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SERVICES

Service Delivery

The provider shall provide all mandatory services. Mandatory services shall not be subcontracted. The provider may choose to provide the optional services, either in house or through a subcontractor. If the provider chooses to subcontract the optional services, the subcontractor must meet all provider participation requirements including, but not limited to, licensing and certification requirements. The provider shall prevent a duplication of services by ensuring that services requested and offered to a recipient are not available and offered by a non-MHR provider. Prior to submitting a request for services, the provider shall gather necessary information from non-MHR providers including, but not limited to, residential programs, case management services, counseling centers, school based programs, and assertive community treatment teams to prevent such a duplication. To prevent duplication of services, a copy of the OCS, OJJ, Office of Addictive Disorders (OAD), Office of Citizens with Developmental Disorders (OCDD), or any other therapeutic intervention plan must be submitted to the Service Access and Authorization Unit when requesting services.

There shall be family and/or legal guardian involvement throughout the planning and delivery of services for children and youths. The agency or individual who has the decision-making authority for children and youths in state custody must request and approve the provision of services to the recipient. If applicable, the OCS or OJJ case manager or person legally authorized to consent to medical care must be involved throughout the planning and delivery of all services and the provider must document the involvement in the recipient's record.

The child or youth must be served within the context of the family and not as an isolated unit. Services shall be appropriate for the following characteristics:

- Age,
- Developmental level,
- Educational level, and
- Culture.

If a recipient/family is unable or not willing to attend a scheduled appointment, the provider shall make a reasonable effort to conduct follow-up and outreach services. This may include scheduling the appointment in the evening or on a weekend, in the recipient's home or another community location. It is a clinical decision when a reasonable effort has been made. Documentation of all attempts to contact the recipient should be entered in the recipient's record. You may use a service log marked "For File Only".

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When a recipient is discharged, a referral must be made to available community resources and documented in Mental Health Rehabilitation Services Information System (MHRIS). If telephone contact with the recipient or his/her family is not possible, the referral information must be mailed.

Mandatory Services

Assessment and Service Planning

Service Definition

The initial assessment and reassessment are an integrated series of diagnostic, clinical, psychosocial evaluations conducted with the recipient and his/her significant others to develop an effective, comprehensive individualized services and recovery plan (ISRP). It may also be used to determine the recipient's level of need and medical necessity.

Program Requirements

The initial assessment must be completed for all new recipients and for those with a twelve (12) month or more lapses in service. The initial assessment form must be completed within thirty (30) calendar days following the initial screening and submitted to the Bureau for approval. Under exceptional circumstances, at the discretion of the Bureau, extensions beyond the thirty (30)-day assessment period may be granted on a case-by-case basis. Requests for extensions should be thoroughly documented and directly related to the reason for the delay. (Example: a fifteen (15) day extension is being requested because the recipient was hospitalized for fifteen (15) days.)

Information in an initial assessment shall be based on current circumstances (within thirty (30) days) and face-to-face interviews with the recipient, as well as consider pertinent historical data. If the recipient is a minor, the information shall be obtained from a parent, legal guardian or other person legally authorized to consent to medical care.

With the recipient's and/or family's consent, historical data, including but not limited to past treatment records, school reports, and/or past assessments, must be requested prior to the start of the assessment. This data should be reviewed as part of a complete and accurate assessment. The recipient's record must contain documentation of all efforts to obtain this data.

A reassessment must be completed every ninety (90) calendar days after the initial assessment or as deemed necessary by the Bureau. For example, a reassessment may be required after sixty (60) calendar days if a provider is requesting a Request for Revision.

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Information in a reassessment shall be based on circumstances since the most recent authorization and a face-to-face interview with the recipient. Reassessment data must be approved by the Bureau. If the recipient is a minor, the information shall be obtained from a parent, legal guardian or other person legally authorized to consent to medical care. This data is the foundation of the recipient's ISRP.

In order to ensure an adequate and recovery/resiliency focused assessment, providers are required to utilize a variety of methods to gather assessment data. Assessments must be complete and accurate given the condition and circumstances of the recipient. To make a clinically valid assessment, additional methods to gather assessment data should include:

- A review of all prior services that the recipient has received in the past year. This may include discharge summaries, service summaries, or copies of clinical records.
- Collateral contacts (telephone, face-to-face, and/or written correspondence) with prior service providers and other systems (e.g. social services, corrections, schools, etc) who are involved with the recipient.
- Interviews with individuals who have directly observed the recipient's functioning and behaviors in his/her natural environment (home, school, work, community).

The information outlined below must be documented in the initial assessment:

- Presenting problem including source of distress, precipitating events, associated problems or symptoms and recent progressions,
- Risk assessment, including suicide risk,
- Mental status including at least:
 - Appearance, attitude and behavior,
 - Orientation to person, place, time, and date,
 - Affect and mood, and
 - Thought content/processes including:
 - Intelligence,
 - Fund of knowledge,
 - Cognitive processes,
 - Memory,
 - Insight and judgment,
 - Homicidal/Suicidal risk.
- Personal strengths, abilities and/or interests,
- Previous behavioral health services data (such as a clinical record, discharge summary, etc) including:

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- Diagnostic information,
- Treatment information (dates, locations, duration, frequency modalities, efficacy—including factors that have contributed to or inhibited previous recovery efforts), and
- Efficacy of current and previously used medications.
- Physical health history and current status including medication allergies and adverse reactions within the last year. There must be evidence of a review by a treating psychiatrist as a part of the assessment,
- Medication use profile,
- Developmental history (for recipients under the age of eighteen),
- Pertinent current and historical life situation information that establishes a recovery/resilient environment including:
 - Age,
 - Gender,
 - Employment history,
 - School/education history including current level of functioning,
 - Legal involvement, and
 - Family history,
- History of abuse (including trauma survivor issues, spousal/partner abuse, physical, psychological, sexual, emotional abuse, and whether the recipient was a victim or a perpetrator of said abuse),
- Relationship including natural support,
- Housing or living environment including where, with whom, how long, and how stable,
- Use of alcohol, tobacco, and/or other drugs,
- Current level of function in life skills,
- Individualized needs and preferences (e.g., recipient choices of location, service type, provider, and focus of services),
- Issues important to the recipient including, but not limited to:
 - Cultural background,
 - Spiritual beliefs, and
 - Sexual orientation,
- Need for and availability of social supports,
- Risk taking behaviors (e.g., unprotected sex, run away, etc.),
- Advance directives if applicable,
- Diagnostic impressions using DSM-IV(or current version), Axes I-V, and
- List of individuals interviewed including location.

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A comprehensive initial assessment includes the development of a written Integrated Summary to synthesize, evaluate, integrate, and interpret the data gathered in the assessment. The Integrated Summary section must include:

- Presenting problem(s) and/or illness(es),
- LOCUS/CALOCUS score,
- The recipient's strengths and needs,
- The recipient's preferences in services (cultural, location, etc),
- Significant features from any aspect of the assessment including mental status, risk factors, medical, medications, etc.,
- Summary of base line functioning,
- DSM IV diagnosis, Axes I-V, and
- Recommended prioritized service objectives and interventions.

The information outlined below must be documented in the reassessment:

- DSM IV diagnosis, Axes I-V;
- The results from the LOCUS/CALOCUS including specific documentation to support the overall level of care recommendation and the rating in each dimension;
- Medications, including efficacy of current and previously used medications;
- Utilization of crisis services;
- Risk assessment, including risky behavior and suicide risk;
- Current Functional Status including basic needs and mental status exam; and
- Describe:
 - The presence of a co-morbid condition(s),
 - Stressors in the natural environment,
 - Need for and availability of social supports,
 - Resiliency and recovery,
 - Engagement,
 - Treatment barriers,
 - Strengths and needs,
 - Preferences in services (cultural, location, etc), and
 - Barriers to accomplishing goals and objectives.

Reimbursement for initial assessment and reassessment includes all activities but is not limited to:

- Review of all prior services including discharge summaries, service summaries, or copies of clinical records.
- Collateral contacts (telephone, face-to-face, and/or written correspondence) with prior service providers, and other systems (e.g., social services, corrections, schools, etc).
- Interviews to support direct observations.

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- Face-to-face meeting(s) with the recipient and his/her significant others.
- Administration of the LOCUS/CALOCUS.
- All relevant documentation including service logs and assessment documents.
- Any team or internal meetings required to discuss or review assessment process and findings prior to service planning team meeting.

Service Planning

Service Planning is the team process of developing and/or finalizing the recipient's individualized service and recovery plan (ISRP) and Contingency Crisis and Discharge Plans, periodically reviewing progress toward the goals of the ISRP, and modifying it as indicated. The ISRP is an individualized, structured, goal-oriented schedule of services developed jointly by the recipient and treatment team. Recipients must be actively involved in the planning process and have a major role in determining the direction of their ISRP. The ISRP must identify the goals, objectives, interventions, and units of service based on the results of an assessment and agreed to by the adult or youth and his/her parent/guardian. Service planning does not include regular team meetings, staff training or supervision.

All service requests on the ISRP must be individualized to meet the recipient's needs. It is not permissible to use terms such as 'as needed' or 'PRN' to describe frequency or duration of services. The ISRP must be developed and reviewed as follows: all timeframes are calendar days and must be tracked by the date of recipient signature.

An interim ISRP must be developed as part of a recipient's initial assessment. Goals and objectives must address immediate needs identified in the recipient's initial assessment, especially health and safety issues. The initial ISRP must be completed within thirty (30) days of notice to the provider of the recipient's eligibility (refer to section 31.2 Service Access and Authorization for more detail regarding interim authorizations) and must address the recipient's needs for the first ninety (90) day authorization.

The licensed mental health professional (LMHP) along with the recipient, natural support, and the treatment team must develop the initial ISRP. ISRP updates are submitted to the Bureau every ninety (90) days as part of the reassessment, with a request for revision, or as requested by the Bureau. The community support worker may draft updates to the ISRP with the recipient and natural support. The LMHP must review and sign the final ISRP as part of the service planning team meeting as outlined below.

The ISRP must be updated to reflect changes made to services. Changes may include developing and revising goals, objectives, interventions, the discharge plan, and the crisis plan. The recipient and/or family members must sign or initial each change. Though the ISRP does not need to be resubmitted each time a change is made, a summary of the changes must be described when requesting a reauthorization.

The ISRP must:

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- Be based on the needs and desires of the recipient and focused on his/her integration and inclusion into the local community, the family, and, when appropriate, natural support systems.
- Involve the family of the recipient when applicable and permitted.
- Identify any needs beyond the scope of the MHR program.
- Specify the services that will be provided.
- Specify referrals to any services provided by other providers or community resources.
- Be provided to the recipient/family in writing.

The ISRP must be written using language that the recipient will understand. Complex words and phrases, medical terms, and abbreviations must not be used in an ISRP. The ISRP must be appropriate to the recipient's culture and age (chronological and developmental). Updated ISRPs must include an explanation of progress made toward meeting goals and objectives (i.e. met, not met, and discontinued). Failure to meet a goal or objective indicates the need for an ISRP revision.

The ISRP must include a list of prioritized needs identified in the most recent assessment as well as a list of services beyond the scope of what the agency can provide (for example, access to substance abuse treatment, physical health treatment, sexual abuse treatment, vocational rehabilitation, recreational activities, and inpatient care). The provider is responsible for coordinating all services.

The ISRP must include the following components:

- Goals
- Objectives with target dates
- Interventions
- Individualized/Recovery Focused Crisis Plan
- Discharge Plan

Goals

A goal is defined as a broad statement that reflects what a recipient hopes to accomplish to address a priority need. They are more general than objectives and should be targeted for completion within the authorization period. Each goal must include:

- A description of the recipient's strengths, resources, and supports,
- Specific objective(s) with target dates, and
- Specific intervention(s).

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Objectives

Objectives are defined as the smaller more specific steps necessary to accomplish a goal and reflect the recipient's and treatment team's expectations. They must take into account the recipient's age, development, disabilities and concerns. Objectives must be developed following the principles of S-M-A-R-T, which requires objectives to be:

- Specific,
- Measurable,
- Action-oriented,
- Realistic, and
- Time limited.

Objectives that are not developed in accordance with the principles of S-M-A-R-T may result in a denied authorization request and/or sanctions following a post payment review.

Specific objectives make it clear to the recipient, family, and staff exactly what is to be done. Specific objectives allow the recipient, family and staff to determine if changes are needed to the service plan including, but not limited to, frequency of contact, service type, and effectiveness of a behavioral intervention plan. Objectives must be based on observable behaviors/skills the recipient will target for development or improvement during the authorization period. Objectives which include phrases such as "improve school behavior" or "will learn more independent living skills" are considered to be too general.

Measurable objectives allow recipients, natural supports, and staff to determine whether an objective is being accomplished. In order to establish measurable objectives, staff must gather baseline data as well as collect ongoing data while services are being provided. Data collection determines the extent to which a recipient needs to improve his/her behavior or skills as well as to determine the type of measure that will be used to verify that an objective has been achieved.

Data collection may include the use of standardized assessment tools, checklists, and observations. Measures may include improved grades (from a C to an A), an increase in the frequency of a positive behavior or skill, or the dollar amount a recipient may deposit in his/her savings account.

Action oriented objectives make it clear to the recipient, family, and staff what the recipient is expected to do, instead of what the recipient is to stop doing. Action oriented objectives are positive in nature, and give the recipient a road map for dealing with problems or issues related to his/her mental illness. Objectives that are negative such as "I will stop fighting" or "I will reduce my symptoms" do not promote positive changes and learning.

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Objectives should be based on a recipient's strengths, needs, interests, and abilities. Developing realistic objectives involves building on strengths while developing new skills, abilities, interests, and personal insight. The team members must work closely with recipients and family to establish objectives that are reflective of the recipient's abilities.

Objectives must include realistic target dates that do not exceed the authorization period. For planning purposes, target dates are used to identify for the recipient, family, and staff the amount of time that the team expects it will take to accomplish each objective. If an objective is not accomplished by the established target dates, the team may adjust the time-period or modify the objective.

Interventions

Interventions are methods that the provider uses to help a recipient achieve his/her objectives. LMHP staff is responsible for ensuring that staff members are competent to provide the interventions detailed in the ISRP. Interventions should be well defined for all team members, and relate to an objective. Interventions that include teaching skills should be very specific and should include the teaching methods (modeling, role-play, etc.). Interventions must be active in nature, and do not include "watchful oversight." The recipient, family, natural support, and staff should be clear as to how the objective will be addressed.

Therapeutic interventions such as cognitive-behavioral therapy (CBT) and behavior modification should be documented in the intervention. Evidence based strategies should be used, if appropriate. Interventions that are general such as "assist", "develop", "teach" without specific details may result in a denied authorization request and/or sanctions following a post payment review.

NOTE: For a list of evidenced based strategies, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) website at www.samhsa.gov or visit the MHR website, www.mhrsla.org, for a link to resources.

Individualized/Recovery Focused Crisis Plan

The crisis plan must be developed as part of the initial assessment and updated with the ISRP. The recipient, family, and staff develop and update the crisis plan based on an ongoing assessment of the recipient's risk, skills, and natural support. The recipient must have a copy of the current plan. The plan should be posted in a common area of the home near a telephone. MHR staff must ensure that the recipient and his/her natural support understand all aspects of the plan. This may include skills training with the recipient as well as natural supports who will be involved in the implementation of the plan.

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Providers must not list 911 as the first and only contact telephone number. Instead, the provider must educate the recipient regarding circumstances that will necessitate calling 911 for emergency assistance. Current contact telephone numbers must be maintained on the crisis plan. Evidenced based methods such as the Wellness Recovery Action Plan (WRAP) should be used if appropriate.

When an agency agrees to provide services to a recipient at Level five (5), it is done with the understanding that it is imperative that the agency develop a safety/crisis plan that will provide for the safety of the recipient twenty four (24) hours a day. Those agencies who do not have the expertise or resources available to meet this requirement should **not** agree to provide services to recipients who score a Level five (5) on the LOCUS/CALOCUS. Services for Level five (5) recipients must include comprehensive clinical services, support services, crisis stabilization services, and prevention services.

The crisis plan must:

- Describe what constitutes a crisis for the recipient. The team may consider events that caused the need for hospitalization in the past and caused significant distress for this recipient. Staff should ask the recipient to describe events he/she would consider a crisis.
- Describe events/situations that may be precipitants to a crisis. The team may describe behaviors/situations that have happened just before (triggered) crisis in the past and list observable behaviors which, for this recipient, mean that things have worsened and may be close to becoming a crisis (warning signs).
- Describe what action (s) can be taken by the recipient and/or natural supports to address the crisis which may include specific behavior strategies and environmental safeguards. If there are currently no natural supports available, the team should consider including goal (s) on the ISRP to focus on developing natural supports.
- Describe what action (s) can be taken by staff based on the needs of the recipient to ensure primary health and safety needs are met. Staff responding to a crisis must have a copy of the current plan and must receive training regarding the intervention methods detailed in the plan.

Include the name, address, telephone number of supporters the recipient wishes to help them when at risk of entering or in a crisis. It is important that the list of supporters is current with accurate information including name/contact number/assigned task of each supporter.

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- Include the name, title, and contact information for the primary community support worker and other agency support staff including the LMHP and the psychiatric director. Staff shall ensure that agency contact information is clear, accurate, and up-to-date.
- Include other instructions from the recipient as well as information that he/she would want others to know/follow in times of crisis. The plan should include pertinent information from the recipient's advance directive.

Discharge Plans

Discharge planning is the formal process that leads to the development of an ongoing individualized plan of care that meets the assessed needs of the recipient upon discharge from service. The first discharge plan is developed during the interim authorization. The plan is updated as needed. The updated plan is submitted with each quarterly authorization request or at the request of the Bureau. MHR staff, particularly the community support worker, is responsible for coordinating and implementing the plan. Any specific recipient circumstances (e.g., housing, job, school) that must be in place prior to discharge or transition. The plan should address the following areas:

- Physical health
- Safety/Emergency
- Use of medication
- Home management (cleaning, cooking, maintenance)
- Budgeting
- Transportation and travel
- Recreation and leisure
- Social and personal skills

A written draft of the proposed ISRP may be developed outside of the service planning team meeting with final changes made during the meeting. Effective service planning must include representation from all systems of support and care in which the recipient is engaged. The service planning team at a minimum must be comprised of the:

- Recipient,
- Recipient's primary LMHP,
- Recipient's primary community support worker,
- Recipient's family or caretaker(s), if the recipient is a youth, and
- OJJ or OCS caseworker, if the recipient is in their custody. If the OJJ or OCS caseworker is not physically present at the service planning team meeting, a good faith effort shall be made to schedule a teleconference or videoconference during the service planning team meeting or to arrange the meeting at the OCS or OJJ office.

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It is desirable for the following additional team members to participate in service planning as applicable:

- All staff providing direct services to the recipient and his/her family,
- Prescribing psychiatrist if other than the MHR contracted or employed psychiatrist, and
- Representatives from other systems of care or services in which the recipient is engaged including but not limited to:
 - Schools,
 - Juvenile/adult corrections or justice related,
 - Acute care facilities,
 - Child welfare/social services,
 - Other service/community providers.

The provider must have an original completed, dated sign-in team meeting document, as well, as evidence of invitations extended to the meeting such as copies of letters, emails or service logs.

Each ISRP must be reviewed, signed and dated by the:

- Recipient,
- Recipient's primary LMHP,
- Recipient's primary community support worker,
- Recipient's family or care taker(s), if the recipient is a youth

OJJ or OCS representative if the recipient is in their custody, and the psychiatrist. In the event the psychiatrist is not present at the meeting during review of the ISRP, the MHR or Non-MHR psychiatrist must review the ISRP within ten (10) calendar days following the meeting and sign a certification statement. If the recipient has selected a non-MHR psychiatrist, the MHR psychiatrist must complete a service log to document consultation with the non-MHR psychiatrist prior to submitting the initial ISRP and at least quarterly thereafter. Documentation of all required invitation and participation of service planning stakeholders as delineated above must be maintained.

Staffing Requirements

The psychiatrist shall:

- Conduct a face-to-face interview with the recipient at initial assessment.
- Review and sign the Medical History Questionnaire section of the initial assessment during a face-to-face contact.
- Review, sign and date the ISRP at initial assessment and reassessment.
- Review and sign the Electronic Clinical Data Inquiry (e-CDI) screen print. If no data is available, the screen print must also be signed.

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NOTE: The provider must ensure and document that a recipient who chooses a non-MHR physician who is not a psychiatrist receives a face-to-face interview, review of Medical History Questionnaire section, review of the ISRP and review of the e-CDI screen performed by a qualified psychiatrist.

The licensed mental health professional (LMHP) shall:

- Direct the gathering of the assessment data.
- Conduct a face-to-face interview with the recipient. The recipient's family/significant other(s) should also be interviewed when possible if approved by the recipient. For a recipient who is a minor, an interview with the custodial parent(s) is mandatory.
- Score LOCUS/CALOCUS if he/she has been designated by Medicaid Behavioral Health Section as an Approved Clinical Evaluator (ACE).
- Develop the Integrated Summary as part of the initial assessment.
- Conduct a mental status exam as part of the initial assessment and reassessment. LMHP staff must have documented experience with conducting mental status exams.
- Determine the presence of a DSM IV diagnosis, Axes I-V as part of the initial assessment and reassessment. The LMHP must have documented experience with determining psychiatric diagnosis.
- Develop, sign and date the initial assessment and the reassessment forms.
- Obtain information about the recipient that may minimize the need for use of restraint or seclusion.

NOTE: An advanced practice registered nurse (APRN), clinical nurse specialist (CNS) or a nurse practitioner (NP) may not sign the initial assessment without the signature of the treating psychiatrist.

The initial assessment and reassessment shall be billed by the LMHP coordinating the assessment activities. Although they may not bill for the service, other qualified staff such as a mental health professional (MHP) or a mental health specialist (MHS) may participate in gathering data. The LMHP must complete a service log on the date the assessment is completed and enter into MHRISIS to be reimbursed.

NOTE: Staff must not bill community support while gathering and reporting reassessment information.

Service Specific Documentation Requirements

Service logs must be completed for all contacts during an assessment and filed in the recipient's record, though not all logs are entered into MHRISIS. Providers shall follow current MHRISIS policies regarding entering data.

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Service Authorization Periods

- Thirty (30) days for initial assessment
- Up to ninety (90) days for the reassessment

Community Support**Service Definition**

Community support is the foundation of the recovery-oriented ISRP and is essential to all recipients. Its goal is to increase and maintain competence in normal life activities and gain the skills necessary to allow them to remain in or return to their own natural environment. It provides the necessary services to assist the recipient in achieving and maintaining rehabilitative, resiliency and recovery goals related to education, work, housing, mental health treatment, financial and social supports and other support needs. Community support includes crisis intervention, coordination of MHR and non-MHR services, and individual skills training.

Specific goals of the service are:

- To achieve the restoration, reinforcement, and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of his/her psychiatric symptoms.
- To minimize the effect of mental illness.
- To maximize the recipient's strengths with regard to the mental illness.
- To increase the level of the recipient's age-appropriate behavior.
- To increase the recipient's independent functioning to an appropriate level.
- To enhance social skills.
- To increase adaptive behaviors in family, peer relations, school and community settings.
- To maximize the skills to link and engage with other community services including natural supports and resources.
- To apply decision-making methods in a variety of skill building applications.

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Program Requirements

Community support is an individualized service and is not billable if delivered in a group setting. Each recipient shall have one designated provider who will serve as the “mental healthcare home” for the recipient and family. The recipient will choose a designated community support worker who is the primary point of contact. While the community support worker provides the majority of community support activities, he/she may not be the exclusive provider.

The community support worker acts as the first responder (triage, support and intervention) for recipients in crisis, which may include face-to-face contact. When he/she is unavailable, there must be a backup worker. The name of the backup worker and how to contact him/her must be provided in writing to the recipient and the family (if the recipient is a minor) or caregiver. If the emergency is of a clinical nature, the MHP/MHS must consult with the LMHP or psychiatric director if the recipient’s circumstances are beyond his/her ability to ensure the safety of the recipient and others.

The community support worker assures access to and coordination of MHR and non- MHR services, subject to the face-to-face and community ratios, through the following activities:

- Establishing/maintaining interagency coordination, which may include education, Louisiana Rehabilitation Services (LRS), OAD, OCDD, OCS and OJJ.
Example: A youth who is at risk of entering the juvenile justice system may need coordination with the Family In Need of Supervision (FINS) program.
- Engaging in collateral consultation with other service systems or individuals (family members, significant others and professionals) who are actively involved in the recipient’s care, ensuring a comprehensive set of services and preventing duplication.
- Promoting active recipient involvement by:
 - Contacting the recipient face-to-face and by telephone.
 - Providing aggressive outreach if recipient participates less than specified in the ISRP. Aggressive outreach includes making every reasonable effort to provide continuing care, which may include enlisting the help of natural supports. Aggressive outreach should continue until the recipient resumes services or is successfully referred to another service provider.
- Monitoring the recipient’s self-management of symptoms.
- Drafting updates to the ISRP with the recipient and natural supports. The LMHP must review and sign the final ISRP as part of the service planning team meeting as outlined below.

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NOTE: Services that meet the service definition of Medication Management are excluded.

The community support worker provides individual skills training, which must be based on a curriculum or other published material that represents nationally recognized best practices. Targeted areas of skills training typically include:

- Socialization skills.
 - Communication,
 - Interpersonal relationships, including those with peers, family, and authority figures,
 - Problem solving/conflict resolution,
 - Management of sensory input and stress.
- Natural support system development that includes self-directed engagement in community social activities and the development of a social plan.
- Adaptation skills.
 - Identification of behaviors that interfere with performance,
 - Implementation of interventions to alleviate problem behavior, including coping with symptoms of mental illness that affect the person's ability to successfully work and/or attend school,
 - Development of the ability to follow directions and carry out assignments,
 - Acquisition of appropriate school habits,
 - Adaptation to community, environmental and/or family circumstances and realities,
 - Education in mental health/mental illness,
 - Development of individual day-to-day skills necessary for the recipient to comply with taking prescribed medications (services that meet the definition of medication management should be provided by staff credentialed to offer that service),
 - Development of day-to-day skills necessary for the recipient to identify, monitor, and self-manage his/her psychiatric symptoms, which interfere with their daily living, financial management, personal development, school or work performance.
- Developmental issues.
 - Physical changes,
 - Emotional changes, and
 - Sexuality.
- Daily living skills.
 - Age and developmentally appropriate daily and community living skills,
 - Personal hygiene and grooming,
 - Nutritional services,
- Food planning, grocery shopping, cooking, and eating,

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- Household maintenance, including housecleaning and laundry,
- Money management and budgeting, and
- Shopping for daily-living necessities.
- Community awareness and current events.
- Identification and use of social and recreational skills.
- Use of available transportation.
- Personal responsibility,
- Work readiness activities (excepting skills related to a specific vocation, trade, or practice) including:
 - Work related social and communication skills;
 - Work related personal hygiene and dress;
 - Work related time management; and
 - Other related skills preparing the recipient to be employable.

Place of Service and Frequency of Contact

Community support is primarily a face-to-face service and is primarily provided in the home or other community setting. Sixty (60) percent of the contacts provided during an authorization period must be face to face. No less than eighty (80) percent of those face-to-face contacts must be provided in the home or community. Contacts occur during times and locations best suiting the recipient's needs including after school, after work, evenings and weekend hours and include the following settings:

- Recipient's home;
- School;
- Other community environment which allows for privacy and confidentiality and is appropriate to the age, level of need, and structure needed for the recipients; or
- The MHR facility.

Staffing Requirements

Community Support may be provided by an:

- LMHP
- MHP or MHS under the supervision of an LMHP

Caseloads shall be effectively managed based on the recipient's needs and shall not exceed 1:30 (one (1) community support worker for each thirty (30) recipients receiving community support services).

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Service Authorization Periods

- Interim – thirty (30) days
- Initial – ninety (90) days
- Subsequent – ninety (90) days

Group Counseling**Service Definition**

Group counseling is a face-to-face interaction between two to eight recipients. It is a therapeutic service utilizing specific interventions, which must be documented in the recipient's ISRP. Evidenced based strategies should be used when applicable. Sessions are typically limited to one (1) hour.

Clinical Exclusions

The provider shall not admit any recipient who poses a documented health and safety risk to himself/herself, to other recipients, or for whom the provider cannot provide the necessary care.

Program Requirements

The service is directed to the goals on the approved ISRP. Sessions are scheduled to provide effective treatment consistent with the ISRPs of the group members. It should be available at times most convenient to the recipient/family needs and requests, including evenings and weekends. Participants must be of similar age, developmental level and psychosocial need. For children, if age difference exceeds three (3) years, the provider must document the basis for inclusion in the group in the recipient's record (service log or progress note).

Group counseling will be limited to the following topical areas:

- Anger management.
- Behavior management.
- Grief/loss.
- Trauma (sexual/physical/verbal).
- Sexual offenders.
- General symptom management skills, including:
 - Identification and management of symptoms of mental illness;
 - Compliance with physician's medication orders; and
- Reduction and alternatives to aggression.

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Topics and interventions (including those conducted in multi-family groups) must be consistent with the above topics and be directed exclusively to goals/objectives on the recipient's ISRP. Parenting skills training related to these topics may also be included.

NOTE: Collateral contacts or other non-face-to-face contacts are not billable under this service code.

Place of Service

This service may be provided at an MHR facility or off-site service delivery location as defined in Section 31.4. However, it shall not be provided at a site that serves as a group living environment, such as a board and care facility, group home or apartment building that serves as a residence for more than one MHR recipient.

Staffing Requirements

Group size may not exceed one (1) staff member to eight (8) group participants. A staff member must be present at all times during the group session. If a group is co-facilitated by more than one (1) staff member, only one (1) staff member can bill for each recipient.

The following individuals may provide Group Counseling:

- An LMHP
- An MHP under the supervision of an LMHP

Service Authorization Periods and Service Limits

- Interim – None
- Initial – ninety (90) days
- Reassessment – up to ninety (90) days

Individual Intervention**Service Definition**

Individual intervention is an interaction between the counselor/therapist and the recipient. It is a face-to-face structured service based on a range of professional therapeutic strategies, which must be documented in the recipient's ISRP. Evidenced based strategies should be used when applicable. Sessions are typically limited to one hour. For contacts lasting longer than one hour, the service log must include the reason for the extended session.

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This service is provided to ameliorate the psychosocial barriers that impede the development or enhancement of skills necessary to function in the community.

Individual Intervention is relevant to the recipient's needs and relate directly to the individualized goals and objectives specified in the ISRP.

These services are based on psychological treatment principles. Specifically, these include counseling and therapy services that:

- Maximize strengths;
- Reduce behavioral problems;
- Change behavior;
- Improve interpersonal skills;
- Explore and clarify values; and
- Facilitate interpersonal growth and change.

Place of Service

This service may be provided in the recipient's home, an MHR facility, school, or other off-site service delivery location. It should be available at times most convenient to the recipient including evenings and weekends.

NOTE: Collateral contacts or telephone contacts are not billable under this service code.

Staffing Requirements

The following individuals may provide Individual Intervention:

- An LMHP
- An MHP under the supervision of an LMHP

Service Authorization Periods

- Interim – None
- Initial – ninety (90) days
- Reassessment – up to ninety (90) days

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Medication Management**Service Definition**

Medication management is provided to:

- Assess,
- Monitor a recipient's status in relation to treatment with medication,
- Instruct the recipient, family, significant others or caregivers of the expected effects of therapeutic doses of medications, or
- Administer prescribed medication when ordered by the psychiatrist (or other prescriber as allowed under applicable law) as part of an ISRP that is inclusive of additional rehabilitation services and supports.

Program Requirements

All activities of medication management must be provided face-to-face and at a minimum shall be available to recipients during normal operating hours. It cannot be provided in a group setting. Necessary collateral or telephone contacts are included in the reimbursement for this service and must not be billed.

This service includes four primary activities:

- Initial Medication Assessment—the initial assessment of the need for, type and dosage of medications directed toward maximizing a recipient's functioning and reducing symptoms. This assessment is minimally inclusive of:
 - Medical history-general health.
 - Review of past medication history.
 - Other prescriptions including non-psychotropics.
 - Untoward side effects and contraindications.
 - History of compliance.
 - Efficacy of past/current medication prescribed to treat a behavioral disorder.
 - Review of abuse history (prescription/non-prescribed).
 - Medication type and dosage ordered as a result of the assessment.
- Medication administration—the administration of therapeutic doses of medication for the treatment of mental disorders that have been prescribed and are monitored by a psychiatrist (or other prescriber as allowed under applicable state law) and indicated in the recipient's ISRP.

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“Administration” shall be interpreted consistent with applicable state law but minimally is inclusive of injectables (shots), direct dosing of oral medications, and repackaging of oral medication into “pill boxes” or daily dosage boxes when pills are placed in the boxes directly by staff credentialed to administer medications.

- Medication monitoring—the ongoing review of symptoms, side effects, effectiveness, applicable lab or other measures, compliance, and prescription renewal and adjustment of psychotropic medications.
- Medication education—involves the instruction of the recipient, family, significant others, and care givers on the expected effects of prescribed medication.

Medication Education may include but is not limited to:

- Proper use and storage of medications.
- Rationale for the medication.
- Possible side effects, including impact on pregnancy, age, sex, or disability.
- Early warning signs of relapse and signs of non-adherence and noncompliance with medication prescription.
- Circumstance/symptoms requiring contact with a medical professional.
- Use/interactions with other substances (prescribed/non-prescribed).
- Instruction on the proper self-administration of medications.

If an individual is in crisis and the prescribing practitioner changes the medication or dosage, medication education must be provided within one (1) business day.

The following frequency of service requirements apply to all recipients on psychotropic medications for which the provider is the primary prescribing and monitoring entity:

- Initial medication assessment – completed and documented in the clinical record during the interim authorization period, not to exceed thirty (30) days from the date eligibility was determined.
- Monitoring – provided as justified by recipient need but in no case less frequently than once every ninety (90)-calendar days.
- Medication administration – frequency as required by prescription, orders and the ISRP.

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- Medication education – as required in the ISRP, but minimally must be documented in the clinical record at the time of any change in medication including dosage or type.

The administration of all medications, medication errors, and adverse drug reactions must be documented. Within thirty (30) days of the initial assessment and ninety (90) days thereafter, a physician must conduct an evaluation. There must be a process for immediately notifying the attending physician of drug reactions, medication errors, and /or other related problems.

Storage of Medications

Only staff authorized to administer or supervise self-administration of medication shall have access to medications. All medications must be handled in accordance with applicable state and federal law including:

- Labeling all medications properly and storing them under lock and key.
- Storing medications for external use separately from internal and injectable medications.
- Storing disinfectants separately from all medications.
- Storing medications under proper conditions of sanitation, temperature, light, moisture and ventilation.
- Removing outdated medications and disposing of them.
- Disposing of needles in accordance with the established Occupational Safety and Health Administration (OSHA) policy for handling medical waste.

The telephone number of existing poison control centers, ambulance and other emergency medical centers should be readily accessible to the staff and recipient.

Staffing Requirements

Medication Management is limited to licensed medical practitioners operating within their scope of practice as allowed under the applicable state law(s). In addition, psychiatrists (M.D. or D.O.) shall be board eligible (as defined by the Bureau) or board certified. Advanced Practice Registered Nurse (APRN)/Clinical Nurse Specialist (CNS) or a Nurse Practitioner (NP) must operate under an approved collaborative practice agreement with a board certified or board eligible psychiatrist. The Louisiana State Board of Nursing must approve the collaborative practice agreement prior to delivering services.

Credentials allowable for core activities within medication management are as follows:

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- **Initial Medication Assessment**
 - Psychiatrist
 - APRN/CNS or NP certified in psychiatry
- **Medication Administration**
 - Psychiatrist
 - APRN/CNS or NP certified in psychiatry
 - Registered Nurse (RN)
 - Licensed Practical Nurse (LPN)
- **Medication Monitoring**
 - Psychiatrist
 - APRN/CNS or NP certified in psychiatry
 - Registered Nurse (RN)
- **Medication Education**
 - Psychiatrist
 - APRN/CNS or NP certified in psychiatry
 - Registered Nurse (RN)

Service Specific Documentation Requirements

In addition to documentation required for each contact, the following specific documentation must be present in recipients' records for whom Medication Management is provided:

- Medication Administration Record (MAR)
- Medication Errors and Reporting Form
- Adverse Event Drug Reporting Form (pharmacy or drug related)
- e-CDI printout
- Medication Consent
- Physician's Orders
- Lab results (as applicable)
- Medication education documentation (for each prescribed drug when initially prescribed)

Place of Service

This service may be provided at the MHR office, an off-site service delivery location or in a recipient's natural environment (schools, home, etc) appropriate to the recipient's needs and circumstances and in compliance with privacy and confidentiality requirements.

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Service Authorization Periods

- Interim – thirty (30) days
- Initial – ninety (90) days
- Reassessment – up to ninety (90) days

Parent/Family Intervention (Counseling)**Service Definition**

Parent/Family Intervention (Counseling) is a face-to-face therapeutic intervention involving the recipient and one or more family members. The primary goal is to help the recipient and family improve their overall functioning in the home, school, work and community settings. This goal is accomplished by helping the recipient and family increase effective coping mechanisms, healthy communication strategies, constructive problem-solving skills and increased insight into the nature of the recipient's difficulties and the impact on the family. This service utilizes specific interventions, which must be documented in the recipient's ISRP. Evidenced based strategies should be used when applicable and tailored to address the recipient's and family's needs. These services are intended to be time limited with services reduced and discontinued as the family functions more effectively.

Parent/Family Intervention includes regularly scheduled face-to-face interventions, with the recipient and family designed to improve family functions. Specific interventions may include:

- Assisting the family with developing and maintaining appropriate structure within the home.
- Assisting the family with developing increased understanding of the recipient's symptoms and problematic behaviors and developing effective strategies to address these issues, and encouraging emphasis on building upon the recipient and family's strengths.
- Facilitating the family's ability to effectively manage, teach, and positively reinforce the recipient's strengths.
- Facilitating effective communication and problem solving between the recipient and family members.

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Program Requirements

The service should be available at times of operation most convenient to the recipient/family needs and requests, including evenings and weekends.

The recipient must be present for counseling sessions except where therapeutically contraindicated. Reasons must be documented in service logs for each meeting in which the recipient is not present. Necessary collateral or telephone contacts are included in the reimbursement for this service and are not billable.

Place of Service

Services may be provided at the MHR office, an off-site service delivery location, or in a recipient's natural environment (school, home, etc.) as appropriate to recipient needs and circumstances and in compliance with privacy and confidential requirements.

Staffing Requirements

The following individuals may provide Parent/Family Intervention (Counseling):

- An LMHP
- An MHP under the supervision of an LMHP

Service Authorization Periods

- Interim – None
- Initial – ninety (90) days
- Reassessment – up to ninety (90) days

Psychosocial Skills Training – Group (Youth)**Service Definition**

Psychosocial Skills Training – Group (Youth) is a face-to-face therapeutic, rehabilitative, skill building service for children/youth to increase and maintain competence in normal life activities and gain the skills necessary to allow them to remain in or return to their communities. It is an organized service based on models incorporating psychosocial interventions. The goals of the service include:

- To achieve the restoration, reinforcement, and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of his/her psychiatric symptoms.

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- To minimize the effect of mental illness.
- To maximize the recipient's strengths.
- To increase the level of the recipient's age-appropriate behavior.
- To increase the recipient's independent functioning to an appropriate level.
- To enhance pro-social skills.
- To increase adaptive behaviors with family and peers and in school and community settings.

Clinical Exclusions

The provider shall not admit any recipient who poses a documented health and safety risk to himself/herself, to other recipients or for whom the provider cannot provide the necessary care.

Program Requirements

Psychosocial Skills Training has a structured curriculum that is adapted to the recipient's needs and teaches skills necessary to succeed in his/her environment. The curriculum must be nationally recognized best practice standards and be age and developmentally appropriate and culturally relevant.

Participants must be of similar age, developmental level and psychosocial need. If age difference exceeds (3) three years, the basis for inclusion in the group must be documented.

Training material must include activities that will allow the recipient to practice the skill(s) taught during the group session and natural settings. This will allow the recipient to further develop and integrate the skill.

If a recipient completes a curriculum but needs additional training, Community Support should be used during or after the group sessions as a more individualized method of training.

The curriculum is designed to improve or maintain the recipient's ability to function in normal social roles and should include but not be limited to:

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Socialization skills

- Communication,
- Interpersonal relationships, including those with peers, family, and authority figures,
- Problem solving/conflict resolution,
- Management of sensory input and stress,
- Natural support system development,
- Self-directed engagement in community social activities (development of a social-recreational plan for the recipient), and
- Decision-making.

Adaptation skills

- Identification of behaviors that interfere with performance,
- Development of interventions to alleviate problem behavior, including coping with symptoms of mental illness that affect the person's ability to successfully work and/or attend school,
- Development of capacity to follow directions and carry out assignments,
- Acquisition of appropriate school habits, and
- Adaptation to community, environmental and/or family circumstances and realities.

Education in mental health/mental illness

- Management of symptoms of mental illness to minimize the negative effects of psychiatric symptoms, which interfere with the recipient's daily living, personal development, and community integration (services that meet the definition of medication management should be provided by staff credentialed to offer that service).
- Developing skills necessary for the recipient to comply with prescribed medications.
- Developmental issues including:
 - Physical changes,
 - Emotional changes, and
 - Sexuality.

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Daily living skills for children/youth transitioning to independent living or as otherwise needed including:

- Age and developmentally appropriate daily and community living skills,
- Nutritional services,
- Food planning, grocery shopping, cooking, and eating,
- Personal hygiene and grooming skills,
- Household maintenance, including house cleaning and laundry,
- Money management and budgeting,
- Shopping for daily-living necessities,
- Community awareness and current events,
- Identification and use of social and recreational skills,
- Use of available transportation, and
- Personal responsibility.

Work readiness activities (excepting skills related to a specific vocation, trade, or practice):

- Work related social and communication skills;
- Work related personal hygiene and attire;
- Work related time management; and
- Other related skills preparing the recipient to be employable.

Psychosocial Skills Training must have an ongoing process to ensure that recipients participate in the development and periodic revision of program curricula as appropriate to their age and developmental capacity. Training occurs after school and during weekend hours when this meets the recipient's needs. The staff must be present at all times during the course of the group skills training. A group recreational outing is not billable for this service.

NOTE: Anger management and alternatives to aggressive behavior are more appropriately addressed in Group Counseling and must not be provided as part of this service.

Place of Service

This service must be provided in a location, which ensures confidentiality. Locations including, but not limited to retail outlets, libraries, sporting events, etc. do not meet guidelines for confidentiality and may not be used for groups. Individual skills training could be provided in locations, if related to the ISRP, and conducted in such a manner as to promote normalization and prevent stigmatization. This service shall not be provided at a site that serves as a group living environment, such as a board and care facility, group home or apartment building that serves as a residence for more than one MHR recipient.

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Staffing Requirements

The service must be provided under the supervision of an LMHP with a minimum of two (2) years experience providing services to children, youths and their families. The services must be provided by one of the following:

- An LMHP,
- An MHP, or
- An MHS.

Group size may not exceed eight (8) recipients for any single skill building activity.

Service Authorization Periods

The training material must be organized into a specific number of sessions, not to exceed twenty (20) sessions, (services that meet the definition of medication management should be provided by staff credentialed to offer that service) for each topic area (curriculum). A recipient would normally participate for six (6) to eighteen (18) months.

- Interim – None
- Initial – ninety (90) days
- Reassessment – up to ninety (90) days

Optional Services

Optional services may only be offered by providers that have been certified by Medicaid Behavioral Health Section to provide this service. Refer to Section 31.3 for the optional services certification process.

Parent/Family Intervention (Intensive) (Youth Only)**Service Definition**

Parent/Family Intervention (Intensive) (PFII) is a structured service involving the recipient and one (1) or more of his/her family members. It is an intensive family preservation intervention intended to stabilize the living arrangement, promote reunification, or prevent utilization of out of home therapeutic placement (i.e., psychiatric hospitalization, therapeutic foster care) for the recipient. This service focuses on the family; and is delivered to children and youths primarily in their homes. Therefore, PFII is not appropriate for recipients whose families refuse to participate or to allow services in the home. This service utilizes specific interventions, which must be documented in the recipient's ISRP. Evidenced based strategies should be used when applicable and tailored to address the recipient's and family's needs.

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The goals of PFII include but are not limited to:

- Diffusing the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- Ensuring the linkage to needed community services and resources;
- Ensuring the clinical appropriateness of services provided; and
- Improving the recipient's ability for self care (age appropriate), as well as the parent's or legal guardian's capacity to care for their children.

Program Requirements

To qualify for this service, the recipient must be at risk of out of home therapeutic placement due to his/her emotional/behavioral disorder or reintegrating from out of home placement and score a Level five (5) or six (6) on the CALOCUS.

Services are based on the individual's unique needs, strengths and family culture with the goal of self-sufficiency. Documentation should incorporate the child/family's strengths and weaknesses and reflect their unique culture and values. Outcomes should include evidence of a decreased reliance on the formal system of providers and an increased reliance on family resources and informal supports.

This is a team-based service and there must be evidence of team coordination and interaction with the recipient and his/her family as a single organizational unit. A recipient would normally receive services at this intensive level for a ninety (90) to one hundred eighty (180) day period, depending on medical necessity, with a period of less intensive services to follow.

Services are individually designed in partnership with the recipient and his/her family to minimize intrusion into the family and maximize the skills necessary to increase independence. Telephone contact and collateral contacts (face-to-face and telephone) are allowed subject to the overall face-to-face service ratio referenced below. The contacts must be relevant to the ISRP and appropriately documented. PFII is comprehensive and includes all other rehabilitative services except initial assessment and medication management.

If a provider does not offer PFII services, the recipient/family must be given a list of PFII providers from which to choose a provider. The PFII provider must do all service planning until the recipient is no longer in need of intensive services. The referring provider may only provide the initial assessment, reassessment and medication management. At the completion of PFII services, the recipient may choose to return to the referring provider. Since a recipient has the freedom to choose providers, he/she may choose to refuse the PFII referral. The provider should document the effort to educate the recipient and family regarding the need for the intensive services provided by PFII.

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Service parameters must encompass the following:

Duration of Treatment

Services normally range from ninety (90) to one hundred eighty (180) days, depending on the presenting stabilization needs of the recipient and family. Providers may request a service extension in exceptional cases. However, the vast majority of recipients served should complete this phase of treatment within the allotted time range.

Intensity of Service

Services typically follow a course of treatment with intensive and frequent services in the early phases of treatment. A minimum of sixteen (16) contacts must occur within the first month. For the second and third months of services, an average of ten (10) contacts per month must occur. It is the expectation that service frequency will gradually reduce over the last two (2) months. All service contacts are subject to the face-to-face and community ratios described below.

Face-to-Face Contact and Location of Service

The majority of the service is provided face to face with the recipient (no less than sixty (60%) percent) of contacts over the span of the authorization period) in the home or other natural setting (no less than eighty percent (80%) of contacts over the span of the authorization period). The service shall be available at times convenient to the recipient/family needs and requests, including evening and weekends.

Team Caseload

Each team of three staff may not exceed a caseload of twelve (12) families at any given time. Staff to family ratio takes into consideration required evening and weekend coverage, crisis service needs, and geographical coverage.

Crisis Management

The provider must demonstrate the presence and application of policies and procedures addressing the following:

- **Availability**

The PFII team must be available for 24/7 telephone response and mobile outreach response to the recipient's home, school, etc., as needed. Coordination of care, resources and supports must be provided for each crisis episode.

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- **Planning and Management**

Comprehensive crisis protocols, including triage for psychiatric hospitalization must be developed, implemented and modified as needed. A crisis needs assessment with the participation of the family, must be completed for all recipients and families. The written crisis plan must clearly define intervention steps, incorporate natural supports and must not rely exclusively on professional resources. The plan must be filed in each recipient record and be re-evaluated and modified with each crisis that occurs.

Family Involvement

Services are family-driven, and they are an equal partner in all aspects of the service delivery. This includes involving the recipient/parents in strength based treatment planning. It also includes the recipient/parents involvement in the service planning meetings and signatures on the ISRP.

Team Case Coordination

There must be documentation of team coordination on each case at least once per week. This is covered under the PFII fee and is not a separate billable service. A structured weekly time should be set aside for team case coordination and review. All changes in the ISRP must be documented.

The team approach should incorporate flexible services and a capacity to address concrete therapeutic and environmental issues in order to stabilize the family situation as soon as possible. The best practice of such an approach should allow the child and family to view the services as delivered by a single organizational unit or team.

Comprehensive Mix of Services

PFII includes a comprehensive set of services designed to meet the mental health needs of the recipient and family. Services must be uniquely matched to each individual's presenting needs. Services shall include at a minimum:

- Crisis management,
- Intensive care coordination,
- Identification of needed community resources,
- Linkage to such resources,
- Follow-up to determine adequacy and appropriateness of resources,
- Individual and family counseling/therapy,
- Skills training, including all skills training delineated in the Community Support service description,
- Behavioral management,

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- Development of behavior management plans,
- Training of behavior management skills, and
- Monitoring, updating and adapting behavior management plan.

System Collaboration

Services for the recipient must address coordination and collaboration with family and significant others, and with other professional systems of care, including but not limited to education, OAD, OCDD, OJJ and OCS when appropriate.

The provider must take a lead in facilitating collaborative meetings, which include the recipient and family, in the various environments where the formal and informal supports are located.

The development of working relationships with other systems of service (i.e., schools, OJJ and OCS) may include written agreements such as memorandums of understanding, referral networks, etc. Such tools demonstrate the provider's capability and practice of providing services in the various related environments, including but not limited to homes (birth, relatives, adopted, foster), schools, temporary holding facilities, homeless shelters, etc.

Any requests for prior authorization of services for recipients involved in other systems of care shall include a copy of the treatment plan developed by that entity. This will ensure a full range of needed services are provided and prevent duplication of effort.

Staffing Requirements

PFII is provided by a team including the recipient, his/her family, significant others and a minimum of the following provider staff in each team (*total of three (3) staff per team*):

- One (1) full time team leader who is an LMHP with a minimum of three (3) years experience working with children, youths and their families; and
- Two (2) additional full time staff who must be one of the following:
 - An LMHP;
 - An MHP; or
 - An MHS.

No more than one staff member per team may be an MHS. No more than thirty three percent (33%) of contacts per authorization period may be provided by an MHS. Staff assigned to a PFII team must be exclusive to this team and provide no other services.

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Service Authorization Periods

- Interim – None
- Initial – up to ninety (90) days (review and/or authorization may be more frequent)
- Reassessment – up to ninety (90) days (review and/or authorization may be more frequent)

Psychosocial Skills Training – Group (Adult)**Service Definition**

Psychosocial Skills Training (PSR) - Group (Adult) is a face-to-face therapeutic program based on a psychosocial rehabilitation philosophy that assists persons with significant psychiatric disabilities to build the skills necessary to live successfully in the natural environments they choose.

This service should achieve the following outcomes:

- Enable the recipient to become a productive member of society, earn a wage, and live as independently as possible, thereby, reducing the recipient's dependency on state and/or federally funded programs.
- Achieve the restoration, reinforcement, and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of his/her psychiatric symptoms.
- Minimize the effect of mental illness.
- Maximize the recipient's strengths.

Clinical Exclusions

The provider shall not admit any recipient who poses a documented health and safety risk to himself/herself, to other recipients, or for whom the provider cannot provide the necessary care.

Program Requirements

A Psychosocial Skills Training program must be open and available for recipient participation no less than twenty-five (25) hours a week, and no less than five (5) hours per day. The service duration shall be based on individual need and as authorized on the recipient's ISRP. Sessions must be offered at times to meet the recipient's needs, including evenings and weekends.

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No collateral contact or other non-face to face service is billable under this service description. A group recreational outing is not a billable service.

Psychosocial Skills Training teaches skills necessary for the recipient to succeed in his/her environment including but not limited to:

- Daily and community living skills:
 - Nutritional services,
 - Food planning, grocery shopping, cooking, and eating,
 - Household maintenance, including house cleaning and laundry,
 - Money management and budgeting,
 - Shopping for daily-living necessities,
 - Community awareness and current events,
 - Identification and use of social and recreational skills,
 - Use of available transportation, and
 - Personal responsibility.
- Socialization skills:
 - Communication,
 - Interpersonal relationships, including those with roommate(s) and neighbors,
 - Problem solving/conflict resolution,
 - Management of sensory input and stress,
 - Natural support system development, and
 - Self-directed engagement in community social activities (development of a social-recreational plan for the recipient).
 - Decision-making skills.
- Adaptation skills:
 - Identification of behaviors that interfere with performance;
 - Development of interventions to alleviate problem behavior, including coping with symptoms of mental illness that affect the person's ability to successfully work and/or attend school;
 - Development of capacity to follow directions and carry out assignments; and
 - Acquisition of appropriate work habits.
- Development of leisure time interests and skills.
- Symptom management skills - focusing on day-to-day management of symptoms. (Technical medication training should be provided under the medication management service).

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- Identification and management of symptoms of mental illness.
- Compliance with physician's medication orders.
- Education in mental health/mental illness:
 - Management of symptoms of mental illness to minimize the negative effects of psychiatric symptoms which interfere with the recipient's daily living, financial management, personal development, and community integration (services that meet the definition of medication management should be provided by staff credentialed to offer that service); and
 - Developing skills necessary for the recipient to comply with prescribed medications.
- Work readiness activities as part of a clubhouse model (excepting skills related to a specific vocation, trade, or practice):
 - Work related social and communication skills;
 - Work related personal hygiene and attire;
 - Work related time management; and
 - Other related skills preparing the recipient to be employable.

This service must have an ongoing process to ensure that recipients participate in the development and periodic revision of program curricula. The curriculum must be designed to improve or maintain the recipient's ability to function in normal social roles and ensure that the methods and materials utilized are age and developmentally appropriate and culturally relevant.

It must utilize one (1) or more of the following three (3) Medicaid Behavioral Health Section designated psychosocial rehabilitation program models or combine elements from each in a clearly delineated program approach:

- Boston Psychiatric Rehabilitation Model,
- Clubhouse Model, or
- Social Skills Training Model.

Training material must include activities that will allow each recipient to practice the skill(s) taught during the group session and in natural settings. This will allow the recipient to further develop and integrate the skill taught. The training material must be organized into a specific number of sessions for each topic area (curriculum). If a recipient completes a curriculum but needs additional training, community support should be used during or after the group sessions as a more individualized method of training.

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If a provider does not offer PSR services, the recipient must be given a list of PSR providers from which to choose a provider. The name of the provider of choice is placed on the ISRP along with other requested services. The authorization staff will authorize all medically necessary services on the ISRP, by provider and send the prior authorization decision for each service to the appropriate provider.

It is the responsibility of the community support worker to ensure services are coordinated between the two (2) providers. Providers should develop ongoing working relationships with PSR providers in their area that may include the development of a memorandum of understanding.

Place of Service

Services must be provided in a location that ensures confidentiality. Locations including, but not limited to retail outlets, libraries, sporting events, etc. do not meet guidelines for confidentiality and may not be used for groups. Individual skills training could be provided in such locations, if related to the ISRP and conducted in a manner as to promote normalization and prevent stigmatization.

This service shall not be provided at a site that serves as a group living environment, such as a board and care facility, group home or apartment building that serves as a residence for more than one MHR recipient. No collateral contact or other non face-to-face service is billable under this service description. A group recreational outing is not a billable service.

Staffing Requirements

All staff providing direct services must have documented orientation to the psychosocial rehabilitation model used.

This service shall be furnished under the supervision of an LMHP who is on site a minimum of 50 fifty percent (50%) of the service operating hours. The supervising LMHP shall be a Certified Psychosocial Rehabilitation Practitioner (CPRP) as designated by the Commission for Psychiatric Rehabilitation Certification through United States Psychiatric Rehabilitation Association (USPRA). If the LMHP is not a CPRP, he/she must be eligible for certification with a written plan for achieving certification. This must be accomplished within twelve (12) months of the provider's certification or within twelve (12) months of being hired.

Providers must submit information requested by the Bureau regarding the certification status of each LMHP supervisor. Failure to do so may result in administrative sanctions or decertifying the program. If an LMHP does not pass the certification exam, a written corrective action plan must be submitted to the Medicaid Behavioral Health Section within thirty (30) calendar days of the notification.

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For more information regarding the CPRP certification process and exam, visit the USPRA website at www.USPRA.org.

The following individuals may provide psychosocial skills building (group):

- An LMHP or
- An MHP or MHS under the supervision of an LMHP.

The program must have a minimum of one (1) direct service staff for eight (8) recipients at all times of active program participation.

Group size may not exceed fifteen (15) recipients for any single skill building activity.

All staff providing direct services must have completed:

- The associated population-specific orientation, and
- Orientation to the psychosocial rehabilitation model used in the program.

Service Authorization Periods

- Interim – None
- Initial – ninety (90) days
- Reassessment – up to ninety (90) day

A recipient would normally participate in Psychosocial Skills Training Group (Adult) for six (6) to eighteen (18) months.