

SECOND EDITION – 2/1/01

**PSYCHIATRIC REHABILITATION MEDICAL NECESSITY
CRITERIA AND STANDARDS**

PSYCHIATRIC REHABILITATION MEDICAL NECESSITY CRITERIA

I.	Admissions	3
II.	Continued Stay	3
III.	Discharge	4

STANDARDS

I.	Program Description	
	A. General Program	5
	1) Scope	5
	2) Description of Services	5
	3) The Psychiatric Rehabilitation Program	6
	B. Specific Programs	8
	1) Site-based Services	8
	2) Mobile Services	11
	3) Concurrent use of Site-Based and Mobile	13
II.	Provider Enrollment/Organization	
	A. Provider Eligibility	13
	B. Provider Responsibility	14
	C. Initial Program Description	15
	D. Linkages	16
	E. Organization and Structure	16
III.	Program Requirements	
	A. Staff Qualifications	17
	B. Staff Training Requirements	18
	C. Record Keeping	19

1)	Provider Records	19
2)	Consumer Records	20
D.	Continuous Quality Improvement	21
E.	Conflict of Interest	22
F.	Consumer Rights	22
1)	Consumer Participation and Freedom of Choice	22
2)	Confidentiality and Nondiscrimination	22
3)	Complaint and Grievance Process	23
DEFINITIONS FOR PSYCHIATRIC MEDICAL NECESSITY CRITERIA AND PSYCHIATRIC REHABILITATION STANDARDS		23
Attachment I Relationship of Psychiatric Rehabilitation to other Services		25
Attachment II International Association of Psychosocial Rehabilitation Practice Standards		31

PSYCHIATRIC REHABILITATION MEDICAL NECESSITY CRITERIA

I. ADMISSION

Admission criteria includes the following:

- A. The person is 18 years or older and has the presence or history of a serious mental illness, based upon medical records, which includes one of the following diagnoses by a psychiatrist: schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder or borderline personality disorder. 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.

AND

- B. As a result of the mental illness, the person has a moderate to severe functional impairment that interferes with or limits role performance in at least one (1) of the following domains: educational (i.e., obtaining a high school or college degree); social (i.e., developing a social support system); vocational (i.e., obtaining part time or full time employment); self maintenance (i.e., managing symptoms, understanding their illness, managing money, living more independently) relative to the person's ethnic/cultural environment.

AND

- C. The person chooses to participate in the program.

II. CONTINUED STAY

- A. An assessment appropriate to the model of PRS as specified in the standards, indicates at least one (1) of the following:
- 1) As a result of the mental illness, there are or continue to be functional impairments and skill deficits which are effectively addressed in the psychiatric rehabilitation plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues.

OR

- 2) There is a reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the consumer.

OR

- 3) A change in program or level of service is indicated and a transition plan is in place reflecting the proposed change.

AND

- B. The person chooses to continue participation in the program.

III. DISCHARGE

Must meet criteria A and B, or C, or D and E

- A. The person is not expected to receive additional rehabilitative benefit from the program

AND

- B. There is a reasonable expectation that the withdrawal of services will not result in loss of rehabilitation gains or goals attained by the consumer.

OR

- C. The person has successfully achieved rehabilitation goals and sustained them for a period of time as designated in the rehabilitation plan

OR

- D. The person voluntarily terminates from the program

AND

- E. Upon discharge or termination the person is informed of his/her rights and the process for appeal.

PSYCHIATRIC REHABILITATION STANDARDS

I. PROGRAM DESCRIPTION

A. General Program

1) Scope.

These standards establish the minimum requirements for the provision of both site-based (clubhouse and other site-based psychiatric rehabilitation) and mobile psychiatric rehabilitation for individuals with serious mental illness as defined by the Department of Public Welfare. They are applicable to psychiatric rehabilitation providers under the HealthChoices initiative; and they may also be used as best practice guidelines by psychiatric rehabilitation providers who are funded by their respective counties.

2) Description of Services.

Psychiatric rehabilitation assists persons, 18 years or older, with functional disabilities resulting from mental illness to develop, enhance, and/or retain: psychiatric stability, social competencies, personal adjustment and/or independent living competencies so that they experience more success and satisfaction in the environments of their choice and can function as independently as possible. These interventions should occur concurrently with necessary clinical treatments and should begin as soon as clinically possible, following diagnosis. A planned program of goal setting, functional assessment, identification of needed and preferred skills and supports, skill teaching and managing supports and resources is needed to produce the desired outcomes consistent with a person's cultural environment.

Psychiatric rehabilitation programs are founded on the principles of consumer choice and the active involvement of persons in their rehabilitation. Psychiatric rehabilitation practice is guided by the basic philosophy of rehabilitation that people with disabilities need opportunities to identify and choose for themselves their desired roles in the community with regard to living, learning working and/or social environments.

Psychiatric rehabilitation programs provide both informal and formal structures through which participants can influence and shape program development. The practice of psychiatric rehabilitation, is comprised of three strategies:

(1) helping persons identify goals; (2) helping persons plan strategies and acquire necessary skills to reach and maintain desired goals; and 3) helping persons develop necessary supports to maintain those goals.

Agencies may provide site-based (clubhouse and other site-based psychiatric rehabilitation) and/or mobile psychiatric rehabilitation services.

Practices employed in Psychiatric Rehabilitation programs aim to assist persons to develop, reach and maintain goals of their choice in the community. Practices include:

- Engaging persons in the program
- Assessing with the person his/her interest and preferences for rehabilitation services
- Developing rehabilitation plans
- Defining the person's preferences regarding a rehabilitation environment
- Educating the person about mental illness and recovery
- Helping the person learn about what is available in the community and identifying options the person may be interested in pursuing as rehabilitation goals.
- Assessing what the person needs and prefers in terms of skills and supports to develop, achieve and maintain rehabilitation goal(s)
- Direct or indirect skills teaching
- Assisting the person in gaining and utilizing supports and resources including linking the person with appropriate community services that are mindful of cultural content
- Advocating for the person as needed
- Creating a socio-cultural environment which supports recovery
- Developing and implementing strategies to assist the person in developing, achieving and maintaining rehabilitation goal(s)

These psychiatric rehabilitation activities/techniques are designed to provide the person with the opportunity to: (1) become informed about the illness; (2) assess what is needed to recover; (3) choose rehabilitation goal(s); and (4) plan for and obtain the experiences needed to develop the skills to achieve recovery. A key element of rehabilitation is experiencing a valued role in the community and obtaining and using the power to make choices about one's life. Such experiences are essential to the cognitive and behavioral change that underpin the recovery process for any person.

3) The Psychiatric Rehabilitation Program

The psychiatric rehabilitation process consists of three phases - assessment, planning and implementation. Each phase involves the

person, the person's chosen support system and service provider in designing the development of wanted and needed skills and supports relevant to the person's background:

- a. A functional or goal-based individualized assessment includes the completion of an evaluation of social and environmental supports and an evaluation of strengths and unmet needs in areas of psychosocial functioning as they relate to the person's goals and priorities consistent with the person's culture.
- b. Planning includes developing a participant-specific rehabilitation plan which establishes goals and objectives and plans for skill and support development. The plan development process involves both staff and participant (if he/she chooses) involvement using methods appropriate to the psychiatric rehabilitation program model. The plan and updates must include:
 - i) Progress reviews that demonstrate shared staff and participant responsibility for evaluating progress in goal areas.
 - ii) Progress notes that should be signed by the participant and the staff. If the participant's signature is not present, the reason must be documented.
- c. In site-based programs, the implementation of services may take place individually or in groups. In mobile programs, services are delivered individually (or for up to two persons, as outlined under mobile description). The following are examples of appropriate services which should be addressed consistent with the person's culture.
 - i) Psychoeducation: Mental health education regarding self-management of symptoms, medication and side effects.
 - ii) Health education: Education regarding optimal physical health.
 - iii) Assessing rehabilitation preferences: Determining with the person his or her personal perspectives and preferences regarding participation in the psychiatric rehabilitation process.
 - iv) Setting rehabilitation goals. This is the process by which the person chooses desired rehabilitation goal(s).
 - v) Functional Assessment: Determining with the person the

specific skills and supports or resources the person needs and prefers to develop, achieve and maintain rehabilitation goal(s)

- vi) Skills Teaching and Development: Providing persons with needed and desired skills to develop, achieve and maintain rehabilitation goals. Teaching methods may be direct or indirect. Examples of areas for skill teaching/development include:

- Solving problems
- Maintaining the living environment
- Managing resources
- Using public transportation
- Planning menus and preparing food
- Skills for self-care
- Skills for socializing
- Skills for budgeting
- Communication and interpersonal skills
- Pre-vocational and vocational supports

- d. The psychiatric rehabilitation program may provide the following services which are not Medicaid reimbursable.

- i) Vocational activities or training such as job development, placement and coaching that prepare an individual for a specific job.
- ii) Educational services including GED programs or educational programs that prepare persons for a particular trade.

B. Specific Programs

1) Site-Based Services

a. Description/Characteristics of Site-Based Services

- i) Site-based programs include the clubhouse model and other approaches that may draw upon a combination of models such as the clubhouse model, the Boston University approach, and social skills training model.
- ii) Site-based programs that choose to operate as a clubhouse model must be certified as a clubhouse through the International Center for Clubhouse Development (ICCD).

- iii) ICCD certification must be received within two years of start-up.
- iv) Services are provided primarily at a specific program facility.
- v) Many services are provided in groups.
- b. Indicators for site-based services:
 - i) Person is willing and able to participate in groups.
 - ii) Person is interested in participating in a variety of site-based experiences as part of choosing a goal.
 - iii) Specific skills, supports and experiences needed for the person to be able to accomplish his/her PR goals are available in the context of the site-based program.
 - iv) Person chooses to participate in the program.
- c. Staffing Pattern for Site-Based Services
 - i) The program must be supervised by a program director.
 - ii) The ratio of staff to participants in site-based psychiatric rehabilitation programs must be based upon the needs of the population served, the program model, and program location (urban vs. rural) as well as other factors that may impact ratios.
 - iii) Staffing patterns should be outlined in the program description included in the contract between the county/managed care organization and the provider.
 - iv) Programs must have a minimum of one full-time equivalent staff for every ten participants based upon average daily attendance. Programs do not have to meet these staff to client ratio standards if they are accredited by one of the national accrediting organizations or if they are certified by the International Center for Clubhouse Development (ICCD).
 - v) At least one psychiatric worker or specialist must be present at all times.

- vi) A minimum of 25% of the staff must be a specialist or above, within a one year timeframe.
 - vii) Staff will reflect the cultural diversity of the participant population.
 - viii) Trained staff will be available or other accommodations made to address the language needs of participants, including signing, braille, and foreign language.
 - ix) Site-based staff must receive weekly case supervision, appropriate to the model being used, by the director or specialist.
 - x) Site-based staff must be employed by an agency approved by the Department of Public Welfare to provide psychiatric rehabilitation services.
- d. Case Records for Site-Based Services
- i) Rationale for the service must be identified and provided to the payor by the first day of service.
 - ii) An initial planning process must begin upon the first day of attendance and an individualized, person-specific rehabilitation assessment and plan (as outlined in Consumer Records), must be developed by the 20th day of attendance not to exceed two months from the date of admission and must be reviewed and revised every three months thereafter.
 - iii) The case record (as outlined in Consumer Records), must include monthly progress notes for site-based rehabilitation.
- e. Physical Facility
- i) Adequate space, equipment and supplies must be provided in order that services can be provided effectively and efficiently. Décor is to reflect the participants' cultures (see attached CSP indicators). The facility must be readily accessible to the consumer and community served.
 - ii) Program space, equipment and furnishings must be separate and distinct from other services within the facility.
 - iii) Programs space, furnishings and equipment must be well

maintained.

- iv) Applicable federal, state and local requirements for fire, safety and health must be met.
- v) There must be office space that is suitably equipped with chairs, desks, desks, tables and other necessary equipment.
- vi) Adequate space must be available, as needed, in the event that privacy is indicated or requested by the participant.

2) Mobile Services

a. Description/Characteristics of Mobile Services

- i) The service is generally designed to be a short term intervention based upon individual goals.
- ii) Mobile services are generally provided on a weekly basis for a limited number of hours (up to six hours/week).
- iii) Requests for services above six hours/week must be approved through a program exception process that is developed by the BMHCO.
- iv) Services are provided in the community such as at the person's home, an educational setting or other community setting.
- v) Community resources are used rather than program-based resources.
- vi) Services are on an individual (1:1 basis) and are face-to-face. Note: On a case by case basis, a 2:1 staffing approach may be used in certain situations when two clients are working on similar goals. All services to be delivered on this basis must have approval from both clients involved in the service as well as from the county or managed care organization.
- vii) The use of community-based services and supports is expected to promote the person choosing, getting and keeping psychiatric rehabilitation goals.

b. Indicators for MPR services:

- i) The person is currently unable to attend a site-based

service, OR

- ii) The person is setting a goal which needs substantial community exploration or practice. Example:* person is planning to live independently in his/her own house or apartment in the community, OR
- iii) The nature of the person's goal indicates the preferred site for service delivery and supports is the community. Example:* person is returning to college to complete a college degree, OR
- iv) The person is already in a role in a community site and needs MPR services to be successful and satisfied in this role.

*Note: Examples are illustrations of possible services and are not meant to limit psychiatric rehabilitation goals to these services.

- v) The person chooses to participate in a mobile program.

c. Staffing Patterns for Mobile Services

- i) MPR services are provided on a one-to-one and face-to-face basis. MPR services may be provided on a 1:2 basis when justified; approved by both clients and approved by the county or managed care organization.
- ii) The ratio of staff to the number of MPR recipients must be adequate to support the services required by individual rehabilitation plans.
- iii) Staffing patterns should be outlined in the program description included in the contract between the county/managed care organization and the provider.
- iv) Staff should reflect the cultural diversity of the participant population.
- v) MPR services must be provided by a psychiatric rehabilitation worker or psychiatric rehabilitation specialist. Services may be provided by a psychiatric rehabilitation assistant only in the presence of a psychiatric rehabilitation worker or specialist.
- vi) Mobile staff must receive weekly case supervision from a

psychiatric rehabilitation specialist or psychiatric rehabilitation program director.

- vii) Mobile staff must be employed by an agency approved by the Department of Public Welfare to provide psychiatric rehabilitation services.
- viii) Mobile services must be administered from the approved agency and all records maintained on site.

d. Case Records for Mobile Services

- i) Rationale for the service must be identified and provided to the payor by the first day of service.
- ii) An individualized, person-specific rehabilitation assessment and plan (as outlined in Consumer Records), must be developed within the first five visits (not to exceed 30 days) and must be reviewed and revised every three months.
- iii) The case record (Consumer Records), must include progress notes for each encounter in mobile rehabilitation.
- iv) The records should also include documentation of duration of and scope of services provided during each visit.

3) Concurrent use of Site-Based and Mobile Services.

Mobile and site-based psychiatric rehabilitation can be provided concurrently under certain limited circumstances as follows:

- a. The person is transitioning to a site-based service and needs assistance in the transition.
- b. The person is transitioning from site-based to mobile and needs assistance in this transition.
- c. Specific issues have been identified which require both services.

II. PROVIDER ENROLLMENT/ORGANIZATION

A. Provider Eligibility

- 1) County MH/MR programs and public and private agencies under the HealthChoices initiative are eligible to enroll under the Medical Assistance Program as providers of psychiatric rehabilitation services if

they are so designated by a county MH/MR program or MCO.

- 2) Providers seeking federal reimbursement for psychiatric rehabilitation services must meet the provisions of these standards, and be eligible to provide specific, approved site-based (clubhouse or other site-based) and/or mobile psychiatric rehabilitation services.
- 3) Providers must complete and submit an Enrollment Information Packet which will permit federal share reimbursements through Medical Assistance.
- 4) Providers must sign a provider agreement, as specified in Chapter 1101 (relating to Medical Assistance general provisions), to participate as providers of psychiatric rehabilitation services.

B. Provider Responsibility

- 1) The psychiatric rehabilitation provider shall:
 - a. Show evidence of embracing psychiatric rehabilitation principles through the development of an organizational culture committed to those principles. Such evidence should initially be found through a written plan defining the mission, vision, values of the organization, as well as strategic, operational, and program-related materials designed around fundamental psychiatric rehabilitation principles. The principles listed below, although not exhaustive, are key indicators of a psychiatric rehabilitation program:
 - i) CSP principles serve as foundation for all community services. (See "Indicators of the Application of CSP Principles" attached).
 - ii) Services are person-centered and empowering.
 - iii) Services are always focused on strengths and wellness, not on deficiencies or illness.
 - iv) Services are community-based with emphasis on development of on-going natural supports.
 - v) Services and assessments are consistent with the individual's cultural values and address the unique needs of the individual.
 - vi) Service providers always consider individual preference as critical to all planning.
 - vii) Service and rehabilitation planning include the participant as the primary member of the rehabilitation team and the participant signs all rehabilitation plans.
 - viii) Program staff always use people-first language both verbally and in written materials.
 - ix) Services incorporate the ultimate goals of psychiatric

- rehabilitation which are recovery, re-establishment of normal roles in the community, development of a personal support network, and increased quality of life.
- x) Training advances staff knowledge and skills in psychiatric rehabilitation.
- xi) Services are integrated and coordinated with other services.
- b. Show evidence that the board of directors has received an orientation regarding the psychiatric rehabilitation principles listed above. (Applicable when the provider has a board of directors).
- c. Show evidence that all program staff have received an introduction to rehabilitation principles. It is further expected that those individuals working directly with participants in the rehabilitation division of the organization would receive additional training as listed later in this document.
- d. Show evidence of consumer and family participation in governing board activity, advisory board activity, and/or organizational rehabilitation planning processes for continuous quality improvement.
- e. Comply with the requirements of these standards.
- f. Comply with all applicable federal, state and local requirements.

C. Initial Program Description

- 1) Submit for approval to the County Administrator/behavioral health managed care organization an initial description of program services and any subsequent changes to include:
 - a. Description of particular psychiatric rehabilitation model(s) utilized, type of intervention(s) practiced, typical program day or services, and expected outcomes.
 - b. Service delivery patterns including average frequency of services received (days per week, month) intensity (hours) and duration of services (length of stay).
 - c. Agency Table of Organization which includes staffing patterns, staff to consumer ratios and program capacity, staff qualifications, and cultural diversity reflective of the population.
 - d. Populations served including diagnoses, age and any specialization.
 - e. Program philosophy.

- f. Staff training plan.
- g. Linkages with treatment, rehabilitation, medical and community resources.
- h. Schedule of fees.
- i. Days and hours of operation.
- j. Physical plant description including a description of separate and distinct physical space/floor plan utilized by psychiatric rehabilitation program and copies of all applicable licenses/certificates including Labor and Industry, fire and health.
- k. Continuous Quality Improvement procedures and reports of findings and actions taken to enhance/improve the quality of services.
- l. Agency commitment to collect and report cost, service and consumer data, as required by DPW to monitor and evaluate the psychiatric rehabilitation service initiative.

D. Linkages With Other Parts of the Service System

- 1) Psychiatric rehabilitation programs must establish and document linkages with other appropriate mental health treatment and rehabilitative programs as well as medical services and community resources. If the consumer provides signed, informed consent, per applicable state/federal regulations, appropriate linkages would include periodic rehabilitation progress reports to the referral source and treatment providers.
- 2) Providers must make available to participants a list of community resources, which are consistent with a person's culture, related to housing, leisure, legal entitlements, emergency needs, and mental health treatment services.

E. Organization and Structure

- 1) Each psychiatric rehabilitation program must be identified separately with a designated director and staff.
- 2) A program director may oversee more than one mental health program within a single agency.
- 3) The structure of the program with all service components must be described in an organizational chart.

III. PROGRAM REQUIREMENTS

A. Staff Qualifications

- 1) A psychiatric rehabilitation program director must have:

A minimum of a Bachelor's Degree and at least three years work experience in direct mental health services, which must include either 60 hours of psychiatric rehabilitation training or two years of work experience in psychiatric rehabilitation. Management or supervisory experience is highly recommended.

or

Three years as a psychiatric rehabilitation specialist.

- 2) A psychiatric rehabilitation specialist must have:

A minimum of a Bachelor's Degree and two years of mental health direct care experience, which must include either 60 hours of psychiatric rehabilitation training or two years of work experience in psychiatric rehabilitation.

or

A minimum of a high school diploma or equivalency and 6 years of mental health direct care experience, which must include either 60 hours of psychiatric rehabilitation training or two years of work experience in psychiatric rehabilitation.

- 3) A psychiatric rehabilitation worker must have:

A minimum of a high school diploma or equivalency and two years work experience in human services which must include one year of mental health direct care experience or a BA with academic concentration in an area relevant to the position.

- 4) A psychiatric rehabilitation assistant must have:

Education or experience as appropriate.

- 5) The County/Managed Care Organization may accept accreditation or certification by a nationally recognized psychiatric rehabilitation registry or organization as evidence that an individual has met the appropriate staff qualifications, provided that the certification standards equal or exceed those delineated above.

- 6) At least 25% of all staff within each psychiatric rehabilitation program

must be registered/certified through the International Association of Psychosocial Rehabilitation Services (IAPSRs) as psychiatric rehabilitation practitioners within a two-year timeframe of program start-up.

- 7) Criminal history checks will be completed for all employees of the facility who will have direct contact with consumers.
- 8) Facilities shall develop and implement written policies and procedures regarding the action that will be taken based on the outcome of the criminal history background checks.

B. Staff Training Requirements

- 1) Practitioners within psychiatric rehabilitation programs must be able to demonstrate competency in psychiatric rehabilitation principles, values and practice. This is achieved through an orientation program, service specific training and continuing education.
- 2) Completion of a 12 hour orientation, offered by certified trainers (in accordance with guidelines defined by the Department), is required for all staff in psychiatric rehabilitation programs in HealthChoices. The orientation must be completed within one year of hire or program start-up.
- 3) Completion of 18 hours of training per year in psychiatric rehabilitation is required for all staff in psychiatric rehabilitation programs. Providers shall implement a staff training plan that ensures that each practitioner in psychiatric rehabilitation receives training appropriate to his/her needs. This may include training in specific models, as appropriate (e.g., clubhouse, Boston University approach, social skills training, etc.).
- 4) Staff qualified as psychiatric rehabilitation workers and employed in mobile psychiatric rehabilitation programs must meet the following training requirements.
 - a. For mobile rehabilitation “workers”, the first 18 hours of psychiatric rehabilitation training, as required above, must be on the mobile model used by the agency. The 18 hours are in addition to the 12 hour orientation training which is required for all staff within the first year.
 - b. Mobile rehabilitation “workers” must receive no less than eight hours of classroom training on the specific mobile model used by the agency, prior to working alone in the field. These eight hours can be included in the annual 18 hour training requirement.
 - c. Mobile rehabilitation “workers” must receive no less than six

hours of on-site supervision/mentoring in the field, prior to working alone in the field. These six hours are in addition to the 18 hour annual training requirement.

- 5) Courses must be authorized by the program director of the agency and documented in the agency's records. Only courses that have clear learning objectives (such as those required for continuing education units (CEU) shall be approved). The initial 12 hour orientation qualifies for 12 hours of the first year's training.

C. Record Keeping

1) Provider records

Provider records must, at a minimum, contain the following:

- a. Documents which verify employee work schedules, such as payroll records and employee time sheets.
- b. A job description for each employee.
- c. Affirmative action policies and documentation of compliance with state and federal non-discrimination statutes and regulations.
- d. Documents which verify employee qualifications, annual employee performance reviews and training as described in this chapter.
- e. Training protocols and records.
- f. A record of the complaint and grievance process which conforms to the Complaint and Grievance Process, ~~p. 19~~ of these standards (relating to recipient).
- g. Description of services to be provided.
- h. A record of daily site-based or mobile psychiatric rehabilitation units and specific types of service provided to each consumer.
- i. A conflict of interest policy on file, if the provider is also the base service unit or provides other MH treatment, rehabilitation or support services.
- j. Personnel policies and procedures.
- k. Infection control policies including standards reflecting compliance with Occupational Safety and Health Administration

(OSHA) guidelines on transmission prevention of blood borne pathogens.

- l. Continuous Quality Improvement plan.
- m. Documentation that the agency follows CSP principles.

2) Consumer Records

Participant records must, at a minimum, contain the following:

- a. Participant identifying information.
- b. Referral source and reason for referral.
- c. Documentation that the individual meets the admission and continued stay eligibility criteria
- d. Documentation of coordination of care with health care providers and social service agencies.
- e. Consent forms signed by the consumer to release information as required, by the Department under Pa Code §5100.34 (relating to consensual release to third parties.)
- f. An individualized, person-specific rehabilitation assessment and plan (based on participant's goals and priorities) signed by the participant, if the participant desires.
 - (i) Refer to the Psychiatric Rehabilitation Program, ~~p. 7~~ for details regarding the assessment and the plan.
 - (ii) Refer to Specific Program Descriptions, ~~pp. 8-10~~ for frequency of plan updates.
- g. Progress notes.
 - (i) Progress notes must include, but are not limited to, documenting progress in goal areas.
 - (ii) Progress notes must be legible and signed and dated by the person providing the service and the participant. If the participant's signature is not present, the reason must be documented.

- (iii) Refer to Specific Program Descriptions, ~~pp. 8-10~~ for frequency of progress notes.

- h. Discharge requirements

- i) A discharge plan must be completed for all consumers to include next steps and a connection to necessary services.
- ii) When the participant ends his/her enrollment in the program, a summary of participation, services provided, progress made, and the reason for closure is documented within 30 days. Information regarding re-enrollment is provided to the participant.

- D. Continuous Quality Improvement

- 1) Each psychiatric rehabilitation service provider shall develop a written CQI plan document that is reviewed and updated annually to reflect the needs assessment process, quality assessment process and outcome evaluation process. A report shall be generated annually to describe the population served and the results; this report shall be made available to provider staff, the agency director, other appropriate agencies, the County MH/MR Administrator, the managed care organization, and consumers/families.
- 2) Each psychiatric rehabilitation provider shall provide for a systematic review of services to ensure quality, timeliness, and appropriateness of services. The procedures shall include types of reviews (professional, peer, case, internal, external) and frequency of reviews. The procedure will also ensure that persons served are involved in the development of the CQI plan document and the resulting processes.
- 3) At a minimum, the CQI plan should monitor the following:
 - a. Exceptions to the five diagnoses listed in the admission criteria.
 - b. Approval of mobile rehabilitation above the six hour/week limit.
 - c. Overall cost and utilization of PRS and partial hospitalization.

- E. Conflict of Interest

When an agency that provides psychiatric rehabilitation services also is the base service unit or an agency that provides other mental health treatment, rehabilitation or support services, the responsible county administrator shall ensure that the provider agency:

- 1) Does not restrict the person's freedom to choose services or provider agencies and provides, upon request, information needed to access alternative services/providers.
- 2) Provides each person in psychiatric rehabilitation services a listing of all providers of mental health treatment, rehabilitation and support services available within a reasonable proximity to the person's home where needed services could be obtained.
- (3) Documents that the information in this section has been presented and reviewed by the participant.

F. Consumer Rights

- 1) Consumer Participation and Freedom of Choice
 - a. Participation in psychiatric rehabilitation services is not dependent upon compliance or participation in other services.
 - b. No service decisions may be made in violation of a consumer's civil rights as set forth in 55 PA Code, Chapter 5100, Sections §5100.53 -§5100.56.
 - c. Efforts must be made to re-engage consumers who are not participating in the rehabilitation plan. If it is necessary to discharge a consumer from psychiatric rehabilitation, due to the consumer's disengagement, the circumstances and rationale must be fully documented prior to termination. The decision to terminate should be a joint decision between the consumer and provider whenever possible. If the decision to terminate is reached, the consumer should be offered the opportunity to use the services in the future if the consumer is willing and able to do so.
 - d. The provider must post consumer rights and notify individuals of their rights verbally and in writing. This information must include phone numbers of advocacy and consumer agencies.
- 2) Confidentiality and Nondiscrimination.
 - a. Information about consumers who are receiving psychiatric rehabilitation services must be treated with respect and confidentiality by those providing service as set forth in 55 PA Code, Chapter 5100, Sections §5100.31 to §5100.39 (relating to confidentiality of mental health records). Other applicable Federal and State requirements, including Act 148 of 1990, 35 PS Section 7601 (HIV Confidentiality Act) also apply.
 - b. Providers may not discriminate against staff or consumers on the basis of age, race, sex, religion, ethnic origin, economic status or sexual preference, or persons with disabilities as described in the Americans

With Disabilities Act and shall observe applicable State and Federal Statutes and regulations.

3) Complaint and Grievance Process

Each psychiatric rehabilitation provider must develop a clearly written internal procedure for complaints and grievances that complies with the complaint and grievance procedure requested through the behavioral health managed care initiative. Each provider must ensure consumers served are informed of complaint and grievance procedures.

DEFINITIONS FOR PSYCHIATRIC MEDICAL NECESSITY CRITERIA AND PSYCHIATRIC REHABILITATION STANDARDS

The following definitions apply when the words or terms are used in this chapter.

Clubhouse – A site-based psychiatric rehabilitation service certified by the International Center for Clubhouse Development (ICCD) or actively engaged in the certification process by ICCD.

Collateral - A person who acts to seek help for a consumer or who provides information or support for a consumer.

Consumer - A recipient of psychiatric rehabilitation services.

County Administrator - The Mental Health/Mental Retardation Administrator who has jurisdiction in the geographic area.

Continuous Quality Improvement Plan - A formal process to assure quality care and maximize program benefits to consumers.

Cultural Competency -- A set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals which enables the system, agency or professionals to work effectively in cross-cultural situations.

Department - The Department of Public Welfare.

Enrolled Providers - Agencies specifically identified as providers of psychiatric rehabilitation by the county/managed care organization and which are enrolled in the Department's Medical Assistance Program.

Managed Care Entities -- Those companies, organizations, states, counties, EAPs that are charged with approving the treatment facility, what type of treatment is provided and how much is paid for such services.

MH/MR - Mental Health/Mental Retardation.

Mental Health Direct Care Experience - Worked directly with consumers of mental health services providing services such as case work or case management, individual or group therapy, crisis intervention, vocational training, residential care or social rehabilitation in a facility or program that provides services to persons with mental illness.

Mobile Psychiatric Rehabilitation (MPR) - Psychiatric rehabilitation services are provided in community settings (such as a person's home, a YMCA, a university, etc.) and occur on a one-to-one basis. Services are designed to help persons meet one or more rehabilitation goals. On a case by case basis, a 2:1 staffing approach may be used as defined in the standards.

People First Language -- Language that refers to consumers in ways that respect them as persons and specifically prohibits referring to consumers by the name of their diagnosis.

Site Based Psychiatric Rehabilitation - Psychiatric rehabilitation services provided at a program facility or, on occasion in community sites under the supervision of site-based staff as reflected in the consumer's individualized rehabilitation plan. The clubhouse model is one example of site-based psychiatric rehabilitation.

ATTACHMENT I

Relationship of Psychiatric Rehabilitation To Other Services

Introduction:

Recovery from serious mental illness involves more than diminishing symptoms and alleviating distress from the illness. It also involves finding new purpose and meaning in life. As individuals recover, their illness is no longer the main focus of their lives. Individuals in recovery are interested in gaining or regaining roles that they value in the community. Among the roles individuals are interested in attaining and maintaining are worker, independent community resident, student, and member of a social network.

Individuals generally benefit from a variety of services to facilitate recovery. Two essential services to promote recovery are treatment and psychiatric rehabilitation. The focus of treatment is to reduce the frequency and discomfort of symptoms of the illness and to reduce emotional distress. Examples of treatment services are medication evaluation and management and psychotherapy, either individually or in groups. Psychiatric rehabilitation has as its mission helping individuals to gain or regain valued roles in the community. Examples of psychiatric rehabilitation services including choosing goals about future roles such as going to school or getting a job, functional assessment to determine the specific skills and supports to attain and maintain goals individuals have chosen, teaching skills either directly or indirectly, and arranging supports to assist individuals to get and keep goals.

Psychiatric rehabilitation service interventions should occur concurrently with necessary treatment services and should begin as soon as clinically possible.

Relationships among psychiatric rehabilitation services and other types of services are summarized below:

Psychiatric Rehabilitation and Partial Hospitalization: The primary mission of partial hospitalization is treatment-oriented. Partial hospitalization aims to stabilize the person's symptoms and reduce distress from these symptoms. Partial hospital programs use various treatment modalities such as medication and psychotherapy to impact on the individual's symptomatology and experience of the illness. Services offered in partial hospital programs frequently include 1) individual psychotherapy, 2) group psychotherapy, 3) medication evaluation and management, and 4) biopsychosocial assessment.

Psychiatric rehabilitation services focus on planning for the future for the person to select, attain and maintain goals of personal choice such as obtaining employment, enrolling in and completing an educational program, or moving from a supervised community residence to living independently in an apartment or house. Psychiatric rehabilitation services have as their mission assisting the person to identify individualized, personally satisfying rehabilitation goals, developing plans with the person to get and keep the chosen goal, and providing critical skills and supports to facilitate the person accomplishing the goal.

Partial hospital programs have specific requirements for services provided by a psychiatrist as

well as other requirements for mental health professional staffing. While individuals must have a diagnosis from a psychiatrist to enroll in psychiatric rehabilitation services, there are no services offered by a psychiatrist as part of a psychiatric rehabilitation program or service. Individuals enrolled in psychiatric rehabilitation services must also be enrolled in a separate mental health treatment program to receive necessary treatment services such as antipsychotic medication or verbal therapy.

A person may be enrolled concurrently in a partial hospital program and a psychiatric rehabilitation program. While one provider agency may offer both of these services, each service must be offered in a distinct manner including having separate program space.

Relationship of Psychiatric Rehabilitation to Intensive Case Management

The mission of intensive case management is to assist individuals to obtain needed resources and services. Intensive case managers do not provide services directly. Instead, they link individuals with other providers of service and assure these services are delivered. Intensive case management is often used to facilitate transitions from the hospital to the community and to decrease the use of expensive services such as psychiatric hospitalization. Traditionally, it has been directed toward individuals who are heavy users of these expensive services. Examples would be individuals who experience frequent crises and emergency room admissions and individuals who have repeated psychiatric hospitalizations. Intensive case management assures service linkages are made and maintained in order to increase the person's stability in the community, increase cooperation with treatment interventions, and decrease use of crisis services and psychiatric hospitalization. Often, intensive case management services are made available to the person on a 24-hour, 7-day a week basis, if needed.

Psychiatric rehabilitation services are directed toward individuals who are interested in finding new meaning and focus in their lives. Generally, the person enrolling in psychiatric rehabilitation services has benefited from treatment services although the person may still experience significant symptoms. While the job of the intensive case manager is to link individuals with services, the psychiatric rehabilitation provider works directly with the person in a process of determining goals of interest to the person with regard to choosing, getting and keeping roles the person values in community environments such as work, school, independent living settings and social settings. As part of goal attainment, the psychiatric rehabilitation provider may personally engage in skill teaching and providing other supports to help the person obtain and maintain the desired goal. Psychiatric rehabilitation services are typically not offered on an around the clock basis.

Intensive case management has been described as an intermediate service in a mental health system. It does not have the intensity of acute services such as crisis intervention or psychiatric hospitalization, which often have as a mission to stabilize the person's symptoms. Intensive case management generally offers high support to the person and linkages to services in the community to maintain stability and to keep the person in the community. In contrast, psychiatric rehabilitation services are directed toward accomplishing complex future-directed goals such as enrolling in college, securing paid employment or expanding one's social network.

Intensive case managers may refer individuals for psychiatric rehabilitation services. However,

psychiatric rehabilitation services and intensive case management must be provided by different staff.

Relationship of Psychiatric Rehabilitation to Mobile Crisis Services:

Mobile crisis services are an outreach response to an unplanned emergency in a person's life which might otherwise result in psychiatric hospitalization. Mobile crisis services generally deal with distress related to the illness and its symptoms. Psychiatric rehabilitation is not a crisis service and is not equipped either through mission or staffing to address treatment emergencies. For example, there are no services from a psychiatrist as part of a psychiatric rehabilitation service. Persons enrolled in psychiatric rehabilitation services would be enrolled in a separate treatment program to receive any necessary clinical services such as medication therapy or psychotherapy.

Psychiatric rehabilitation is a service designed to assist individuals to achieve specific rehabilitation goals related to living, learning, working and socializing environments. While psychiatric rehabilitation providers attempt to assist individuals to resolve issues related to getting and keeping identified goals in these community environments, it is not the mission of the psychiatric rehabilitation service to address treatment-related emergencies. It is expected psychiatric rehabilitation providers would notify treatment providers and crisis service providers of the person's needs for crisis intervention services.

Relationship of Psychiatric Rehabilitation to Supported Living:

Certain portions of the services provided in supported living may be considered psychiatric rehabilitation services. Examples of psychiatric rehabilitation services in a living environment include identifying skills and supports necessary for success and satisfaction in the living environment, teaching identified skills, and working with individuals to choose, get and keep more independent living arrangements such as their own apartments. Certain housing support services are clearly not psychiatric rehabilitation services eligible for Medicaid reimbursement. Examples of services which are not Medicaid reimbursable include landlord assistance, rental management, and developing housing stock.

Relationship of Psychiatric Rehabilitation and Vocational Rehabilitation Services:

Both psychiatric rehabilitation services and vocational rehabilitation services can assist a person to choose, get and keep employment. An individual may receive both psychiatric rehabilitation services, which are Medicaid reimbursable, and vocational rehabilitation services, which are not Medicaid reimbursable, at the same time. Vocational services such as transitional employment, vocational and on-the-job training programs, as well as supported and competitive employment are not Medicaid reimbursable even though they may be an integral part of attaining the person's employment goal. These services must be paid for through Office of Vocational Rehabilitation (OVR) funds, 100% state funds or other non-Medicaid funding streams.

Psychiatric rehabilitation services which are Medicaid reimbursable would include a variety of pre-vocational services as well as services that enable the person to access vocational rehabilitation services. Pre-vocational services may be directed at assisting the individual to

develop a general vocational direction such as deciding whether to enroll in transitional employment or apply for a formal vocational training program. Pre-vocational services can also be aimed at improving the overall functioning of the person in preparation for vocational rehabilitation services. Examples of such improvements might include learning to work as part of a team, learning to ask for assistance, and learning skills to be able to report to assignments on time. Additionally, psychiatric rehabilitation services may assist the person to learn skills and use supports to be able to participate in a vocational rehabilitation program or to gain and maintain employment. Examples of such services are learning to take transportation to the job site, improving coping skills for job-related stress, learning how to negotiate with a supervisor, and learning how to navigate the vocational rehabilitation system including working with agencies such as OVR and the Social Security Administration.

Case Examples: Attending a work-ordered day in a Clubhouse is a psychiatric rehabilitation service if it is directed towards goals such as learning to work as part of a team, learning to follow directions or deciding whether to pursue competitive employment. A Transitional Employment Placement (TEP) in which a person is employed through the Clubhouse at a competitive job placement with support from a Clubhouse staff generalist is a vocational rehabilitation service. It is a type of supported employment and is not a psychiatric rehabilitation service.

A person attends a vocational training school to learn to be a computer technician. This is a vocational training program and is considered to be a vocational rehabilitation service. The person is experiencing difficulty at the school in asking for assistance from the instructor and does not know how to socialize with other students at the lunch hour. The psychiatric rehabilitation practitioner meets with the person in the community to teach the person how to ask for help so that the person can be more successful in class. The psychiatric rehabilitation practitioner also teaches the person the skill of discussing impersonal topics so that the person can be more satisfied in social relationships with other students. This is considered psychiatric rehabilitation because it assists the person to be able to participate in the vocational training program. It does not provide vocational skills directly but does enable the person to benefit from vocational rehabilitation services paid for by another funding source such as OVR.

Relationship of Psychiatric Rehabilitation and Education:

Medicaid will not pay for the cost of educational programs and services such as vocational schools, GED services and tuition for post-secondary education. However, some services which are currently referred to as “supported education” may be Medicaid reimbursable. Supported education refers to the provision of a variety of services that assist individuals to be successful and satisfied in a formal educational program in the community such as a college or other post-secondary program. Services provided in supported education frequently include counseling to help individuals to develop educational and career choices, assisting individuals to coordinate community services and campus-based services, teaching skills such as asking for help or participating in class discussions that individuals need to be successful and satisfied as students, and assisting in problem solving if any difficulties arise.

Individuals may also benefit from psychoeducational services to learn more about managing their illnesses and developing strategies to cope with symptoms in target environments such as

school or work. Psychoeducational services are considered to be a psychiatric rehabilitation service and are reimbursable under Medicaid.

Relationship of Psychiatric Rehabilitation and Recreational/Leisure and Social Activities:

Individuals may choose to develop and implement specific goals related to increasing their social network and making other changes in their social roles and environments such as socializing with others in drug-free activities. When recreation, leisure and social activities are part of an individualized rehabilitation plan, they are psychiatric rehabilitation services and are eligible for Medicaid reimbursement. In addition to helping individuals to identify goals related to social environments, psychiatric rehabilitation services may include skill teaching to increase the person's success and satisfaction in target social environments. Examples of skills which may be taught depending upon the person's needs and interests are introducing yourself to others, inviting others to activities, and discussing topics other than yourself.

Recreation, leisure and social activities not related to a rehabilitation plan are not eligible for Medicaid reimbursement. Such activities are considered to be enrichment activities in that they are not expected to have specific, identifiable outcomes related to setting and accomplishing rehabilitation goals in social environments.

Relationship of Psychiatric Rehabilitation and Personal Care Services:

The mission of personal care services is to provide services for another person or assist with services that the person cannot perform independently. Examples of personal care services include preparing meals, assisting the person to take medications, and assisting with grooming and personal hygiene tasks. Personal care is distinguished from psychiatric rehabilitation in that the personal care provider does not work with the individual to improve ability to perform these tasks independently, and the services are not part of a plan to attain and maintain an individualized rehabilitation goal. In psychiatric rehabilitation, the practitioner works with the person to increase independence and self-sufficiency as part of accomplishing an identified individualized rehabilitation goal.

PSYCHIATRIC SERVICES FOR RECOVERY

Service	Purpose	Outcome	Examples of Services
Treatment	Reduce symptoms and distress of the illness	Symptoms and emotional distress of illness decreased	Medication, Psychotherapy
Psychiatric Rehabilitation	Increase success and satisfaction in roles and environments of personal choice	Individuals gain or regain roles they value	Goal setting, skills teaching; work-ordered day
Basic Support	Provide essentials for survival	Personal survival assured	Physical health care; financial support; providing meals, shelter, clothing
Case Management	Obtain services to solve problems and maintain gains (often used to facilitate transition to the community)	Individuals access services they need and want	Linking to services; advocacy for service improvements
Crisis Intervention	Stabilize and resolve critical or dangerous events	Personal safety assured	Medication evaluation, crisis counseling
Self-Help	Self-led recovery	Personal empowerment	Consumer-run support groups
Rights Protection	Advocacy to assure legal protections	Equal opportunity and access	Advocacy services
Enrichment	Engage in satisfying activities to increase quality of life	Self-development and enjoyment	Leisure activities; socializing; community trips
Vocational Rehabilitation	Choose, get and keep paid employment	Obtain and maintain employment	Vocational training, job development and placement
Supported Education	Participate in a structured learning program, often postsecondary	Completion of an educational degree or certificate	Skill and support development: Career counseling
Leisure, Social and Recreation Activities	Develop an expanded social network	Use of leisure time is satisfying and constructive	Varies depending on purpose: psychiatric rehabilitation or enrichment
Personal Care Services	Provide activities of daily living services	Care of personal needs assured	Perform cooking, personal hygiene services for the person

Adapted from: Cohen, M., & Mynks, D. (1993). Compendium of activities for assessing and developing readiness for rehabilitation services. Boston: Center for Psychiatric Rehabilitation.