



Performance Standards

Psychiatric Rehabilitation

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

Disclaimer: These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

PSYCHIATRIC REHABILITATION – SITE BASED AND MOBILE MODELS

PERFORMANCE STANDARDS

BRIEF DESCRIPTION

Psychiatric rehabilitation services assist 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. Psychiatric rehabilitation programs are founded on the principles of member choice and the active involvement of a member in his/her rehabilitation. The practice of psychiatric rehabilitation is composed of three strategies:

- Helping persons identify goals.
- Helping persons plan strategies and acquire the necessary skills to reach and maintain the desired goals.
- Helping persons develop necessary supports to maintain those goals.

Psychiatric rehabilitation services require that a member be actively involved in the design, development, and management of the overall program as well as of the individual's planned activities. A member who is effectively involved in a psychiatric rehabilitation program should be able to articulate his/her individual goals and objectives (although not necessarily in "professional" terms) and to identify ways in which his/her current activities are intended to assist the member to achieve those goals and objectives.

A member who is effectively involved should have a reasonably clear understanding of his/her illness and the nature and intent of the member's treatment program and service plan. Community based resources, recovery principles, and self-help resources should be incorporated into the collaborative service planning and implementation approach with the member. Member initiated service plans are to be encouraged to the extent possible.

Because psychiatric rehabilitation is intended to be a member directed and oriented service, the overall intent of this document is to establish broad parameters within which a variety of successful models can flourish. Key elements include effective member participation in planning, delivery and control of services, along with emphasis on the recovery and self-help resources that are available. Psychiatric rehabilitation services are provided within a context of a complex variety of treatment, recreational, social, and other services that provide supports to the adult with serious and persistent mental illness. This includes members 18 years of age and older who have a history of severe and persistent mental illness and have a diagnosis of schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder or borderline personality disorder on Axis I of the *DSM IV* classification.

The member must also have a moderate to severe functional impairment as a result of the mental illness and be agreeable to participation in the program. There is no single program model that is defined as effective; rather, services and programs are expected to identify and utilize one or more models that have been demonstrated to be effective in responding to the needs of a particular member and their community. Because of this, programs are expected to have an emphasis on the continual assessment of resources and needs and to have in place processes to assure that services are modified and/or re-structured to meet changing need. Member satisfaction and progress are key elements of the quality management (QM) programs for such services (regardless of the name by which the QM programs are known).

SETTING

Psychiatric rehabilitation programs may be provided within site based facilities (clubhouse or other site based psychiatric rehabilitation) and/or as mobile psychiatric rehabilitation services.

MA provider Enrollment

To be included in the HealthChoices program, psychiatric rehabilitation programs must be enrolled in the Medical Assistance (MA) Program as provider Type 11, Specialty 123 and must have a current, signed provider agreement with the Department of Public Welfare (DPW) to provide psychiatric rehabilitative services. The provider must contract for the service with Community Care.

Credentialing

To be included in the HealthChoices program, the program and staff must meet and maintain compliance with Community Care credentialing standards, and the program must maintain compliance with the standards established by DPW. The DPW standards are attached to the final psychiatric rehabilitation performance standards document for reference.

Program Specifications

A provider may offer site based and/or mobile psychiatric rehabilitation services and may employ any or all of the accepted models to meet a member's preferences and needs. Each model employed, if there is more than one, must be able to function on a "stand alone" basis. The provider is expected to be able to:

- Articulate the principles and elements of the model(s) used.
- Demonstrate competency in using the model.
- Provide a service (program) description that denotes ways in which the program is consistent with the model(s).
- Demonstrate that the model(s) chosen are appropriate for the population served.

Psychiatric rehabilitation activities/techniques are designed to provide the member with the opportunity to:

- Become informed about his/her illness.
- Participate with staff, significant others, and/or independently to determine existing strengths and resources, skills, and abilities needed to recover.
- Plan for a program of services and activities that are logically likely to assist the person to develop the skills to achieve and maintain recovery.

The program is expected to have resources necessary to facilitate an educational opportunity for the member, including access to information regarding traditional and non-traditional interventions that have proved successful in symptom amelioration and recovery.

Programs must demonstrate initiative in working with a member and other stakeholders to identify and assist the member to overcome likely potential obstacles to effective program participation, if any. Examples of such obstacles might include (but are not limited to) hours of operations, transportation, issues of stigma and inclusion, cultural competence, etc.).

Site Based Psychiatric Rehabilitation

Description

Site based psychiatric rehabilitation programs provide rehabilitation services within facilities and at community sites under the supervision of site based staff. The provider must demonstrate that the site based psychiatric rehabilitation program is offered in a manner distinct from, but coordinated with, other mental health programs. The implementation of services may take place individually or in groups.

Psychiatric rehabilitation programs are included in a continuum of services to adults with serious mental illness, and programming should reflect careful, systematic, and collaborative analysis of the goals, strengths, and needs of the individual taking part in the program. This requires that the activities of the program, and the individualized service plan, be organized systematically so as to reflect a recovery environment in which growth and choice opportunities are available for the member. Recreational, educational, vocational, and other goals should be included in the development of the service plan, but these and similar goals are not themselves directly the intended outcomes of a psychiatric rehabilitation program.

Inasmuch as substance abuse is a significant issue in the lives of many persons with serious mental illness, psychiatric rehabilitation programs should demonstrate competence in the identification of and attention to substance abuse as well as mental health issues. This may take the form of activities such as on-site AA/NA activities, psycho educational groups emphasizing recovery models, or other relevant activities (activities such as AA/NA meetings are adjunctive to the psychiatric rehabilitation process for the appropriate member; they are not in and of themselves psychiatric

rehabilitation activities). Formal program linkages with substance abuse treatment services, as well as mental health treatment resources, are encouraged to meet member needs.

Clubhouse programs should have certification from the International Center for Clubhouse Development (ICCD) within two years of start-up, and should be able to demonstrate that the program's qualities and operating standards are consistent with those of the ICCD. This requires a clear operational description of the role of the member in governance of the program as well as compliance with other facets of site based programs.

Hours of Operation

The program must operate at hours convenient to the member and must be available to the member at least 24 hours a week. A substantial proportion (at least 20%) of the program hours should be at times outside of normal business hours (such as weekday evenings after 5:00 p.m., weekends, and legal holidays). If the program proposes to provide services with a schedule that is not in conformance with these guidelines, the program must provide a written statement detailing the ways in which its proposed schedule is more responsive to member needs than one which is consistent with the guidelines.

Staffing Patterns

The ratio of staff to members 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.

- Programs must have a minimum of one full time equivalent staff for every 10 members based on average daily attendance.
- Average daily attendance is computed at least monthly.
- At least one psychiatric rehabilitation worker or specialist must be present at all times.
- A minimum of 25% of the staff must be a specialist or above within a one year time frame.
- Staff will reflect the cultural diversity of the participant population.
- Trained staff will be available or other accommodations made to address the language needs of the participants, including signing, Braille, and foreign language.
- Site based staff must receive weekly case supervision appropriate to the model being used, by the director or specialist.
- The site based psychiatric rehabilitation program must be supervised by a program director.

The program director must have the following:

- 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.

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 six 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.

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 bachelor's degree with academic concentration in an area relevant to the position.

A psychiatric rehabilitation assistant must have:

- Education or experience as appropriate.

The county/managed care organization (MCO) may accept accreditation or certification by a nationally recognized organization as evidence that an individual has met the appropriate staff qualifications, provided that the certification standards equal or exceed those delineated above.

At least 25% of all staff within each psychiatric rehabilitation program must be registered/certified through the International Association of Psychosocial Rehabilitation Services (IAPRS) as psychiatric rehabilitation practitioners within a two year timeframe of start-up.

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

Case Records

An initial planning process must begin upon the first day of attendance. Individualized, member specific rehabilitation assessment and plan must be developed by the 20th day of attendance, not to exceed two months from the initial date of attendance and must be reviewed and revised every three months thereafter. The plan must be comprehensive and it must be in written form; it should include means of integrating the psychiatric

rehabilitation goals with the goals of treatment and community support. The plan should be co-signed by the member, indicating his/her agreement. The rehabilitation plan should also incorporate the member's wishes regarding treatment (the "directed care plan") during periods of increased psychiatric symptomatology when relevant and when the member agrees that this is of importance. It is understood that the provider may, for any number of valid reasons, be unable to implement the directed care plan. The intent of this section is to provide observable evidence of attempts to implement psychoeducational elements of the psychiatric rehabilitation plan and to demonstrate that the member has increased understanding of the nature and course of his/her illness.

Case records for site based rehabilitation must include progress notes that are written at least monthly, and more often when indicated by member activities. These should include an evaluation of the impact of rehabilitative services on the goals outlined in the plan. Notes should be specific in terms of the measurable objectives identified in the plan. Whenever feasible, the member should participate in the regular evaluation of progress, including participation in the writing of progress notes. The member will co-sign each progress note, indicating his/her agreement with the content thereof. If the member is unable or unwilling to co-sign, the provider must document the reason for not signing, and the note must include documentation of the provider's efforts to re-engage the member in a collaborative service effort. Record keeping must also be consistent with the requirements of the Pennsylvania MA Program.

Physical Facility

Adequate space, equipment, and supplies must be provided in order that services can be provided effectively and efficiently. Program space, equipment, and furnishings must be separate and distinct from other services within the facility and kept well maintained. There must be office space suitably equipped with chairs, desks, tables, and other necessary equipment. Adequate space must be available, as needed, in the event that privacy is indicated or requested by the participant.

The facility must be readily accessible to the member and should be an integrated part of the community(ies) served. Sites should be compliant with the requirements of Section 504 and with the requirements of the Americans with Disabilities Act (ADA). The provider's program service description should include written documentation of the assessment process undertaken to ensure that facilities used are in compliance with the ADA and Section 504, and with any other applicable laws, rules, and regulations. The service description should also identify the means employed to ensure that this information, and compliance, remains current.

Mobile Psychiatric Rehabilitation Services

Description

Mobile psychiatric rehabilitation is generally designed to be short term based on individual goals. The services are generally provided on a weekly basis limited to six hours per week (above six hours must be approved through the exception process). Indicators for mobile psychiatric rehabilitation include a person unable to attend a site based service, a goal needing substantial community exploration or practice or the person is choosing to participate in a mobile program.

Mobile psychiatric rehabilitation must be delivered individually to each member. Services are provided in community settings such as a person's residence, an educational program or a YM/WCA. Services are designed to help the member meet one or more documented psychiatric rehabilitation goals. The provider must demonstrate that mobile psychiatric rehabilitation is distinct from other mental health programs.

Staffing Patterns

Mobile psychiatric rehabilitation services are provided on a one-to-one and face-to-face basis (may be provided on a 1:2 basis when justified) and must be provided by a psychiatric rehabilitation worker.

The ratio of staff to the number of recipients must be adequate to support the services required by individual psychiatric rehabilitation plans.

Staff should reflect the cultural diversity of the participant population. Mobile staff must receive weekly case supervision from a psychiatric rehabilitation specialist or program director. Mobile 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.

Case Records

Rationale for the service must be identified and provided to the payor on the first day of service. A member specific rehabilitation assessment and plan must be developed within the first five visits (not to exceed 30 days). The plan can be revised subsequently as appropriate to meet member need. The plan must be comprehensive and it must be in written form; it should include means of integrating the psychiatric rehabilitation goals with the goals of treatment and community support. The plan should be co-signed by the member, indicating his/her agreement. The plan should incorporate specific objectives that are suggested and/or endorsed by the member as relevant to his/her life goals. Each objective should include a standard of observable measurement that will form the basis of review by the member and the program.

Psychiatric rehabilitation plans must be reviewed and revised with the member at least every three calendar months. The rehabilitation plan should also incorporate the member's wishes regarding treatment (the "directed care plan") during periods of increased psychiatric symptomatology when relevant and when the member agrees that this is of importance. It is understood that the provider may, for any number of valid reasons, be unable to implement the directed care plan. The intent of this section is to provide observable evidence of attempts to implement psychoeducational elements of the psychiatric rehabilitation plan and to demonstrate that the member has increased understanding of the nature and course of his/her illness.

Case records for mobile psychiatric rehabilitation must include progress notes that are written after every encounter and must include duration and objectives of services. These should include an evaluation of the impact of rehabilitative services on the goals outlined in the plan. Notes should be specific in terms of the measurable objectives identified in the plan. Whenever feasible, the member should participate in the regular evaluation of progress, including participation in the writing of progress notes. The member will co-sign each progress note, indicating his/her agreement with the content thereof. If the member is unable or unwilling to co-sign, the provider must document the reason for not signing, and the note must include documentation of the provider's efforts to re-engage the member in a collaborative service effort.

Concurrent use of Site-Based and Mobile Services

Mobile and site based psychiatric rehabilitation can be provided concurrently under certain limited circumstances. This would include a person transitioning to a site based service or from a site based service to mobile service and who needs assistance in the transition, or other specific issues that have been identified as requiring both services.

PROCESS SPECIFICATIONS

Admission

Psychiatric rehabilitation recipients must be 18 years or older and have a current diagnosis of serious mental illness (consistent with current DPW policy), based on medical records, including a diagnosis by a psychiatrist of (but not necessarily limited to) schizophrenia, major mood disorder, psychotic disorder NOS, schizoaffective disorder or borderline personality disorder. Persons with co-existing disorders, e.g., mental retardation, substance abuse disorders, physical disability and organic brain dysfunction, are eligible to participate in a psychiatric rehabilitation program, unless the individual's limitations related to those conditions are so severe as to clinically preclude active participation.

- Recipients must also have moderate or severe difficulties in functioning in at least one of the following domains as a result of their mental illness: vocational, social,

educational, and self-maintenance relative to the person's ethnic/cultural environment, **AND**

- The person chooses to participate in the program.

Psychiatric rehabilitation programs must conduct a comprehensive re-assessment **with each recipient** (appropriate to the model of the rehabilitative service being utilized) of strengths, skill deficits, and needs relevant to recovery. This assessment must occur at least quarterly and should coincide with the progress reporting and must involve the member and appropriate significant others (including providers of treatment and other support services). The assessment of member strengths and needs and subsequent service plan will be conducted by a psychiatric rehabilitation specialist or program director, who is also responsible for reviewing the plan with the member and others as appropriate.

The assessment should indicate that the person has or continues to have difficulties functioning in at least one of the following life domains:

- Vocational
- Social
- Educational
- Community success
- Self-maintenance

The member will co-sign the assessment and updated plan signifying informed participation and agreement with the goals and objectives.

Effective and meaningful participation in service planning and delivery is a hallmark of psychiatric rehabilitation services. Demonstration of these key elements is a critical part of the functioning of each program.

It is recognized, however, that some individuals may not, at the time of entry into a psychiatric rehabilitation program, have the cognitive or emotional skills necessary to identify or articulate measurable goals.

Continued Stay

Psychiatric rehabilitation programs must conduct a comprehensive re-assessment of member strengths, needs, and interests at least every three months. Assessment may be done more frequently if warranted by change in circumstance or in the individual. The re-assessment should result in a revised service plan developed with the member. The re-assessment should indicate that that member meets one of the following criteria:

- 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**
- There is reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the member, **OR**

- A change in program or level of service is indicated and a transition plan is in place reflecting the proposed change, **AND**
- The person chooses to continue participation in the program

Successive rehabilitation plans must include goals and objectives that address specifically the identified need(s) in terms of psychiatric rehabilitation services. The member will co-sign the reassessment, signifying informed participation and agreement with the goals and objectives.

Discharge Criteria

A member may be deemed ready for discharge if the member meets the following criteria:

- The person is not expected to receive additional rehabilitative benefit from the program, **AND**
- There is a reasonable expectation that the withdrawal of services will not result in decompensation. Reference should be made to the documentation of precipitants of symptom exacerbation, **OR**
- The person has successfully achieved rehabilitation goals and sustained them for a period of time as designated in the rehabilitation plan, **OR**
- The recipient voluntarily terminates from the program, **AND**
- Upon discharge or termination the person is informed of his/her rights and the process for appeal.

It is understood that some members will be unable to participate effectively in psychiatric rehabilitation services because of limitations related to disability, the effect of co-existing conditions, life style preferences or similar factors.

At the time of discharge or termination, it is expected that the psychiatric rehabilitation provider will work with the person with primary case management/coordination responsibilities, the member, significant others, behavioral health, and physical health care providers and others involved in providing ongoing or needed services to develop effective linkages.

Coordination of Care

It is expected that individuals involved in psychiatric rehabilitation services will have access to case management services and that they will, to the extent that the member is willing, receive medically necessary case management services (Intensive Case Management, Resource Coordination and/or Administrative Case Management). The psychiatric rehabilitation provider is expected to participate with case management services and to have communication with all behavioral health treatment teams (within the scope of applicable laws, rules and regulations) for collaboration on coordination of care issues. The provider is also expected to assist the member in accessing other levels of clinical and supportive services. Liaison with mutual support networks and member advocacy groups, member and family participation, status reports to clinical

treatment teams, and coordination with educational or vocational programming will also be available according to member needs.

STRUCTURAL SPECIFICATIONS

Provider Qualifications

The provider shall show evidence of the incorporation of 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, and values of the organization. Evidence will also be found in the strategic, operational, and program related materials designed around fundamental psychiatric rehabilitation principles. Further detail is included in the DPW standards. Staff to client ratios must be adequate to support the activities of the program as defined by the outlined program description.

Staff Training Requirements

Completion of a 12 hour competency based orientation is required and is provided through DPW. *Staff is expected to have completed this training within one year of the hire date or program start-up.* Staff must complete 18 hours per year in continuing education in areas directly relevant to psychiatric rehabilitation services required for all staff in psychiatric rehabilitation programs. *The initial 12 hour orientation qualifies for 12 hours of the first year's training.* The provider is expected to maintain accurate records of all training and education efforts and to ensure that these are in compliance with DPW, county/oversight and Community Care standards.

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. Mobile rehabilitation workers must receive no less than eight hours of classroom training on the mobile model used by the agency prior to working alone in the field and must receive no less than six hours of on-site supervision/mentoring in the field, prior to working alone in the field (in addition to the 24 hour annual training requirement).

Provider Records

Provider records must include documents verifying employee work schedules, job descriptions, employee qualifications and performance reviews as well as the training protocol and records. Documented policies are to include affirmative action, complaint and grievance process, and a conflict of interest policy. There must be a description of services to be provided and a record of daily site based or mobile psychiatric rehabilitation units and specific types of service provided to each member.

Member Records

Psychiatric rehabilitation programs must maintain records on each member receiving service. In addition to referrals and member identifying information, an individualized rehabilitation assessment and plan signed by the participant must be included as well as documentation that the participant meets the admission and continued stay eligibility criteria, documentation of coordination of care with health care providers and other social service agencies and any required consent forms. Progress notes should be reflective of the goals established on the service plan, with ongoing reviews. Progress notes must be legible and signed and dated by the person providing the service and the participant.

QUALITY MANAGEMENT

Each psychiatric rehabilitation service provider shall have in place a written quality management (QM) plan document that is reviewed and updated annually to reflect the outcomes of member needs assessment, quality assessment, and outcome evaluation processes. The QM plan must be submitted to Community Care as part of the credentialing process. A copy shall also be submitted to the Department of Human Services. The provider is expected to provide an annual review of the implementation of the QM plan to payors upon request.

The QM plan should include at least the following elements:

- Assessment of the on-going effectiveness of the program.
- Means of assuring the effectiveness of staff and of staff training.
- A process for the effective management of and response to member complaints and the ability to aggregate complaints to improve program effectiveness.
- Means to assess member satisfaction with services.
- Assessment of the effectiveness of linkages between behavioral health programs.

Each psychiatric rehabilitation service provider shall provide for a systematic review of services to ensure quality, timeliness, and appropriateness of services. An outcome evaluation system also needs to be developed to determine program effectiveness, efficiency, and member satisfaction. The outcome evaluation system must be written in a manner so as to assure that a member's service goals and objectives are incorporated into the evaluation plan.

At a minimum, the QM plan should monitor the following:

- Exceptions to the five diagnoses listed in the admission criteria.
- Approval of mobile rehabilitation above the six hour per week limit.
- Overall cost and utilization of psychiatric rehabilitation services and partial hospitalization.

Outcome Measurements

Psychiatric rehabilitation programs have been noted to be of significant value to individuals with serious and persistent mental illness. Qualities that have been documented in research studies are among those that have been established as outcome expectations for psychiatric rehabilitation programs in the HealthChoices program:

- Increased community tenure
- Reduced psychiatric hospitalization
- Reduced involvement with criminal justice
- Decreased use of illicit drugs
- Improved member satisfaction with:
 - Behavioral health services received
 - Quality of life
- Increased active participation in treatment and service planning:
 - Improved adherence to agreed-upon services
 - Active self-notation of progress
- Heightened self-esteem (self-report)
- Improved vocational functioning
- Improved educational status
- Improved stability of housing status
- Improved GAF score