code Chapter 5230 - Psychiatric Rehabilitation Services. Salisbury Behavioral Health operates three licensed Psychiatric Rehabilitation programs serving individuals in Lehigh, Northampton, Carbon, Monroe, and Pike Counties. PAHrtners Deaf Services in Montgomery County, provides access to the historically underserved population of Deaf or Hard of Hearing individuals in the five-county southeastern Pennsylvania region.

We appreciate the opportunity to provide input on the development of this amendment. The following is our response to the request for comment on the proposed amendment.

Preamble Comments

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

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

We support the revisions of outdated language and the alignment of current language and terminology used by the Federal Substance Abuse and Mental Health Services Administration.

In the Background section of the Preamble, PRS is described as an "integrated therapeutic approach". 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 (live, learn, work, and social). This is achieved through 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. It should also be noted that wellness is mentioned in this section, and we will comment on this later.

We support that telehealth is being identified for psychiatric rehabilitation services and supports as referenced in the Preamble. 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.

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 will address any other 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 'wellness' as a fifth domain. However, wellness should have a clear definition for intended use. In our profession, we understand that wellness incorporates many dimensions of health, each of which is interconnected within an individual's total well-being. We utilize SAMHSA's wellness initiative supporting the eight dimensions encompassing: physical, intellectual, emotional, social, spiritual, vocational, financial, and environmental. Wellness is more than the absence of disease or stress. Wellness involves having purpose in life; active involvement in satisfying work and play; joyful relationships; a healthy body and living environment; and happiness. (Dunn 1961)

We support the addition of the terms: ''Associate's degree'' and ''Bachelor's degree'' to ensure that staff providing PRS have obtained degrees from properly accredited educational institutions.

We support the requirement of the ''Child and Family Resiliency Practitioner (CFRP)'' certification for staff who provide PRS to individuals 14 years of age or older but under 18 years of age.

We support the language revisions of ‘'Serious emotional disturbance'' and ''Serious mental illness'' to define the conditions required for use of the exception process for admission to PRS and to align the definitions used in Chapter 5230 with the definitions currently used by the Federal Substance Abuse and Mental Health Services Administration.

We support the deletion of the definition of ''Axis I'' to be consistent with the current version of the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM).

We support the revisions to the definitions of ''DSM-IV-TR'' and ''ICD-9'' to allow for the use of successor versions of the DSM and ICD.

We support the deletion of the term ''Face-to-face'' from the proposed regulations.

We support the revision to the outdated names of organizations. ''International Center for Clubhouse Development (ICCD)'' and ''The United States Psychiatric Rehabilitation Association (USPRA)''.

We support the definition of ''Full-time equivalent'' by deleting references to ''calendar.''

We support the amendment of the term ''Coordination of care'' to ''Coordination of services'' at the request of stakeholders to reduce the perceived stigma associated with individuals receiving PRS.

We support amending the definition of ''Functional impairment'' to be more specific to the admission requirements for PRS.

We support amending the definition of ''Individual'' to clarify that individuals 14 years of age or older may receive PRS.

We support deleting the term ''individual'' from the definition of ''Licensed practitioner of the healing arts (LPHA)'' to clarify the definition.

We support revising the definition of LPHA to include licensed clinical social workers, licensed professional counselors and licensed marriage and family therapists because the Social Workers, Marriage and Family Therapists and Professional Counselors Act (63 P.S. §§ 1901—1922) to allow licensed clinical social workers, licensed professional counselors and licensed marriage and family therapists to diagnose and treat mental and emotional disorders as part of the scope of their practice.

§5230. 4 PRS processes and practices

(a) We support the term ‘wellness’ being used if a clear definition is made as suggested above in §5230.3.

(f) We oppose the separation and addition of the phrase "or in the individual's home" in the Preamble and in this section as a service location. An individual's 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. This is described and approved in an agency service description. The physical license is coded accordingly. We are concerned that this new distinction will not only create confusion to revise service descriptions and re-code license documents, but also have an impact on billing practices. For example, when the service starts in the home, and then moves to a community location, then concludes in the home. 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. 13 Agency records

We support the proposed rulemaking changes suggested in this section.

§5230. 15 Agency service description

(6) We oppose the addition of "home" as a separate versus inclusive location of community services as addressed in §5230.4(f).

We support the other proposed rulemaking changes suggested in this section.

§5230. 16 Coordination of services

We support the proposed rulemaking changes suggested in this section.

§5230. 21 Content of individual record

We support that the proposed rulemaking provides for parental or caregiver consent to receive PRS if the individual is under 18 years of age and allows for the release of records with the individual's consent or parent's or caregiver's consent if the individual is under 18 years of age to family members and other supports, as appropriate.

(8) We support the addition of the requirement that staff document coordination with other services and supports.

(i) and (ii) We oppose the phrase "A description". This can lead to interpretation not only by staff but also auditors and are recommending that this be removed from the proposed rulemaking and reworded as follows:

(8) Staff documentation of coordination with other services and supports [.], **including:**

(i) Outreach and engagement efforts with natural supports, including family members, as directed by the individual.

(ii) <u>Ongoing contacts and involvement with formal supports.</u>

§5230. 22 Documentation standards and record security, retention and disposal

We support the proposed rulemaking changes suggested in this section.

§5230. 31 Admission Requirements

(a)(2)(i-ix) We support the inclusion of the additional diagnoses, consistent with the current version of the Diagnostic and Statistical Manual (DSM-5) as well as to reduce the use of exceptions for adults, and to prevent unnecessary use of exceptions for youth. However, we would like to advocate for the addition of autism spectrum disorder (ASD). PRS has been shown to be a beneficial service for individuals diagnosed with ASD who can self-identify their overall rehabilitation goal. In addition, ASD has been a focus in other State recovery planning including the OMHSAS Call for Change.

(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. The current assessment is thorough and lists the skills and resources needed for the individual to achieve a goal. It is also required by current regulations to be completed prior to developing the Individual Rehabilitation Plan (IRP). Completing the assessment twice would be redundant and frustrating for the individual in services. PRS focuses on functional and resource assessments of skills and supports needed for success in an environment of choice to achieve a valued role. 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.

We support the other proposed rulemaking suggestions in this section.

§5230. 32 Continued stay requirements

We support the proposed rulemaking changes suggested in this section.

(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. 42 Nondiscrimination

We support the proposed rulemaking changes suggested in this section.

§5230. 51 Staff qualifications

We support the proposed rulemaking changes suggested in this section. However, we do have a few matters to address. First concerns the fiscal impact that was referenced in the preamble. We do need to point out that there is a greater fiscal impact on practitioners and agencies than identified in the Preamble. In addition to the $395 for the cost of the CFRP certification there will also be training costs that were not addressed. Specifically, those that will qualify an individual to gain the knowledge, skills, and abilities to pass the certification exam. Additionally, although not addressed, we wanted to address the added fiscal cost for individuals to maintain dual certifications. Three-year costs per re-certification currently ranges from $129 to $315. This does not include the cost of trainings required to get and maintain certifications. It has not been established if PRA will recognize a single training certificate to count toward CEUs for both CPRP and CFRP certifications or if a practitioner will need additional training to meet required training hours for the two certifications. Some organizations also charge additional fees if more than one type of continue education CEU is being requested, again adding to the potential fiscal impact that needs to be taken into consideration.

§5230. 52 General staffing requirements

We support the proposed rulemaking changes suggested in this section.

§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.

(a)(3) We would like to offer comment regarding this proposed addition. It is our understanding that this addition is referencing services related to telehealth. However, a lesson learned over the past two years has been the power of peer support for recovery. Current practice includes involving the consideration of the personal preferences of an individual and informing an individual of the location of where the group is to meet. If two individuals are willing to work on skills together as agreed prior in one individual’s home, why would this be denied?

(f.1) We would like to offer comment regarding this proposed addition. "Only individuals who receive PRS from the PRS agency may be included in group services delivered in the community." If this statement is interpreted literally, it would exclude participation in any community activity involving natural supports. As mentioned in the Preamble "PRS promotes recovery and resiliency, full community integration and improved quality of life for individuals…". We recommend that this be clarified regarding confidentiality, which is addressed or if referring to a billing concern.

§5230. 55 Supervision

We support the proposed rulemaking changes suggested in this section.

§5230. 56 Staff training requirements

(2)(i) and (ii) We would like to offer comment regarding the inconsistency regarding the focus areas of training. We support that if the PRS agency serves individuals 14 years of age or older but under 18 years of age, that 6 of the required 12 hours "shall be specifically focused on youth services". However, we feel that all PRS staff providing services in a PRS agency shall complete 18 hours of training per calendar year and suggest that 12 hours of the required training shall be specifically focused on psychiatric rehabilitation, recovery practices, or resiliency.

(3)(ii) In this section, the word "mentoring" is being used. We ask for a clearer definition. How does this differ from training, supervision, or on the job support?

We support the other proposed rulemaking suggestions in this section.

§5230. 57 Criminal history checks and child abuse certification

We support the proposed rulemaking changes suggested in this section.

§5230.61 Assessment

(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 rewording: "The individual's identified needs change."

We support the other proposed rulemaking suggestions in this section.

§5230. 62 Individual Rehabilitation Plan

We support the proposed rulemaking changes suggested in this section.

§5230. 63 Daily Entry

We support the proposed rulemaking changes suggested in this section.

§5230. 81 Quality improvement requirements

We support the proposed rulemaking changes suggested in this section.

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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