

35-014 Secure Psychiatric Residential Rehabilitation: Secure Psychiatric Residential Rehabilitation is a secure facility-based, non-hospital or non-nursing facility program for individuals disabled by severe and persistent mental illness, who are unable to reside in a less restrictive setting. These facilities are integrated into the community and provide programming in an organized, structured setting, including treatment and rehabilitation services and offer support to clients with a severe and persistent mental illness and/or co-occurring substance abuse disorders. These individuals demonstrate a moderate to high risk for harm to self/others and are in need of recovery, treatment, and rehabilitation services. The clients who are in need of this level of care have long standing limitations with limited ability to live independently over an extended period of time. These individuals have needed a high level of psychiatric intervention and have limitations in all three functional areas, vocational/educational, social skills and activities of daily living. See definitions in 471 NAC 35-001.01. The Secure Psychiatric Residential Rehabilitation program provides skill building and other related recovery oriented psychiatric rehabilitation services as needed to meet individual client needs. The Secure Psychiatric Residential Rehabilitation Program is designed to:

1. Increase the client's functioning while improving psychiatric stability so that s/he can eventually live successfully and safely in a less restrictive residential setting of his/her choice and capabilities;
2. Decrease the frequency and duration of hospitalization;
3. Decrease and/or eliminate all high risk, unsafe behavior to self or others; and
4. Improve the ability to function independently by improving ability to function.

35-014.01 Program Components: A secure psychiatric residential rehabilitation program provides a variety of on-site psychosocial rehabilitation and skill acquisition activities and treatment each day. The program must facilitate client driven skills training and activities as appropriate. A secure psychiatric residential rehabilitation program must provide services identified on the client specific Individual Treatment, Rehabilitation, and Recovery Plan, providing culturally-sensitive and trauma-informed care. The activities must include, but are not limited to:

1. Ongoing assessment;
2. Arrangement for general medical care including laboratory services, psychopharmacological services, psychological services, as necessary;
3. Provision of a minimum of 42 hours per week of on-site staff led psychosocial rehabilitation activities and skill acquisition;
4. Programming focused on relapse prevention, recovery, nutrition, daily living skills, social skill building, community living, substance abuse, education, medication education and self-administration, symptom management, and focus on improving the level of functioning to get to a less restrictive level of care;
5. Educational and vocational focus as appropriate; and
6. Access to community-based rehabilitation/social services to assist in transition to community as symptoms are managed and behaviors are stabilized.

35-014.01A Assessments: The following assessments must be completed:

1. A comprehensive mental health and substance abuse screening by a licensed mental health practitioner must occur prior to admission;
2. Following admission and within 24 hours of stay, a assessment by the program's psychiatrist must be completed;
3. A history and physical must be completed by a physician or Advanced Practice Registered Nurse (APRN) within 24 hours of admission or one must be completed within 60 days of admission and available in the clinical record;

4. Comprehensive strength-based biopsychosocial assessment must be completed within 14 days of admission to assess the client according to the requirements described in 471 NAC 35-014.01A1;
5. A nursing assessment must be completed by a Registered Nurse within 24 hours of admission; and
6. A functional assessment must be completed initially upon admission and annually with continued stay at this level of service.

35-014.01A1 Components of the Assessment: The assessment must be completed within the timeframe specified in the Secure Psychiatric Residential Rehabilitation program's policies and procedures, however, no more than 14 days after admission. Components 1 through 9 of this assessment must be completed by a licensed mental health practitioner. Clinical impressions, including diagnosis and recommendations for treatment and rehabilitation, must be completed by the program's psychiatrist. The assessment must be in narrative form and include the following components:

1. Client name, Medicaid identification number, emergency contact (name, relationship, and contact information), and other information of the client that is relevant;
2. Provider demographics including: provider name, address, phone number, fax number, and e-mail address, and other contact information;
3. Presenting problem, primary complaint including:
  - a. Signs, symptoms, problems and dysfunctions relating to mental illness;
  - b. Reason for referral to Secure Psychiatric Residential Rehabilitation services and referral source;
  - c. Name and title of the referral professional (MD, psychologist, APRN, or LIMHP);
  - d. Presenting problem from the client's and provider's perspective; and
  - e. External leverage to seek evaluation (courts, family and other);
4. Medical History:
  - a. Dental history and current needs;
  - b. Current medication list;
  - c. Compliance with medication (historical and current);
  - d. Current primary care physician (name and contact information);
  - e. Date of last physical exam and physician providing that assessment;
  - f. Recent hospitalizations; and
  - g. Major health concerns (such as STD's, HIV, Tuberculosis, Hepatitis, and pregnancy);
5. Employment/Education/Military History:
  - a. History of employment;
  - b. Educational history;
  - c. Military involvement; and
  - d. Strengths;
6. Alcohol/Drug History:
  - a. Primary drug(s) of choice;
  - b. Amount, frequency and duration of use;
  - c. Prior treatment(s), location and length of stay;
  - d. Current compliance with relapse prevention plan;
  - e. Periods of abstinence (supports needed);
  - f. Tolerance level/withdrawal/history of complications from withdrawal;
  - g. Prior alcohol/drug evaluations/recommendations, including scores and results of screening tools;

- h. Family history of alcohol/drug use; and
  - i. Other addictive behaviors (gambling, food, etc.);
- 7. Legal History (Information from Criminal Justice System):
  - a. Criminal history and consequences of criminal involvement;
  - b. Connection to alcohol/drug use;
  - c. Current legal charges/disposition of charges;
- 8. Family/Social/Peer:
  - a. Family members (age and level of involvement with client);
  - b. Adult or minor children (names, ages and level of involvement);
  - c. Parenting knowledge or skill level, history of system involvement (courts);
  - d. Social supports utilized by client (previous and current);
  - e. Housing (ability to maintain housing, type of current housing, need for assistance);
  - f. Recreational activities (client's preference);
  - g. Collateral information;
  - h. Client strengths as perceived by client and collateral contacts;
- 9. Psychiatric/Behavioral History:
  - a. Current diagnosis(s);
  - b. Previous treatment(s) and outcome(s) of treatment(s);
  - c. Current mental health and substance abuse providers and treatment currently provided;
  - d. Current psychiatric medication list;
  - e. Compliance with medication (historical and current);
  - f. History of self harm or threats to harm others;
  - g. Board of mental health commitments (reason and dates of commitment);
  - h. Abuse (to include sexual abuse, physical abuse, emotional abuse, neglect, witness domestic violence, victim/witness of community violence, physical assault; and
  - i. Trauma (serious accident/injury, sexual assault/rape, life-threatening medical illness, traumatic loss of a loved one, terrorist act, war/political violence/torture, disasters (tornado, earthquakes), sanctuary trauma (trauma while institutionalized), prostitution/sex trafficking;
- 10. Clinical Impressions: (must be completed by the licensed psychiatrist supervising the program and must be consistent with the psychiatrist's initial diagnostic interview):
  - a. Information that supports/justifies the recommendations; and
  - b. DSM diagnosis, Axis 1-5;
- 11. Recommendations by the program's psychiatrist:
  - a. Primary/ideal level of care;
  - b. Available level of care/barriers to ideal level of care; and
  - c. Client/family's response to recommendations;
- 12. Signature of psychiatrist and the licensed mental health practitioner completing the assessment; and
- 13. Date of signature.

35-014.01B Individual Treatment, Rehabilitation, and Recovery Planning: An initial Individual Treatment, Rehabilitation, and Recovery Plan must be completed within 24 hours of admission. Secure Psychiatric Residential Rehabilitation Service providers must develop an individual treatment, rehabilitation, and recovery plan with the client within 30 days following admission to the program. The plan must include substance abuse issues. The client's family and/or guardian must be included in all assessment

and treatment, rehabilitation, and recovery planning. The provider must make every effort to be available and responsive to the client's family and/or guardian to assist their involvement in the client's recovery. The plan must be reviewed and revised with the client, discussing and documenting the discharge plans a minimum of every 7 days according the following requirements.

35-014.01B1 Individual Treatment, Rehabilitation, and Recovery Plan: The master individual treatment, rehabilitation, and recovery plan must be based upon a comprehensive assessment and completed within 30 days of admission. This plan must:

1. Be oriented to the principles of recovery and meaningful client participation;
2. Apply the principles of recovery – to include meaningful client participation, and a life in the community of the client's choosing;
3. Incorporate and be consistent with best practices;
4. Include the client's individualized goals and expected outcomes;
5. Contain prioritized objectives that are measurable and time-limited;
6. Describe therapeutic interventions to be used in achieving the goals and objectives that are recovery-oriented, trauma-informed, and strength-based;
7. Identify staff responsible for implementing the therapeutic interventions;
8. Specify the planned frequency and duration of each therapeutic method;
9. Delineate the specific behavioral criteria to be met for discharge or transition to a lower level of care and reviewed weekly;
10. Include a plan developed with the client that includes strategies to avoid crisis or admission to a higher level of care using principles of recovery and wellness;
11. Include the signature of the client and/or parent/guardian;
12. Include health care proxy and trauma safety form when available and with client's consent;
13. Document that the individual treatment, rehabilitation, and recovery plan is completed within the timeframe specified in the program's policies and procedures;
14. Document that the plan has been reviewed, updated every 30 days, and revised according to client needs and progress; and
15. Document that the plan was reviewed by the program's treatment practitioners a minimum of every 30 days and that written revisions were approved, signed, and dated each 30 days by the program psychiatrist.

35-014.01C Treatment Services: The program must offer structured, planned treatment and rehabilitation services as prescribed by the individualized treatment, rehabilitation, and recovery plan. The following services must be available and offered to the client.

1. Individual Psychotherapy: An individual treatment and rehabilitation service between an identified client and a qualified licensed practitioner who focuses upon the identified goals of the individual treatment, rehabilitation, and recovery plan;
2. Group Psychotherapy: A service provided by a licensed clinician who is practicing within his/her scope of practice and offers a service in groups of no less than three and no more than twelve clients;
3. Family Therapy: Family therapy is a therapeutic service between the client and his/her family and a qualified licensed practitioner who provides intervention as identified by the family-focused goals of the individual treatment, rehabilitation, and recovery plan. Consent from the

- client must be documented prior to the involvement of the family and delivery of the service; and
4. Psychoeducational services, such as medical education by a registered nurse and skill development groups by a trained and skilled staff able to facilitate these groups supervised by licensed mental health practitioners.

35-014.01D Supportive Services: The program must provide the following supportive services for all active clients: referrals as necessary, problem identification/solution, and coordination of the Secure Psychiatric Residential Rehabilitation program treatment and activities with other services the client may be receiving.

35-014.02 Staffing: The Secure Psychiatric Residential Rehabilitation provider must contract with or employ a licensed psychiatrist for the program. The psychiatrist's hours must be at a sufficient level to provide weekly direct contact with the client; to provide assessment; to review the individual treatment, rehabilitation, and recovery plan; to evaluate client's level of progress; to assist in eliminating barriers to recovery; and to provide psychiatric consultation as necessary on a 24/7 basis. Programs must have staff available in skill and numbers to meet the acuity of the clients being served. Programs must have ability to call staff back when necessary.

35-014.02A Staffing Standards: Secure Psychiatric Residential Rehabilitation providers must meet the following minimum staffing requirements. The program must employ a:

1. Program Director;
2. Licensed Mental Health Practitioner (LMHP) or a Licensed Mental Health Practitioner/Licensed Alcohol and Drug Counselor (LMHP/LADC). A dual Licensed Practitioner is preferred;
3. Registered nurse;
4. Direct care staff.

35-014.02A1 The Program Director must:

1. Be fully licensed as a Mental Health Practitioner (APRN, RN, LMHP, LIMHP or psychologist); and
2. Possess leadership, supervisory, and management skills.

35-014.02A1a Responsibilities of the Secure Psychiatric Residential Rehabilitation Program Director: The program director must:

1. Complete and sign a comprehensive Biopsychosocial Assessment for each client within 14 days of admission or delegate responsibility for the assessment to the program's licensed practitioner who functions as the therapist for the program;
2. Develop, approve, and sign an initial individual treatment, rehabilitation, and recovery plan within the first 24 hours of admission;
3. Supervise and participate in the development of a comprehensive individual treatment, rehabilitation, and recovery plan with the client and the program staff within 30 days of admission. The program director must approve and sign the plan prior to implementation;
4. Supervise the professional staff and direct care staff by on site presence during programming;

5. Assure adequate staff training through initial and ongoing training sessions and provide supervision of staff competency checks;
6. Supervise and provide direction regarding all documentation requirements, including organization and completeness of clinical records; and
7. Supervise and direct the development and implementation of the discharge plan.

35-014.02A2 Responsibilities of the Registered Nurse: The registered nurse must:

1. Complete a nursing assessment within 24 hours of admission;
2. Participate in the development of the individual treatment, rehabilitation, and recovery plan and the plan updates;
3. Oversee and monitor daily medication administration;
4. Provide medication education as necessary;
5. Communicate with the psychiatrist and physician consultants as necessary;
6. Monitor, supervise, and oversee the program's daily activities in conjunction with and in the absence of the Program Director.

35-014.02A3 Responsibilities of the Mental Health Practitioner: The mental health practitioner must:

1. Complete a biopsychosocial assessment within 14 days of admission when this responsibility is delegated by the program director;
2. Participate in the development of the individual treatment, rehabilitation, and recovery plan and the updates;
3. Provide individual, group and family psychotherapy according to the client's individual treatment, rehabilitation, and recovery plan;
4. Communicate with the Program Director and psychiatrist regarding the clinical needs of the client as necessary;
5. Monitor, supervise, and oversee the program's daily treatment and activities in the absence of the Program Director as assigned by the Program Director;
6. Assist with aggressive discharge planning; and
7. Maintain a maximum staffing ratio of 1 to 8 clients.

35-014.02A4 Direct Care Staff: The Secure Psychiatric Residential Rehabilitation Program must employ direct care staff who:

1. Are on site and available to the clients at a ratio of one staff per four clients during awake hours and a minimum of one awake direct care per staff per six clients during overnight hours;
2. Staff to client ratios must be enhanced to meet client need as necessary.
3. Direct Care staff having a bachelor's degree in psychology, sociology or related human services field but two years of course work in the human services field and two years of experience/training or two years of lived recovery experience is acceptable. Each staff must have demonstrated skills and competency in treatment with individuals with mental health diagnosis.

35-014.03 Discharge Planning: Throughout a client's care and whenever the client is transitioned from one level of care to another, discharge planning must occur in advance of this discharge. It must include the client's and client's family/legal guardian's input and be documented in the client's clinical record. The plan must be recovery-oriented, trauma-informed, and strength-based.

Providers must meet the following standards regarding recovery and discharge planning:

1. Discharge planning must begin on admission to the service with input and participation of the client and client's family/guardian;
2. Discharge planning must include the client and family input and be consistent with the goals and objectives identified in the individual treatment, rehabilitation, and recovery plan and clearly documented in the clinical record;
3. Discharge planning must address the client's needs for ongoing services to maintain the gains and to continue as normal functioning as possible following discharge. A crisis/relapse/safety plan must be in place;
4. Providers must make or facilitate referrals and applications to the next level of care and/or community support services, such as use of medications, housing, employment, transportation, and social connections;
5. Providers must arrange for the prompt transfer of clinical records and information to ensure continuity of care; and
6. A written discharge summary must be provided as part of the clinical record. It must identify the readiness for discharge and contain the signature of a fully licensed clinician and date of signature and must identify a summary of the services provided.

35-014.04 Clinical Documentation: Secure Psychiatric Residential Rehabilitation service providers must maintain a clinical record that is confidential, complete, accurate, and that contains up-to-date information relevant to the client's care and services. The record must sufficiently document comprehensive assessments; individual treatment, rehabilitation, and recovery plans; and plan reviews. The clinical record must document client contacts describing the nature and extent of the services provided, so that a clinician unfamiliar with the service is able to identify the client's service needs and services received. The documentation must reflect the rehabilitative services provided; that the care is consistent with the goals in the individual treatment, rehabilitation, and recovery plan; and that the care is based upon the comprehensive assessment. The absence of appropriate, legible, complete records may result in the recoupment of previous payments for services. Each entry must identify the date, beginning and ending time spent providing the service and location of service, and identify by name and title the staff person entering the information.

Clinical records must be maintained at the client's primary rehabilitation site. Records must be kept in a locked file when not in use. For purposes of confidentiality, disclosure of rehabilitation information is subject to all the provisions of applicable State and Federal laws. The client's clinical record must be available for review by the client (and his/her guardian with appropriate consent) unless there is a specific medically indicated reason to preclude this availability. The specific reason must be documented in the clinical record and reviewed periodically.

35-014.05 The clinical record must include, at a minimum:

1. Client identifying data, including demographic information and the client's legal status;
2. Assessment and Evaluations:
  - a. Psychiatric assessment, including the name of the clinician and the date of the assessment;
  - b. Comprehensive Biopsychosocial Assessment; and
  - c. Other related assessments;
3. The client's diagnostic formulation (including all five axes);
4. The Individual Treatment, Rehabilitation, and Recovery Plan and updates to plans;
5. Documentation of review of client rights with the client;
6. A chronological record of all services provided to the client. Each entry must include the date the intervention was performed, the duration of the intervention (beginning and ending time), the place of the service, and the staff member's identity and legible signature (name and title);
7. Documentation of the involvement of family and significant others;
8. Documentation of treatment and recovery services and discharge planning;
9. A chronological listing of the medications prescribed (including dosages and schedule) for the client and the client's response to the medication;
10. Documentation of coordination with other services and treatment providers;
11. Discharge summaries from previous levels of care;
12. Discharge summary (when appropriate); and
13. Any clinical documentation requirements identified in the specific service.

35-014.06 Clients' Rights: Individual staff and the treatment, rehabilitation, and recovery team must provide interventions in a manner that support and maintain the client's rights with a continuous focus on client empowerment and movement toward recovery. Secure Psychiatric Residential Rehabilitation programs must have written a client rights and responsibility policy. Staff must review client rights, responsibilities, and grievance procedures with each new client at admission and on an ongoing manner, and must document this review in the clinical record. Secure Psychiatric Residential Rehabilitation programs must comply with all state and federal clients' rights requirements.

The following rights apply to clients receiving secure psychiatric residential rehabilitation services through Medicaid. The client has the right to:

1. Be treated with respect and dignity regardless of state of mind or condition;
2. Have privacy and confidentiality related to all aspects of care;
3. Be protected from neglect; physical, emotional, or verbal abuse and exploitation of any kind;
4. Be part of developing an individual treatment, rehabilitation, and recovery plan and decision-making regarding his/her mental health treatment and rehabilitative services;
5. Refuse treatment or therapy (unless ordered by a mental health board or court);
6. Receive care which does not discriminate and is sensitive to gender, race, national origin, language, age, disability, and sexual orientation;
7. Be free of any sexual exploitation or harassment; and
8. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed in a timely manner.

35-014.07 Provider Participation: To participate in Medicaid as a provider of secure psychiatric residential rehabilitation services, a program must be enrolled as a Nebraska Medical Assistance Program provider according to the Medicaid regulations. Providers must complete the credentialing into the Medicaid Managed Care network prior to providing services to Medicaid Managed Care beneficiaries. The provider must complete and sign Form MC-19, "Medical Assistance Provider Agreement," and be approved for enrollment in Medicaid. In addition, eligible providers must also provide documentation as requested. Providers must notify Medicaid and/or its designee of any substantive changes in the program or staff providing services. Providers are required to provide annual updates of program information and cost information to determine ongoing compliance with Medicaid regulations. Providers must maintain documentation of policies and procedures that meet the standards and regulations described in this chapter.

35-014.08 Licensure and Accreditation Requirements: The program must be licensed as a Mental Health Center by the Department of Health and Human Services, Division of Public Health, and it must be accredited by a national accrediting agency such as The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA). Providers must have maintained their licensure and accreditation as a condition for continued participation in Medicaid.

35-014.09 Bed Limitation: The maximum capacity for the provider of secure psychiatric residential rehabilitation services must not exceed 16 beds. There must be no waiver of this regulation over the 16-bed limitation.

35-014.10 Treatment Prior Authorization: All Secure Psychiatric Residential Rehabilitation Services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee. These reviews include prior authorization and continued stay reviews. Referrals for Secure Psychiatric Residential Rehabilitation Services must be directed to the Division of Medicaid and Long-Term Care or its designee and must follow established protocols for prior authorization and utilization management.

35-014.11 Therapeutic Pass Days: Therapeutic passes are an essential part of the rehabilitation process for clients involved in secure psychiatric residential rehabilitation services. Documentation of the client's continued need for secure psychiatric residential rehabilitation services must follow overnight therapeutic passes. Therapeutic passes must be indicated in the individual treatment, rehabilitation, and recovery plan as therapeutic passes become appropriate. Medicaid reimburses for 21 therapeutic pass days per client per calendar year when the client is on therapeutic leave for purposes of testing ability to function and transition to lesser level of care.

35-014.12 Hospitalizations: In the event that a client does require hospitalization while in a secure psychiatric residential rehabilitation program, Medicaid will reimburse the Secure Psychiatric Residential Rehabilitation Program for up to ten days per hospitalization. This reimbursement is only available if the bed is not used by another client and the client returns to the bed occupied prior to hospitalization.

35-014.13 Inspections of Care (IOC): The Division of Medicaid and Long-Term Care or its designee may periodically inspect the care which includes the treatment, rehabilitative, and recovery services provided to clients in each type of service. The Inspection of Care team will include staff who are knowledgeable about mental health and rehabilitative psychiatric services and may include clients and/or Division of Medicaid and Long-Term Care consultants.

The purpose of the Inspection of Care is to assess compliance with Medicaid regulations and provide technical assistance to providers.

The activities of the Inspection of Care may include, but are not limited to:

1. Review of clinical documentation;
2. Client interviews;
3. Program review with staff;
4. Review of physical plant;
5. Review of provider policy and procedures;
6. Staff interviews;
7. Financial and payroll records; and
8. Employment records of staff qualification and training issues.

After an Inspection of Care, the IOC team will develop a report summarizing the findings of the visit. If deficiencies are noted, providers must submit a plan of correction.